Eli's Rehab Report

Reader Question: Show Payer the Time You Spend on E/M

Question: One of our insurers downcodes my E/M visits because the diagnoses don't support the service levels that I billed. But I coded these visits based on time, not E/M elements. How can I get paid for higher-level counseling visits?

Nebraska Subscriber

Answer: To prove a visit qualifies for time-based E/M billing, make sure the documentation includes the ratio of the total visit time to the counseling time. This will show the payer that you spent the majority of the visit (more than 50 percent) counseling the patient and/or his family.

Suppose a hip-replacement patient presents for a six-month follow-up after surgery. The patient is concerned about swelling in her opposite hip because she relied so heavily on it during her recovery. The physiatrist performs a level-two established patient office visit (99212, Office or other outpatient visit for the evaluation and management of an established patient ... physicians typically spend 10 minutes face-to-face with the patient), which takes eight minutes. He then spends another 20 minutes discussing exercises that the patient should perform to strengthen her weak leg. He also advises her about the appropriate over-the-counter medications that can alleviate her hip pain but won't interact poorly with her heart medications. For the 28-minute visit you should report 99214 (... physicians typically spend 25 minutes face-to-face with the patient).

Using the documentation tool, you should report "28/20," which represents 28 total-visit minutes and 20 counseling minutes. If the payer downcodes the office visit due to the diagnosis code(s), you should appeal and submit the notes showing that you coded the visit based on time.