Update in Evaluation and Management (E/M) Office Visit Coding for Family PACT Services
May 5, 2021
Question & Answer Document

COUNSELING

NOTE: For policy details about Education and Counseling (E&C) codes, please refer to the Family PACT Program's Policies, Procedures and Billing Instructions (PPBI) Manual section "Office Visits: Evaluation and Management and Education Counseling Services," found at https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/fpact/office.pdf.

1. **Going back to the counseling codes, since they are time based, would this be counted if an RN did the counseling and the client saw the provider for the E/M portion? Since it is time-based would the person doing the counseling add the time to the provider's note?**

A: No. The previous Family PACT policy was that non-clinician counselor time could be added to clinician time, but E&C policy was updated in February 2021 as part of the 2021 HCPCS update. The new policy states:

- The *clinician* portion of the visit is E/M coded by either total time or medical decision making (including record review before the visit, the face-to-face time with the client, and writing or typing a note after the visit).
- The *counselor* portion of the visit (if there is one) is billed with an E&C code based on the total time for the counselor's service.

The E&C codes that can be used for family planning counseling are:

- 99401U6 Up to 15 minutes
- 99402U6 16 thru 30 minutes
- 99043U6 31 thru 45 minutes

There are a number of important rules and restrictions on the use of E&C codes:

- Limited to two E&C code office visits (99401U6 through 99403U6) per client, per 30 days, per provider.
- E&C codes may be billed with Family PACT laboratory, surgical, medication and supply codes.
- These codes may be used to report counseling issues, including lifestyle and relationship issues, risk reduction interventions, method use and adherence, infertility, preconception counseling, pregnancy options and sexually transmitted infection (STI) prevention.
- Medical record documentation must support services claimed for reimbursement.

2. Can non-clinical staff member bill for counseling?

A: Yes, but with certain requirements. From the "Office Visits" section of the PPBI (page 6)

Providers must ensure that: non-clinician counselors have been trained in all family planning methods; are knowledgeable about the Family PACT Standards and program benefits; and have the essential core competence to deliver education and counseling services, including individual client history and assessment of health education and counseling needs. Within the personnel files of non-clinician counselors, providers must maintain documentation of education and counseling training and performance. Non-clinician counselors shall work under the direction of the enrolled Family PACT provider. Practice-specific education and counseling protocols or other written delegation arrangements must be established by non-clinician counselors and must be consistent with Family PACT Standards.

A listing of who is eligible to supervise non-clinician counselors is included in this section as well.

3. To bill counseling codes, would counseling be done by same provider or by other staff?

A. Other staff. Clinicians must bill with E/M codes, including counseling and clinical services; and non-clinician counselors must bill with E&C codes. *Both* can be billed on the same visit.

4. If an RN is doing contraceptive counseling and initiated an OC and the total encounter took 30 min. Can the RN bill a 99203 or is RN limited to a 99202? My understanding is that there are limitations on what E&M codes a RN can bill for.

A: It is important to differentiate whether an RN is administering or dispensing a contraceptive or whether the RN is solely providing education and counseling. In the first case, the PPBI (Office Visits, page 2) states that:

- RNs can <u>administer or dispense hormonal contraceptives</u> (oral contraceptive, injectable contraceptive, contraceptive patch, vaginal ring, and emergency contraceptive pills) pursuant to *California Business and Professions Code* (B&P Code), Section 2725.2.
- If performed by an RN who has completed the required training, E/M procedure CPT codes 99202, 99211, and 99212 must be billed with modifier TD.

An RN who provides education and counseling, but who has not received the required training to administer and dispense contraceptives, may qualify as a non-clinician counselor if they meet the criteria listed in Question 2.

5. Can individual counseling codes and E/M office visits be billed together? We are billing together but receiving denials from Medi-Cal for the office visit.

A: Yes, for Family PACT. According to the "Office Visit" section of the PPBI (pp. 8-10), an E/M and E&C can be billed together. Please contact the Telephone Service Center at 800-541-

5555 and have Claim Control Numbers, Remittance Advice Details, and your clinic's NPI ready for them to assist you.

6. **Could you reiterate what you said about support staff. It sounds like you cannot count MA counseling time in the E&M code (992xx), but you CAN count MA counseling time for 994xx codes. Is that correct? Can 994xx codes be used if *only* MA counseling is done or does the clinician have to have some face-to-face time?**

A: Part one of your question is correct. For part two, an E&C code can be billed independently of an E/M code. Occasionally, a client visit will require only family planning and STI counseling, but not a visit with a clinician. In this case, only an E&C should be billed.

7. **Historically, I was taught for a procedure with counseling that I should bill for the E &C time. Is this no longer true?**

A: An E&C code *can* be billed on the same date of service as an office procedure, but only in limited circumstances. It assumes that a non-clinician counselor has provided a unique service that is *not* included in the CPT for a procedure performed by the clinician. Billing an E&C code on the date of a procedure will not be necessary for some procedures (for example, a colposcopy), but often is done at the same visit as an office contraceptive procedure.

