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# The Insider News

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## *From the California Division of Workers Compensation:*

### **Division of Workers' Compensation new medical treatment utilization schedule regulations approved by Office of Administrative Law New schedule becomes effective July 18, 2009**

The Division of Workers' Compensation (DWC) has adopted new regulations updating the medical treatment utilization schedule (MTUS), commonly referred to as medical treatment guidelines. The final regulations were filed with the secretary of state on June 18, 2009 and become effective July 18, 2009. The regulations add a new section for chronic pain and post surgical physical medicine treatments to the MTUS, as well as updating the chapter on treatment of elbow injuries. The regulations also restructure the MTUS into a clinical topics format, which will allow for easier updates in the future.

"In addition to adding the new sections for chronic pain and post surgical treatment, the clinical topics format allows us to make future updates on a chapter by chapter basis," said DWC acting Deputy Administrative Director Destie Overpeck. "In this way, we can continuously incorporate quality, evidence-based treatment for injured workers, which help them recover quicker and keep costs down for employers."

The post surgical section sets forth an exception to the 24-visit limit for therapeutic and chiropractic care for post surgical physical medicine and rehabilitation services. The section is based on the Official Disability Guideline (OD) with approximately one third based on evidence-based reviews (EBRs) by the DWC in conjunction with the Medical Evidence Evaluation Advisory Committee (MEEAC). The section applies during the post surgical physical medicine period. The section also establishes the goal that therapy should result in functional improvement, patient education and self-management of symptoms. It covers approximately 130 surgeries.

The chronic pain section provides for treatment of close to 200 chronic conditions. The section is based on the OD, but contains an introduction written with input from the MEEAC. It also contains additional treatment recommendations based on EBRs. The section is evidenced-based and stresses the importance of returning patients to work through the use of treatments that show functional improvement and independence.

The revised elbow chapter reflects an update from ACOEM.

The regulations, found in the California Code of Regulations, Title 8, sections 9792.20 through 9792.26, are authorized by Labor Code sections 4604.5 and 5307.27.

Non-substantive changes were made to the text of the regulations. The approved regulations, as filed with the secretary of state, can be found on the DWC Web site at: [http://www.dir.ca.gov/dwc/DWCPPropRegs/MTUS\\_Regulations/MTUS\\_Regulations.htm](http://www.dir.ca.gov/dwc/DWCPPropRegs/MTUS_Regulations/MTUS_Regulations.htm). The final statement of reasons for the rulemaking, a summary of public comments made during the rulemaking, and the division's responses to those comments are also available on the Web site.

## E/M Coding: Coding Based on Time

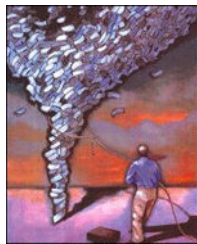
*Editors Note: This is a continuation of our series to cover the guidelines for E/M coding.*

When counseling and/or coordination of care are more than 50% of your encounter with the patient, you may be able to determine your E/M code level based on the time spent rather than the elements within the key components.

### Points to Remember:

- You still have to document the clinical aspects and support the medical necessity of the encounter – this only means the code level isn't determined based specifically on the number of bullet points or HPI elements, etc.
- In the office, you can only count face to face time between the patient and the billing provider towards billing based on time. You can't count time spent outside of the patient's presence, and you can't count time spent by anyone else. That includes time spent by staff, residents, or mid-level practitioners if the mid-level is billing "incident-to".
- CPT defines counseling as "a discussion with a patient and/or family concerning one or more of the following areas:
  - *diagnosis results, impressions, and/or recommended diagnostic studies*
  - *prognosis*
  - *risks or benefit of management (treatment) options*
  - *instructions for management (treatment) and or follow-up*
  - *importance of compliance with chosen management (treatment) options*
  - *risk factor reduction*
  - *patient and family education"*
- In the office, the emphasis on time coding is placed more on counseling than coordination of care. In the physician office, most coordination of care activities (arranging tests, referrals, etc.) do not occur face to face with the patient, therefore don't "count" toward time coding. In the hospital, time is based on both face to face time with the patient and floor time on behalf of the patient, so time coding based on coordination of care is more likely to occur in the hospital setting than the office.
- Documentation guidelines for coding based on time are as follows:
  - *Clinical documentation as appropriate*
  - *The total length of the face to face visit*
  - *The fact that > than 50% of that face to face visit is counseling and/or coordination of care, as appropriate*
  - *The nature of the counseling and/or coordination of care**Example: 30 minutes spent face to face with the patient. >50% of the visit spent discussing management options for the patient's newly dosed diabetes.*
- Visits likely to be coded based on counseling time include encounters primarily to discuss test results, new chronic diagnosis, cancer diagnosis/development of treatment options, patients presenting with depression, ADD encounters, discussion about birth control or hormone replacement therapy, etc. These are all encounters that are mostly discussion and counseling rather than history taking and exam.
- Almost all level of service E/M codes have a typical time assigned. Check your CPT book for the specific time assigned per code.

### Industry News



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