E&M CODING: BILLING FOR TIME, PROLONGED SERVICE CODES, COUNSELING AND COORDINATION, TRANSITIONAL CARE MANAGEMENT AND CHRONIC CARE MANAGEMENT

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Evaluation and Management (E&M) codes are used to bill for patient encounters in the office and on inpatients. E&M codes were created in 1992 by the American Medical Association. Under this system, billing must be supported by clear documentation in the 3 areas of history, patient examination and medical decision making. The patient visits are divided into consultations, new patients, and establish patients. Five codes exist for new patients, consultations, and establish patients in the outpatient setting. For inpatients, there are 3 initial hospital visit codes, 3 for subsequent hospital visits, 5 for consultations, and 2 for discharge days.

This course will discuss billing for counseling and coordination of care, extended visits using the prolonged service codes, transitional care management, and chronic care management. For the most part, these codes do not use information from history taking, the neurologic examination, and medical decision making.

Coding for Counseling and Coordination of Care

When counseling and/or coordination of care dominates a patient encounter, then time is considered the key or controlling factor for selection of a particular level of evaluation and management. The time must be documented in the chart. The face-to-face time associated with services described by any evaluation and management code is a proxy for total work done during the visit on the day of the visit (with the patient present or in proximity). Non-face-to-face time for office services is not included in the time component for the evaluation and management code.

Counseling is a discussion with the patient or family about prognosis, test results, recommended tests, treatment and treatment alternatives, compliance, risk factor reduction and patient and family education. Coordination of care is the arrangement of care with other healthcare providers. This includes any type of coordination of care activity. All of them take considerable commitments of time and serve as justification for billing. Most patient encounters include a combination of history taking, examination, differential diagnosis, and counseling and coordination of care. If more than 50% of the time is spent in counseling and coordination of care, the code would be chosen by the total time spent with the patient and family. A real life example would be a patient with amyotrophic lateral sclerosis who had just been given the diagnosis. The patient asked for a return visit to expound on the diagnosis and to discuss treatment options with his family. Approximately 40 minutes is spent in this counseling session. This would allow the physician to bill a level 5 established visit because of the time factor of 40 minutes. Each evaluation and management code is assigned a time. Table 1 lists the assigned time for new patients and establish patients in the inpatient and outpatient setting.

Table 1

New Outpatient E&M Codes

99201	10 minutes
99202	20 minutes
99203	30 minutes
99204	45 minutes
99205	60 minutes

Established Outpatient E&M Codes

99211	5 minutes
99212	10 minutes
99213	15 minutes
99214	25 minutes
99215	40 minutes

Outpatient Consultation E&M Codes

99241	15 minutes
99242	30 minutes
99243	40 minutes
99244	60 minutes
99245	80 minutes

Initial Hospital Care E&M Codes

99221	30 minutes
99222	50 minutes
99223	70 minutes

Subsequent Hospital Care E&M Codes

99231	15
99232	25
99233	35
99238	30 minutes or less
99239	More than 30 minutes

Initial Inpatient Consultation E&M Codes

99251	20 minutes
99252	40 minutes
99253	55 minutes
99254	80 minutes
99255	110 minutes

Follow up inpatient consultation codes no longer exist. For follow up visits, one uses subsequent hospital care E&M codes.

There are many reasons why one may wish to bill using time rather than bullets for history, exam, and medical decision making. Billing by time is advisable if your patient wants to have a discussion about his or her condition. Another would be if your patient's exam is stable and a repeat examination would not be important to the context of the visit. You may want to bill for time if you wish to review and order additional laboratory studies, including discussion of risks, benefits and alternatives, and completing informed consent for high risk medications. Other reasons might be the discussion of high risk treatments and the patient's and family's desire for more information about the illness and treatment. Since a physician cannot bill for a phone call, a brief follow-up office visit would allow the neurologist to bill for services using time. If coordination of care is a major component of the visit, billing for time would permit the neurologist to receive compensation for time expended. Time-based billing is a good use of your time and patient time if you perform a lot of education and counseling. Appropriate billing is justified and ethical and should be considered a good business practice.

