Greetings!

Hello, and a warm welcome to our subscribers, both new and old!

It’s that time of year when we’re all getting ready to enjoy the holiday season with family, friends and plenty of good food. We hope that all of you will have the opportunity to take a break from your busy schedules to spend time with those you love!

In this month’s issue we’re pleased to provide a variety of articles on how to code more accurately, and how to better use time-based coding to get the most out of your billing dollar. We also encourage everyone to check out our free online CEU management website at www.CEUManager.com. CEUManager allows you to add, view and print your CEU information at any time, without the paper chase!

As always, our goal is to provide you with the tools and tips you need to make your job easier. Enjoy!

Shirley Moy
President
Spring Management Systems, Inc.

In This Issue:

<table>
<thead>
<tr>
<th>Time-Based Coding</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Top 7 Ways to Smooth Out Wrinkles in Your Observation Coding</td>
<td>2</td>
</tr>
<tr>
<td>Coder’s Forum</td>
<td>3</td>
</tr>
<tr>
<td>Smile!</td>
<td>4</td>
</tr>
</tbody>
</table>

“Learn the rules of coding by time, and get paid correctly for what you do.”

-Bill Dacey, CPC

“With a correct understanding of time, and how it relates to coding, physicians can know when a higher code may be justified, even though the history, exam and medical decision-making elements may be lacking.”

-Aris Sophocles, MD, JD

Time-Based Coding

You’ve read the CPT Manual, taken the coursework, and immersed yourself in learning how to document the three Key Components of history, exam, and medical decision-making. But have you considered that you might still be under billing if you aren’t utilizing time-based coding?

In order to code based on time, the doctor-patient encounter must include significant time in counseling or coordination of care. As a matter of fact, more than 50% of the time spent must focus on activities involving either direct communication with the patient, or as in the case of inpatient care, the coordination of treatment and review of the patient’s condition.

Interestingly, many providers are unaware of the potential of time-based coding. A visit is often coded unnecessarily low simply because the time-based aspect of the encounter is ignored.

For example, it may be that during an office visit the doctor is required to talk at length with the patient about test results and the actions or lifestyle changes necessary to treat the patient. In this case the focus was on counseling, and not specifically on the components of history, exam, and decision-making. To assign the proper code, it would most likely be necessary to record the time spent talking with the patient in relation to the time spent for the entire visit, including sufficient supporting details regarding the topics covered during the counseling session.

This last is an important point, and often overlooked. When time-based coding is involved, most payers do not want a “standardized” description of the session, but would prefer real details of the doctor-patient encounter. Proper documentation of what was discussed may mean the difference between quick reimbursement or a more prolonged effort to support a specific code.

In regards to inpatient care, the most significant difference in time-coding is the fact that you’re tracking the time spent in a **24-hour period** rather than in a single office visit. According to the E&M section guidance in the CPT Manual: “For reporting purposes, intra-service time for these services is defined as unit/floor time, which includes the time that the physician is present on the patient’s hospital unit and at the bedside rendering services for that patient. This includes the time in which the physician establishes and/or reviews the patient’s
Even though you know the general rules for reporting observation services in the ED, certain coding mistakes show up more often than you think. Read this to be sure your practice isn't falling prey to observation mishaps.

1. **Dismiss location**

Billing observation services doesn't rely on where the physician performed them. Observation is a type of service, not necessarily a physical place within the emergency department where the patient stays.

2. **Make sure the physician provides the order**

Check the patient's medical record to ensure the physician leaves an indication that he ordered the patient into observation status. You'll need a time note from the doctor, as well as the nurse's time note.

3. **Avoid using observation as a holding space**

The purpose behind observation status is to determine the patient's need for admission, so don't use 99218-99220 (Initial observation care) when observation isn't medically indicated. Remember: The physician needs to order observation prospectively, not retroactively--don't just call a service observation because you have a chunk of care time without a home.

4. **Don't bill a related E/M code and an observation code for the same encounter**

Since you can't report them together, you have to choose between them. Either report an upper-level E/M code, such as 99284 Emergency department visit for the evaluation and management of a patient, which requires these three key components: a detailed history, a detailed examination, and medical decision-making of moderate complexity) or 99285 (...within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history, a comprehensive examination, and medical decision-making of high complexity), or opt for an observation code instead. You can, however, bill for additional procedures or diagnostic test alongside observation codes.