For example, a new client is seen for contraceptive counseling, which is provided by a non-clinician counselor. The client decides to have a contraceptive implant placed, which is then performed by a clinician at the same visit. In this case, coding consists of:

- An E&C code for the methods counseling provided by the non-clinician counselor (by total time, but not counting the time of the implant insertion procedure)
- The CPT code for the implant placement (11981), and
- The HCPCS code for the implant insertion kit. (J7307)

Note that in this case, it is not appropriate to bill an E/M code for clinician services, since discussion about the benefits and risk of implant use and the consent process is included in the CPT code for the implant placement.

Conversely, if the clinician provided additional contraceptive counseling beyond that provided by the non-clinician counselor, an E/M code with a -25 modifier* would be acceptable, since the clinician provided a cognitive service that was separate from the implant procedure itself.

*The "Office Visit" section of the PPBI (page 2) states that:

CPT convention states that if a "significant, separately identifiable E&M service is provided by the same clinician on the same day of the procedure," then an E&M claim for the evaluation of the separate condition may be billed as well. Modifier 25 is used to designate this service for Family PACT and Medi-Cal, based on CPT convention.

8. How should the time spent be supported in the medical record?

A: Rules for medical record entries by non-clinician counselors:

- Medical record documentation must reflect the scope of education and counseling services provided to clients according to Family PACT Standards, including, but not limited to, individual client assessment, topics discussed, name and title of counselor.
- Documentation must support services billed for reimbursement. The total time must be documented in the medical record.

9. If the clinician provided the E&C, can it be billed separately from the E&M or would it be factored in calculating the time or MDM?

A: All services provided by a clinician, *including counseling*, are included in the E/M code for the visit. A separate E&C code cannot be billed for counseling provided by the clinician.

BILLING & CODING

10. Is 99204-99214 only covered by Family PACT for complications i.e., *surgical per the guidelines?

A: 99204 and 99214 are Family PACT benefits for females based on total time or medical decision making. The same two codes are covered for males only in the case of treatment complications, whether medical (i.e., a reaction to an antibiotic given for a sexually transmitted infection) or surgical (i.e., bleeding from a vasectomy incision).

11. Previously we were unable to bill E/M code with E/C together, has that changed now?

A: Yes. See the answer to Question 1 for more detail.

12. If you are choosing time as the criteria for billing do you need to document the exact number of minutes?

A: Yes. See the answer to Question 19 for more detail.

13. In general, are you able to bill a problem-oriented visit along with a preventative medicine service visit?

A: In general, yes. If someone is being seen for a "preventive medicine" visit (for example, a well-woman visit) and a significant problem is managed during the visit, a problem-oriented E/M with -25 modifier (significant, separately identifiable E/M service by same clinician on same day of procedure or other service) can be claimed along with the preventive medicine visit code, which is based on the client's age and whether a new or established patient.

Because the Preventive Medicine Visit codes are *not used* in Family PACT, this approach does not apply. All cognitive services provided at a Family PACT visit, whether preventive,

diagnostic, or therapeutic are coded with problem-oriented visit E/M codes based on either total time or medical decision making.

14. Can you tell us if we can bill a G2012 and an E/M code on the same day if the client is asked to come in by the physician?

A: No. Please refer to the answer to Question 5 for an explanation.

15. To verify, a RN nurse would only be able to bill 99201, 99211 or 99212, is this correct?

A: Correct. Please refer to the answer to Question 4 for an explanation.

16. Can you give more examples about situations that would require the 25 modifier?

A: In reproductive health visits, the most common use of a -25 modifier is if an office procedure and a "significant, separately identifiable" E/M service are done at the same visit.

For example, if a client is seen solely for a colposcopy or IUD removal, only a CPT (procedure) code is billed. However, if a client has a colposcopy and also has a vaginal discharge evaluated at the visit, the evaluation of the discharge qualifies as a "significant, separate problem" and a 992xx-25 can be claimed along with the CPT code for the colposcopy.

17. When will the new superbill be released to reflect these changes?

A: As a result of the 2021 modifications to E/M codes, updates to a superbill are quite limited, e.g., removal of E/M code 99201 and redefinition of the footnotes in the education and counseling (E&C) section. Other than that, there are no "new" E/M or E&C codes in Family PACT. However, there are major policy changes in computing the levels of problem-oriented E/M codes, as well as how E&C codes are used in Family PACT. These changes are far too detailed to be explained in the superbill.

The most current Family PACT superbill is found at:
https://familypact.org/providers/forms/.

18. Is there a simple cheat sheet of sorts for clinicians to use to quickly refer to figure out how to code correctly?

A: Yes. The Reproductive Health National Training Center (RHNTC.org) has lots of coding resources for family planning services at https://rhntc.org/search?keys=coding. In addition, they have developed many "job-aids" that summarize important information about E/M codes, ICD-10 diagnosis codes, and CPT codes for office procedures at https://rhntc.org/search?keys=coding+job+aids

Most of these tools are in the process of being updated to include the 2021 E/M guidelines, as well as rules for coding telemedicine visits, and will be available by June 2021. Stay tuned!!