Coding for the Discharge Day

Many neurologists are not aware of the discharge day codes. Code 99238 would be billed for 30 minutes or less spent on the discharge day with the patient. Code 99239 would be used if more than 30 minutes was expended. The discharge codes are used to summarize all services on the day of discharge including the final examination, discussions, creation of prescriptions, form completion, preparation of discharge records, and referral forms. Time need not be continuous. Total time must be documented for code 99239. A neurologist would not use the inpatient establish codes on the day of discharge as the appropriate codes are 99238 and 99239.

Prolonged Service Codes

Prolonged service codes can be used to bill for direct face-to-face contact in the outpatient setting and for face to face and non-face to face time in the inpatient setting. These codes are used in addition to the standard evaluation and management codes on the same day of service. An hour is defined as 30–74 minutes. The time with the inpatient does not have to be face to face. The codes and required time expenditure are listed below:

- Code 99354-outpatient for additional 30–74 minutes
- Code 99355-outpatient for each extra 30 minutes after the first hour (coded with 99354).
- Code 99356- inpatient for additional 30–74 minutes
- Code 99357- inpatient for each additional 30 minutes after the first hour (coded with 99356)

Transitional Care Management Services

Transitional care management (TCM) codes were developed to allow physicians to bill for services delivered after discharge from the hospital and other settings. They became effective in January 2013. The TCM service must be provided over a 30 day period beginning on the date of the patient's discharge from the inpatient hospital setting and continuing for the next 29 days.

TCM codes are used to report physician or qualifying non-physician practitioner care management services for a patient following the discharge from a hospital, skilled nursing facility, a community mental health center (CMHC), outpatient observation, or partial hospitalization. The patient must be returned to a community setting such as a home, domiciliary, a rest home, or assisted living. Non-physician practitioners include clinical nurse specialists, nurse practitioners, and physician assistants. Medicare will only pay one physician or qualified practitioner for TCM services per beneficiary over the 30 day period following the discharge. It will pay the first eligible claim submitted during the 30 day period that commences on the day of discharge. Other practitioners may continue to report other reasonable and necessary services, including E/M services during those 30 days, but may not bill a TCM code. TCM services are provided in the outpatient setting. Each of the codes includes 3 components: an interactive contact, certain non-face-to-face services, and a face-to-face visit.

Code 99495 requires the following elements:

- Communication by direct contact, telephone, or electronic transmission with the patient and/or the caregiver within 2 business days of discharge from the hospital.
- Medical decision making of at least moderate complexity during the service.
- A face to face visit within 14 calendar days of discharge.

Code 99496 requires the following elements:

- Communication by direct contact, telephone or electronic correspondence with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity during the service.
- A face-to-face visit, within 7 calendar days of discharge.

The face-to-face visit is part of the TCM service and is not reported or billed separately. Medical decision making is determined by the same factors used when billing E & M codes by bullets. Medical decision making is divided into straightforward, low complexity, moderate complexity, and high complexity

TCM services can be reported if the patient is re-admitted in the 30 day period as long as the services described in the code were furnished by the practitioner during the 30 day period, including the time following the 2nd discharge. If the beneficiary dies prior to the 30th day after discharge, the TCM service may not be billed, but any face-to-face visits occurring during the 30 day would be billable using the appropriate E/M code.

RVUs for 99495 professional fee and practice costs: 4.60 in 2016, 4.61 in 2017
RVUs for 99496 professional fee and practice costs: 6.49 in 2016, 6.52 in 2017

Complex Chronic Care Coordination Codes

The chronic care management codes became effective January 1, 2015 for non-face-to-face care coordination services provided to Medicare beneficiaries with multiple chronic conditions. These codes can be used by neurologists who care for patients with comprehensive care needs compared to those whose practice is consultation only. The codes allow payment for clinical

staff time between visits, i.e., work by the office nurse or medical aides. Satisfying the requirements for the complex chronic care management codes is difficult. Strict requirements exist for using the codes. The codes can be billed only by the neurologist who assumes most of the care for patients with chronic neurologic illness. For details on the use of these codes, one is directed to the excellent article by Marc Nuwer, M.D. in Neurology Clinical Practice 2015:5:430-435.

