**Coding Basics and the Coding Calculator**

**How** should I approach a note when choosing an E/M coding level?

For coding purposes, the note can be divided into three parts:

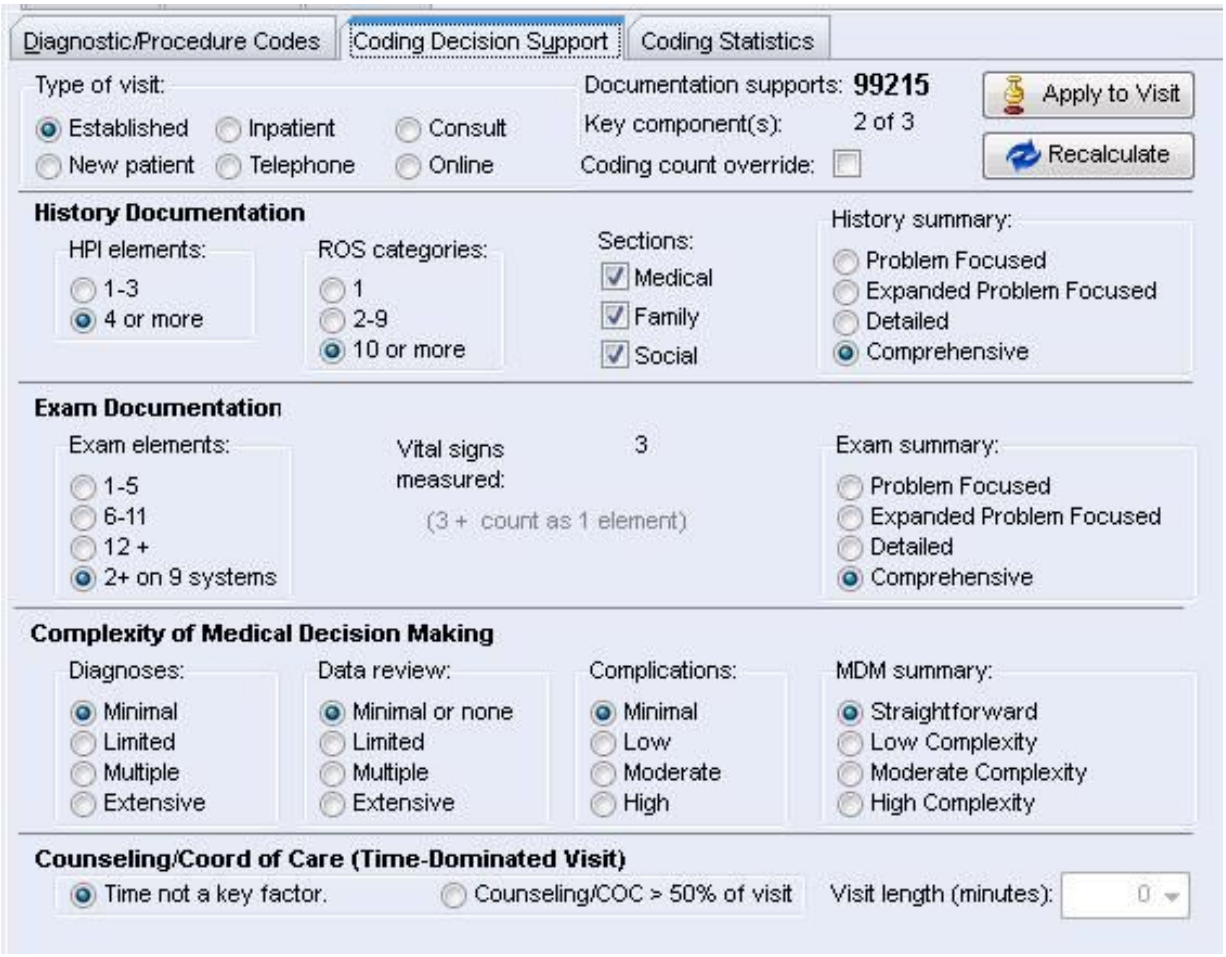
- History
- Exam
- Medical Decision Making

