Documentation and Coding for Time

You are a direct care provider in a UMG clinic and a patient comes in to discuss a new problem or possible treatment options or concerns and you spend all of the encounter time speaking to the patient and possibly with their family members about their condition and concerns.

We encourage you to think about what you would do in this situation. What documentation requirements apply and what is the "right thing to do?"

The E/M guidelines do have a specific provision to allow physicians to use TIME as the controlling factor to determine the level of care in certain circumstances. If you choose to code based on time, you MUST record the duration of the encounter. You must also state that over half the time, or all of your time was spent on counseling and coordination of care.

The Medicare Claim Processing Manual, Chapter 12 states:

"Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, ***the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided****. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim."*

It is absolutely essential to record the total time spent with the patient.

We encourage you to contact the Documentation and Coding Program staff: Janice at x4093, Pam at x7052, and Marcie at x2038 if you would like to discuss this scenario further, have questions, or would like to recommend another "quandary" you may have faced in the past. You may also email us at: compliance.officer@uchc.edu.