Three chronic care management CPT codes exist and are listed below. Please note the first code is considered routine. The last 2 codes are complex. Code 99487 and 99490, but not both, may be reported once in a calendar month. Only one physician may submit a chronic care management code in a given month. Other qualified healthcare professionals, such as a nurse practitioner (NP), may bill these codes but not if he or she is under the guidance of a physician. The physician may bill the chronic care management codes for services provided by any of his or her clinic staff, even those provided by a nurse practitioner as long as the NP is an employee. Under the chronic care coordination codes, the physician serves as the general supervisor. The term general means that the care is furnished under the physician's overall direction and control but the physician does not have to be present during performance. The physician does not have to be on-site to satisfy the requirements for general supervision.

In the year 2016, CMS reimbursed only for the routine code, 99490. Beginning in 2017, CMS is paying for codes 99487 and 99489. Private payers have their own coverage plans.

To use any of the chronic care management codes, a patient must have at least 2 chronic continuous or episodic health conditions. Chronic is defined as a condition expected to last at least 12 months or until the patient's death. Patients with a single chronic disorder do not qualify.

99490 Routine Code

Code 99490 would be used for chronic care management services, at least 20 minutes of clinical staff time, directed by a physician or other qualified healthcare professional per calendar month with the following required elements:

- Two or more chronic conditions expected to last at least 12 months or until the death of the patient
- Chronic conditions placing the patient at significant risk of death, acute exacerbation or decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

99487 Complex Code

Complex chronic care management services with the following required elements:

- Two or more chronic conditions expected to last at least 12 months or until the death of the patient
- Chronic conditions that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline

- Establishment or substantial revision of a Comprehensive Care Plan
- Moderate or high complexity of medical decision-making
- 60 minutes of clinical staff time directed by physician or other qualified healthcare professional per calendar month

99489 Complex Code

- Each additional 30 minutes of clinical staff time directed by physician or other qualified healthcare professional per calendar month (list separately in addition to code for primary procedure, 99487)

Practices must use an electronic health record system in order to bill for the chronic care management codes. All of the chronic care management codes require the reporting of time. Time is collected for all staff participation between visits. Total time for a calendar month must be summated and reported in one note. The patient cannot be an inpatient, in observation care, or in a skilled nursing facility for the minutes to count. There are no strict rules for the billing date, except the billing must be limited to one per calendar month. A recommended practice would be to bill on a specific date during the month. Often the last date of the month would be a good time to summate minutes and submit the bill. Physicians may report standard E&M codes in addition to chronic care management codes during the same calendar month. One must keep in mind that time expended during the evaluation and management service cannot be used towards the total sum of time used to bill for the chronic care management codes.

Typical services that may be included toward billing the chronic care management codes include communication with the patient, family, caretaker, other healthcare professionals, communication with home health agencies, collection of health outcomes data, education of the patient and family, medication management, identifying community and health resources, facilitating access to care, reviewing laboratory studies, and developing, communication and maintenance of a Comprehensive Care Plan.

The care plan addresses all of the health care problems and needs of the patient. Informed consent must be obtained from the patient in order to bill the complex chronic care coordination codes.

The care plan must satisfy a long list of management topics including the problem list, prognosis, measurable treatment goals, medication management, plans to coordinate community and social services, and plans for periodic review and revision of the Care Plan. Note that the patient may revoke the care plan at any time.

The neurologic care plan must provide 24 hour service, 7 days per week with easy access to physicians or clinical staff for urgent needs. Communications may include telephone contact, messaging, internet access, or other secure methods.

The patient must consent to receive the chronic care management services. The patient will be required to pay the co-payments for the service. The current Medicare allowed payment for the routine chronic care management code, 99490, is $40 – 45 per month and the Medicare co-payment would be 20% of the amount.

RVUs for 99490 for professional and practice expenses: 1.14 in 2016 and 1.19 for 2017

RVUs for 99487 for professional and practice expenses: 0.00 in 2016 and 2.61 for 2017
RVUs for 99489 for professional and practice expenses: 0.00 in 2016 and 1.31 for 2017

CF or conversion factor for Medicare payments: $35.89 for 2017.

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