For ***established*** patients the highest level that is documented in 2 out of 3 sections, must be fulfilled when choosing a level for the visit. For ***new*** patients, all 3 out of 3 sections must meet the complexity level. Below is a table from the AAP coding best practices:

| Key Factors that Influence E/M Coding for an Established Patient | | | | |
|---|---|---|---|---|
| CPT CODE | 99212 | 99213 | 99214 | 99215 |
| HISTORY | Problem-focused<br>CC<br>Brief HPI | Expanded-problem focused<br>CC<br>Brief HPI<br>Problem Pert.<br>ROS | Detailed<br>CC<br>Ext. HPI<br>Ext. ROS<br>Pertinent PFSH | Comprehensive<br>CC<br>Ext. HPI<br>Complete ROS<br>Complete PFSH |
| PHYSICAL EXAM | Problem-focused | Expanded-problem focused | Detailed | Comprehensive |
| MEDICAL DECISION MAKING | Straightforward | Low complexity | Moderate complexity | High complexity |

OP's coding calculator does the math for ***established*** patients. The user must be aware that new patients require 3/3 sections.

The screenshot below is an example of an established patient having sufficient documentation in the history and exam sections to meet the criteria for a comprehensive 99215 visit.




Note in the above scenario, the “Complexity of Medical Decision Making” section is all at the 99212 straightforward level. This is not necessary to be higher since in an established patient, only 2/3 sections must be met. However, it is likely that in fact, this section was also higher.

**Why** does the Medical Decision Making (MDM) section always default to the minimal setting? Since much of the complexity of MDM is what the examining provider was thinking, there is no way to safely automate this section. The provider must document (often in the plan section) the diagnoses he made, the differential diagnoses he considered, the data he reviewed (including scanned diagnostic test documents, specialist reports, prior visits, and what the potential for complications are.

The coding calculator does not automate any of this process, always defaults to the minimal level and the provider must change these levels in the coding calculator if they believe it is integral to the coding level chosen and/or they wish the audit note to reveal this information. Remember, MDM coding support documentation is needed for all **new** patients, regardless of whether this is done in the plan section of the note, the coding calculator or both.

If the user wants the MDM level to be included in the audit note, they must choose the appropriate radio buttons for complexity (diagnoses, data review, complications) ***and*** check the "coding count override" box at the top of the form.

**How** should I handle time based coding?
When choosing an E/M level based on time, counseling or coordination of care must represent >50% of the time of the visit. It is important to note that the time bands in the grid below represent "typical" length of times for a visit at each level. The minimum time does not have to be met. If you are more than 1/2 way to the next coding level, you may "round up" and OP's coding calculator assists you with this.

| New Patient | Typical Time (minutes) | Established Patient Visit | Typical Time (minutes) |
|---|---|---|---|
| 99201 | 10 | 99211 | 5 |
| 99202 | 20 | 99212 | 10 |
| 99203 | 30 | 99213 | 15 |
| 99204 | 45 | 99214 | 25 |
| 99205 | 60 | 99215 | 40 |

Additional guidance/examples on rounding rules can be found here:

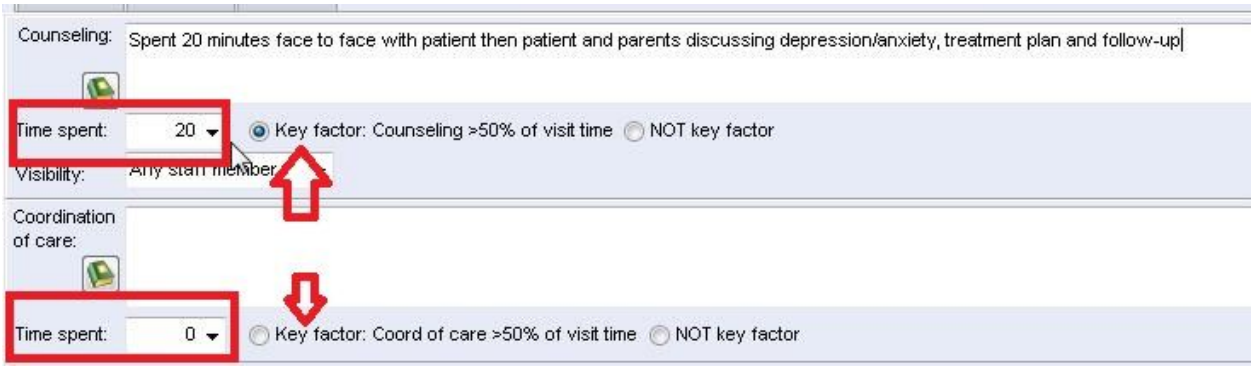
**When Time Spent Falls Between Two Typical Times**
If the total time of a visit falls in between two reference codes (eg, a 20 minute visit, which falls just halfway between a 99213 [15 minutes] and a 99214 [25 minutes]), you need to determine if the time spent is closer to the lesser time [eg, 15 minutes] or the longer time [eg, 25 minutes]. If the time spent is closer to the lower typical time report the code with the lower time. If the time spent is closer to the higher typical time, report the code with the higher typical time.

Example: Physician spends 20 minutes with an established patient and parent. 15 minutes are spent in counseling/coordination of care. Since 20 minutes falls directly in between a 99213 [15 mins] and 99214 [20 mins], what do you report?

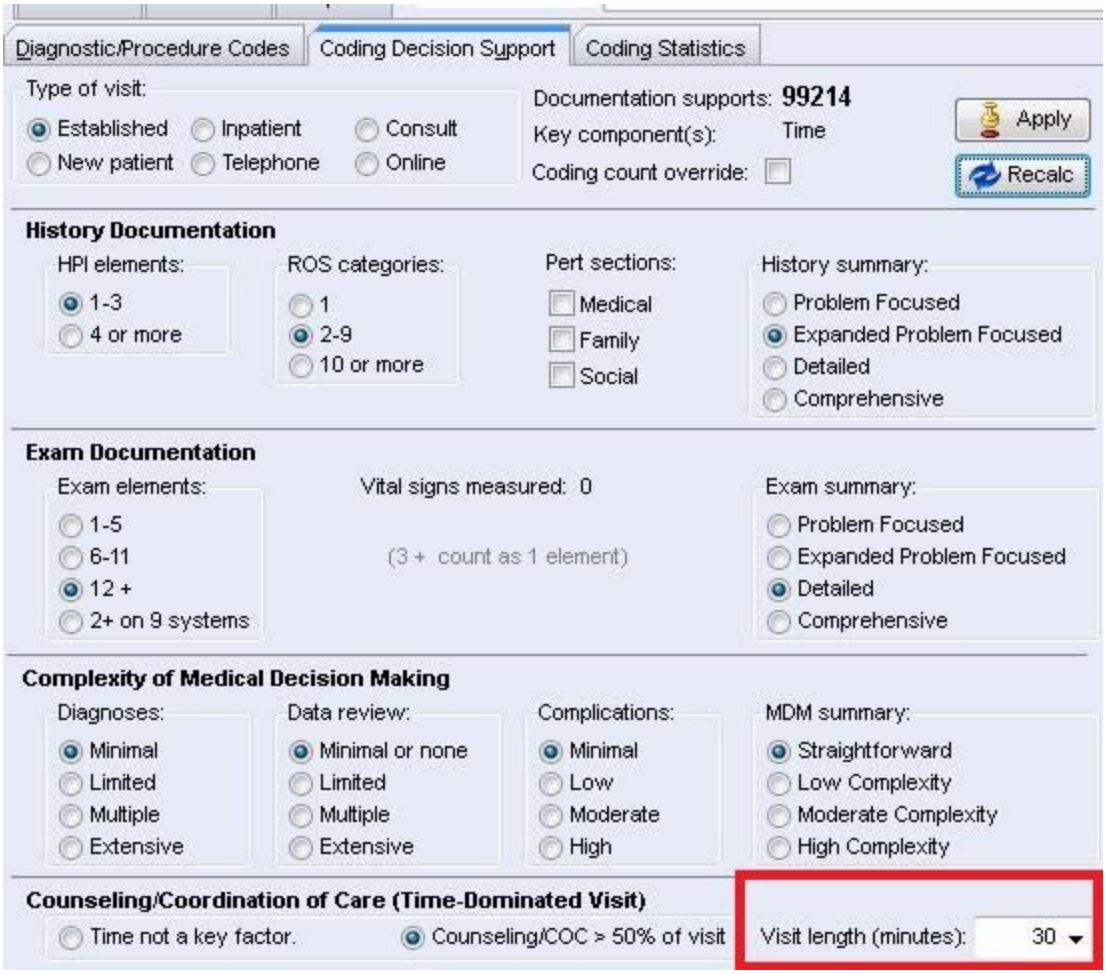
- 99213 – When the time spent is exactly the mid-point between 2 codes, you round down.
  Example: Physician spends 40 minutes with a new patient. Of that time over 30 minutes is spent in counseling/coordination of care. Since 40 minutes falls in between a 99203 [30 mins] and a 99204 [45 mins], what do you report?
- 99204 – Because the typical time mid-point was passed [ie, 38 mins] you can round-up to the higher code.
  Example: Physician spends 30 minutes with an established patient and parent. The entire visit is spent in counseling/coordination of care. Since 30 minutes falls in between a 99214 [25 mins] and 99215 [40 mins], what do you report?
- 99214 – Even though you went over the typical time required for code 99214, you did not pass the mid-point therefore you round down.

Caveat: The above guidelines for reporting when time spent falls between two typical times is a CPT guideline. Some Medicaid payers may differ.
Caveat: If you perform counseling/coordination of care for greater than 50% of a visit yet the total visit time does not meet the typical time requirement of even the lowest level code, you cannot use time as your key factor.

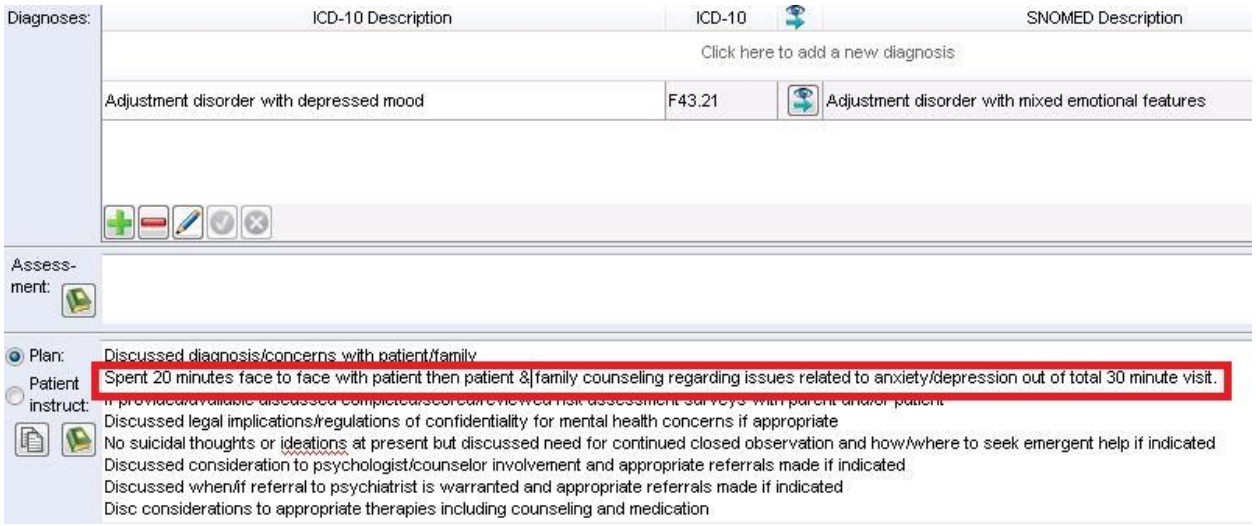
**How** do I document time spent?
There are 2 fields which should contain time to support choosing a coding level based on time. First, it is important to document the time spent counseling **or** coordinating care in the appropriate visit tab and to check the radio button that says this was >50% of the visit:




Secondly, the user should document the length of the entire visit on the coding calculator. This ensures that both the total counseling/coordination of care time and the total visit time will display in the audit note and will meet the documentation standards during an audit.




Many users repeat this information in the body of the plan of their note so there can be no room for misinterpretation. (Remember in the eyes of the audit reviewer/payer: “If it wasn’t documented, it wasn’t done.”)




References:
Coding at the AAP
CMS Outreach Education for E/M Coding
AAFP: Time is of the Essence: Coding on the Basis of Time for Physician Services

Additional AAP Resources: