Coding for Coordination of Patient Care

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Physicians who spend significant time coordinating a patient's care may realize reimbursement in several ways.

**Source:** Physicians Practice

Physicians who spend significant time coordinating a patient's care may realize reimbursement in several ways.

**TIME-BASED E&M SERVICES**

If the physician meets face-to-face with the patient, often the best solution is to report an appropriate evaluation and management (E&M) service using time — rather than patient history, exam, and the extent of medical decision making — as the qualifying factor. CPT guidelines allow time as "the key or controlling factor to qualify for a particular level of E&M services" when counseling and coordination of care dominate (comprise more than half of) the physician/patient encounter.

You should document all pertinent information discussed with the patient in the medical record. For example, "30 minutes spent coordinating care" isn't sufficient. Instead, the provider should summarize the discussion that comprises coordination of care. The best practice is to document the beginning and ending time of the coordination of care, and the beginning and ending time for the overall face-to-face visit.

When reporting E&M services by time (rather than the key components of history, exam, and medical decision making), use CPT "reference times" to determine an appropriate E&M service level. The reference time is stated in the final sentence of the CPT E&M code descriptor (e.g., "Physicians typically spend 30 minutes face-to-face with the patient and/or family"). For example, reference time for established outpatient codes are:

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

Per CPT, "When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used." For example, when reporting a time-based, established outpatient E&M lasting 19 minutes, you would report 99213.

Note that not all E&M service codes include reference times. For example, per CPT, "Time is not a descriptive component for the emergency department levels of E&M services because emergency department services are typically provided on a variable intensity bases ..." Because these services do not include reference times, you cannot report based on time.

**PROLONGED SERVICES**

In addition to (or in place of) time-based E&M services, providers may qualify to report prolonged service codes. There are two types of prolonged services:

1. **Services that require direct, face-to-face physician contact with the patient.**

   The services are specific to setting (outpatient, +99354/+99355; or inpatient, +99356/+99357), and must be reported in addition to a primary E&M code that includes a reference time (explained above). To report prolonged services, the provider must document at least an additional 30 minutes beyond the reference time of the chosen E&M service level. Do not count time spent discussing the patient's case with other physicians, time reviewing data or tests without the patient present, or other activities not involving direct patient contact toward these services.

2. **Services that do not require direct patient contact.**

   Report the first hour of service using 99358, and each additional half hour with one unit of +99359. You do not need to report another E&M service on the same day to claim these services, but the prolonged services must relate to the patient's ongoing management. Note that some payers...
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(including Medicare) may not reimburse for prolonged services without direct patient contact. See the CPT codebook for additional, extensive guidelines to report prolonged services. Documentation should summarize the necessity and specific content of the prolonged services.

Note: The 2016 CPT codebook introduced two new codes (+99415 and +99416) for prolonged clinical staff services with physician or other qualified health care professional supervision; however, these services are unlikely to qualify for coordination of care activities.

* For more information read Improve Compensation by Documenting Prolonged Services.

CARE PLAN OVERSIGHT
Care plan oversight (CPO) services describe regular development and/or revision of care plans, review of subsequent report of patient status, communication for assessment or care decision with healthcare professional(s) and family member(s) and surrogate decision maker(s), integration of new information in the medical treatment plan, and more. The patient does not have to be present to report these services. You may report CPO services separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary services.

Coping for CPO varies, based on the patient's location (e.g., assisted living facility, domiciliary), whether the patient is under the care of a home health agency (HHA) or hospice, the time spent during a calendar month, and the payer class. In CPT, the relevant codes are 99339/99340, 99374-99380, and 94005 for time spent managing a patient's ventilator care. Medicare specifies its own codes to report CPO services (G0181 and G0182), the requirements for which differ from CPT guidelines.

CPO services are time based, and are reported per month. Documentation should summarize the necessity and specific content of the CPO services. See the CPT codebook (or Medicare guidelines, as appropriate) for additional, extensive guidelines to report CPO services.

CHRONIC CARE MANAGEMENT
CPT Assistant (October 2014) defines chronic care management, or CCM (CPT 99490), as services: "... provided by clinical staff, under the direction of a physician or other qualified health care professional. These management and support services are provided to patients who reside at home or in a domiciliary, rest home, or assisted living facility, and may include establishing, implementing, revising, or monitoring the patient's care plan; coordinating the care of other professionals and agencies; and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

"The physician or other qualified healthcare professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and instrumental and basic activities of daily living.

"To report CCM:
- The patient must have two or more chronic conditions expected to last at least 12 months, or until the death of the patient. Examples of chronic conditions include diabetes and advanced cardiovascular conditions such as congestive heart failure.
- The patient's chronic conditions must place her or him at significant risk of death, acute exacerbation/decompensation, or functional decline.
- The billing provider must establish and implement a comprehensive care plan, and that plan must be continuously monitored and revised, as necessary for patient care."

CCM services are time-based, and are billed once per calendar month. Time may be non-contiguous and is totaled over the course of a calendar month. Care management time includes direct patient contact and non-face-to-face time dedicated to the patient's care. The minimum documented time spent must equal at least 20 minutes.

* For more information read Chronic Care Management: Coding and Billing Criteria.

ADDITIONAL OPTIONS
In limited circumstances, providers may turn to Case Management codes (99363/99364 for anticoagulant management or 99366-99368 for medical team conferences) for coordination of care services. Additionally, CPT provides codes for services provided to a patient via telephone (99441-99443) or online (99444), and for inter-professional telephone/internet consultations (99446-99449). Consult the CPT manual for additional information, and double-check with the patient's insurer to verify coverage and reimbursement policies.

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