19. What needs to be charted if you are planning on coding on time?

A: A sentence in your note that states that the E/M code that you have selected is based on "total time" (rather than medical decision making) and the number of minutes that you have computed for total time. Your note does not need to break down total time into its components (pre-visit review of notes and lab results, face-to-face time the visit itself, care coordination, medical record note, etc.). Charting should also reflect the services performed/provided.

20. You mentioned these changes are meant to simplify documentation/copy/pasting, etc. Can you explain what needs to be documented in one's note to support the codes used?

A: When selecting the E/M level based on total time, the medical record note should include the total number of minutes for the encounter. It is not necessary to break it down into pre-visit record review, face-to-face time, and post-visit charting. Documentation should also reflect the services performed/provided.

If MDM is used, ideally you should document the level chosen for each of the 3 MDM elements. For example, "MDM is moderate (problems-low, data-moderate, risk-moderate)."

STI & TESTING

21. What code can be billed when discussing lab results and treatment with a client when they've been seen for an office visit two weeks prior?

A: A problem-oriented E/M code based on either total time or medical decision making.

22. Are we able to bill a pre-op gyn appointment under FPACT? For example, pre-op labs, CBC, PTT/INR CXR etc. that are all required prior to undergoing a covered FPACT surgery such as a BTL?

A. No, if the only purpose of the visit is to obtain the lab tests that you listed. The client must have an interaction with a clinician that qualifies as a cognitive service (for example, a pre-op physical assessment of heart and lungs) in order to bill an E/M visit.

23. Why not bill for screening for cervical cancer and the pap? Can you please review a case where a pap is done in the visit?

A: The act of obtaining a sample for cervical cancer screening (e.g., a cervical brush sampling for cytology and HPV testing) is included as a component of the E/M code for the *entire* visit, whether based on total time or medical decision making. In the CPT Coding Manual, there is no separate code for obtaining a cervical sample (there is in Medicare, but it does not apply to Family PACT).

The charge for running the cervical cytology and the HPV tests and reporting the results will be claimed by the cytopathology lab to which the samples were sent.

In other words, clinics and offices should ***never*** charge any of the CPT laboratory codes for cervical cytology or high-risk HPV testing, since *only the laboratory* that runs the tests and provides the result can do so.

24. When you refer to complexity as high for DVT would that only be for an acute DVT or for follow up after a DVT?

A: An acute DVT. In the "number and complexity of problems" data element, mainly life-threatening conditions can be considered in the "high" level. Follow-up after being treated for a DVT is no longer life-threatening.

25. A new client presents for STI testing without symptoms and does not need to see a clinician face-to-face. Is 99211 billable?

A: No, 99211 is not billable, since this is a new client, who by definition (in the CPT book) must be seen by a clinician. The main reason that 99201 was deleted by the AMA in 2021 E/M guidelines was to emphasize that new client visits needed to be more comprehensive than just a few minutes.

As mentioned in the webinar, there are concerns that this practice is occurring at all, especially with new patients. Family PACT Program Standards and CDC guidelines imply that ordering STI screening tests is a *clinical decision,* based on a detailed sexual history and other personal factors. This can be performed by a clinician (using new client E/M codes 99201-99204) or by a nurse or non-clinician counselor, using an E&C code.

Family PACT Program standards can be found at:
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/fpact/progstand.pdf.

26. If you have our own lab that processes your GC/CT (not point of care) can we count that towards the EM code the day we order it?

A: Providers may include the ordering of labs towards the data element for medical decision making (MDM) to set the E/M level.

27. If someone comes in for a pap only, would you only use the procedure code and not use an E/M code?

A: See above. Answered in Question 23. Additionally, cervical cancer screening is not a "stand-alone service" under Family PACT; it is covered coincident to a family planning visit.

CASE STUDY

28. It is very difficult to get reimbursement from Family PACT for all MEN cases because of main rule: contraceptive method MUST be a primary diagnosis. You did not enter any into Sam's example screen. For condoms – should we use Z30.49 (surveillance of other contraceptives) as contraception?

A. Yes. That was an oversight on my part. Thanks for picking that up! The final version of the slide set has that correction included.

29. Just to clarify regarding the BV case study, what if there is no microscopy in the facility but tested positive for a whiff test, would that lower the billing code to 99212 or continue with 99213?

A. In Betty's case study, doing a whiff test instead of microscopy would not have made a difference in the E/M code at all. Of course, billing for microscopy of the discharge (Q0111) would no longer be appropriate.

To recap: Betty is an established client and using total time, the E/M was 99214. Using MDM, the E/M code was 99213 (problems-low, data-minimal, risk-moderate). You can bill for the higher of the two methods, so the E/M code for this case is 99214.