5. **Observation histories and exams require more than the corresponding ED E/M code**

For example, a "comprehensive" observation history requires you to list three out of three elements for the patient's past/family/social history, whereas the ED E/M codes (99281-99285) only ask you for two of three. For all of the observation codes, you're looking at either detailed or comprehensive physical examinations.

6. **Don't skimp on time documentation**

To bill 99234-99236 (Observation or inpatient hospital care), the doctor must have documentation that satisfies the requirements for both admission to and discharge from inpatient or observation care. Make sure the physician includes the following: length of time for treatment status, timed nursing notes, and timed physician notes. You need to see evidence in the medical record of every time the physician talked to the patient, observed him, checked on his condition, re-examined him, or looked at diagnostic tests.

7. **Bill only once for same-group physicians**

If two physicians in the same group practice both provided observation care to the same patient, you shouldn't report it twice. Trouble: You can't bill an ED E/M service for Physician A and observation for Physician B, either. You'll just have to choose one.

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Tips provided by **Caral Edelberg, CPC, CCS-P, CHC**, President/CEO, Medical Management Resources of TEAMHealth, Jacksonville, Florida (May 2, 2006 - Used By Permission)
What Is CEUManager?

CEUManager is a FREE, online CEU tracking service designed to help you stay certified without the paper chase!

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Coder's Forum

Question: How do I tell whether to bill for a new patient visit or a consult?

Answer:
The rules concerning consultative visits have been vague, but it is important to get the distinction correct since you will lose money if you keep it simple and code everything as a new patient visit.

Most of the confusion happens when patients are referred to a specialist to get an evaluation, and the specialist not only reviews the case and offers an opinion, but also actually initiates treatment. Is that a consult or a visit?

Luckily, Medicare has clarified what counts as a consult. According to the new explanation, a first-time, consultative visit during which care is delivered can be billed as a consult. Specifically, a consult is distinguished from a visit if:

• it is provided by a physician whose advice is requested by another physician or other appropriate source (not the patient himself);
• the need for a consultation is documented in the patient's medical record; and

• the consultant provides a written report of his or her findings to the referring physician.

The Center for Medicare and Medicaid Services (CMS), formerly the Health Care Finance Administration, tells its carriers to pay for an initial consultation if all these criteria are satisfied — regardless of treatment initiation — unless the referring physician transfers the responsibility for the patient’s complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance. If that's the case, you need to report a new or established patient visit instead.

Still confused? Here’s an example from CMS’ Web site of what it considers a consult:

An internist sees a patient that he has followed for 20 years for mild hypertension and diabetes mellitus. The patient exhibits a new skin lesion and the internist sends the patient to a dermatologist for further evaluation.

The dermatologist examines the patient and removes the lesion, which is determined to be an early melanoma. The dermatologist dictates and forwards a report to the internist regarding his evaluation and treatment of the patient.

Based on University of Florida College of Medicine Compliance Tip
chart, examines the patient, writes notes and communicates with other professionals and the patient’s family.”

In other words, a more accurate time-based code would include the work done on charts, coordinating care with nurses, and reviewing patient care with the family - not just the time spent on morning rounds!

If you’d prefer to take the guesswork out of whether or not time-based coding is the most efficient approach for any given visit, you might want to invest in an accurate coding software package. For example, E&M Coder provides the opportunity to include all chart elements as well as documentation of the time spent with the patient. The appropriate E&M code is assigned based on the approach that produces the highest code. By simply entering the visit data accurately, you will always produce consistent, cost effective results without having to spend unnecessary time on option analysis.

In conclusion, it might be more valuable than you think to learn the rules of time-based coding. It’s your time - make the most of it!

To read more about Time-Based Coding, try these two great articles:
“CODING: Your Time Has Value, Too” - by Bill Dacey, CPC, (www.physicianspractice.com)
“Coding on the Basis of Time for Physician Services” by Aris Sophocles, MD, JD, (www.aafp.org)

A woman went to see her doctor. After about 15 minutes with one of the new doctors, she went screaming down the hall. Another doctor stopped and asked her what the problem was and she explained.

The second doctor went back to the first and said, “What’s the matter with you? Mrs. Terry is 63 years old. She has four grown children and seven grandchildren and you told her she was pregnant?”

The new doctor simply smiled and said, “Cured her hiccups though, didn’t it?”

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