Family Planning Coding
Frequently Asked Questions

RHNTC
REPRODUCTIVE HEALTH
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This job aid provides answers to frequently asked questions that Title X clinical services providers, billing staff, and/or grantee staff may have about coding for family planning services, preventive medicine visits, and telehealth visits. Additionally, this job aid reflects updated evaluation and management (E/M) guidance that went into effect on January 1, 2021.

To learn more about the key changes and to practice your coding skills, take the self-paced *Coding in the Reproductive Health Care Environment* eLearning modules.

E/M Coding for Family Planning Services

Q: What are the key changes in the 2021 E/M coding updates for Problem Oriented Visits?

- **A:** New and established patient codes (99202–99205, 99212–99215) no longer require use of either the three key components or face-to-face time. Code selection is now based on:
  - Medical decision making (MDM) level OR
  - Total time on the day of the encounter

Q: What are the modifications to the MDM method?

- **A:** Each of the three MDM elements were updated:
  1. Problems: number and complexity of problems addressed during that visit
  2. Data: amount and/or complexity of data to be reviewed and analyzed
  3. Risk: the risk of complications and/or morbidity or mortality of patient management

  Remember: The level of MDM is based on the highest two out of three elements.

Q: What counts as a data element in the MDM method?

- **A:** If you order a test and review the result—that's 1 point total per test
  - If you review the result of a test ordered by another provider, count this as 1 point per test
  - A multi-test panel (like a complete blood count) is considered 1 unique test
  - Review of prior external note(s) from each unique source
  - Independent interpretation of a test performed by another qualified health care professional
  - Discussion of management or test interpretation with external qualified health care professional/appropriate sources

  For more examples in a family planning context, refer to the RHNTC job aid entitled: Elements of Medical Decision Making During Family Planning Visits.

Q: Do point-of-care tests (urine pregnancy tests, microscoscopy, HIV rapid tests, or office ultrasound) count as a data element in the MDM method?

- **A:** No. These point-of-care tests do not count in the data element, as the work involved is billed separately.

Q: What changes were made to the time method?

- **A:** Effective January 1, 2021, clinical services providers should now use **total** time, including both the face-to-face and non-face-to-face time provided by the clinical services provider on the day of the encounter. Total time needs to be clearly documented in the medical record to support the code billed.

Q: Which activities can be included in the total time method?

- **A:** Activities that can be included in the total time method are:
  - Preparing to see the patient (e.g., review of tests, connecting to the telehealth platform)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, contraceptives, tests, or procedures
  - Referring and communicating with other health care professionals (when not separately reported)
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

Q: Which activities **cannot** be included in the total time method?

- **A:** The following activities **cannot** be included in the total time method:
  - The time devoted to a separately reported office procedure (such as IUD or implant insertion or removal) or the time needed to perform a point-of-care test like microscopy. This is a common error, and, if made, would be considered to be double billing.
  - Time with the front desk and nursing staff
  - Time spent on the visit on a different date, such as when a clinical services provider completes the chart note the following day or two after the visit

Q: Which method should clinical services providers use?

- **A:** Clinical services providers can use either MDM or total time on the date of the encounter to determine the appropriate problem-oriented visits E/M code. One method will not fit all visits, and clinical services providers should compute the E/M level *both* ways, and then choose the highest-level code that is supported in the documentation. It is important to be familiar with both the MDM and total time methods.

  Examples of which coding method to use in commonly encountered family planning situations can be found in Table 6 of the RHNTC's Evaluation and Management Codes Job Aid.

Q: Do the E/M changes impact what payers will pay for?

- **A:** Usually not. However, it is important to review payer-specific policies, as there may be additional documentation or other specified coding and billing expectations. For example, most payers consider time spent by counselors or health educators as a cost of the practice and do not permit including their time or services provided in the computation of the E/M code.

Q: What are the new supply codes for billing contraceptive vaginal rings (CVR)?

- **A:** The supply code "J7303" for the 1-month contraceptive vaginal ring has been deleted for billing as of September 30, 2021, and payment may be denied if billed for dates of service after October 1. There are 2 new codes for the yearly and monthly vaginal rings effective October 1, 2021, and should be entered into your EHR, billing system and CVR/encounter forms as follows:
  - J7294 Contraceptive vaginal ring, 1 year (Annovera ring)
  - J7295 Contraceptive vaginal ring, 1 month (Nuvaring)

  Be sure to bill the correct units dispensed during the visit to ensure proper payment.

E/M Coding for Preventive Medicine Visits

Q: How is a well-person visit coded?

- **A:** The 2021 E/M rules did not change for preventive (check-up) visits. The *Preventive Medicine Services* code set (99384–99397) is based on two criteria: the patient's age and whether this is a new or established patient.

  The *Preventive Medicine Individual Counseling* code series (99401–99404), which is based on face-to-face time, is covered by some payers. These codes are used strictly for counseling visits, and depending on payer policy, may be available for services provided by counselors and health educators.

Q: Which E/M code can be used for a nurse visit for a new patient?

- **A:** 99211 is the only E/M code that is available for a nurse visit. The other code series listed is reserved for physicians (medical doctors and doctors of osteopathy) and other qualified health care professionals (nurse practitioners, physician assistants, and certified nurse-midwives).

E/M Coding for Telehealth Family Planning Visits

Q: How do the E/M coding updates apply to telehealth?

- **A:** The January 1, 2021 updates that deal with total time and MDM also apply to telehealth visits. For a telehealth visit, the same criteria apply. These include preparing for the visit, the actual visit, and charting after the visit on the same day of service.

Q: What are the most widely used codes to bill for telehealth visits?

- **A:** The most widely used codes to bill for telehealth visits are:
  - Office E/M visits using 99202–99205 for new patients and 99211–99215 for established patients with a modifier -95 (telehealth visit)
  - Virtual check-in visit (G2012) and virtual check-in store and forward (G2010)
  - Telephonic-only codes 99441–99443

  For more guidance, review the RHNTC's Coding for Telemedicine Visits Job Aid.

Q: Is there payment parity for in-person visits and telehealth visits?

- **A:** During the public health emergency, the Centers for Medicare & