Coding for Counseling

The correct Evaluation and Management (E/M) code will depend on whether the encounter was for screening or treatment of the disease.

If the encounter was for screening for a patient *without* symptoms, report a preventive medicine code. These codes are selected according to the time spent in face-to-face counseling with the patient. Whether or not these codes will be reimbursed will vary.

Possible procedure codes are:

- 99401–99404 Preventive medicine, individual counseling
- 99411–99412 Preventive medicine, group counseling

Counseling codes list "typical times" in their descriptions. The times noted in the Current Procedural Terminology (CPT)® descriptions are only averages and represent a range of times that may be higher or lower depending on actual clinical circumstances. In most cases, time is used only as a reference and does not influence code selection.

Sometimes, a physician may perform a physical examination and obtain a history, but may spend either

- more than 50% of the total time with the patient providing counseling or
- the entire visit providing counseling for a patient and/or their families.

In these cases, the level of service may be determined using time alone. The Current Procedural Terminology states: *"When **counseling** and/or coordination of care **dominates** (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** may be considered the key or controlling factor to qualify for a particular level of E/M service. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (e.g., foster parents…). The extent of counseling and/or coordination of care must be documented in the medical record."*

Definition of Counseling

Counseling as used in the aforementioned definition is a discussion with a patient, or her family, or both, about the following

- Diagnostic results, impressions, or recommended studies, or a combination of these
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) or follow-up

- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Documenting Time

When time is the determining factor for the selection of the level of service, documentation should include the following:

- The total length of time spent by the physician with the patient
- The time spent in counseling or coordination of care activities
- A description of the content of the counseling or coordination of care activities

Measuring Time

The average times listed for the E/M services represent the "intraservice" time associated with providing the service. Only the time spent providing the time-based code can be used in the selection of the code. Time spent in other concurrent activities, such as procedures, should not be considered in the selection of the time-based code. Time for E/M services is measured as follows:

- **Face-to-Face Time (office and other outpatient E/M codes and office consultations):** Physician time spent face-to-face with the patient, or family, or both. This includes the time in which the physician obtains a history, performs a physical examination, and counsels the patient.
- **Unit or floor Time (hospital observation, inpatient hospital care, inpatient consultations):** Physician time spent with the patient and on the patient's unit. This includes the time during which the physician establishes or reviews the patient's chart, or both; examines the patient; writes notes; and communicates with other professionals and the patient's family.

A unit of time is met when the midpoint is passed (eg, an hour is attained when 31 minutes has passed). Time that falls between two times for codes ranked in sequential typical times, such as some E/M service codes, is reported using the code with the closest actual time. Note that Medicare carriers may require that the time be equal to or greater than the typical time for the reported E/M code.

Time for services measured in units other than days are considered continuous times even if the service extends into another calendar date. An example is critical care services that begin before midnight and extend into the next calendar date. The date of service on which the service began should be reported as the date of service.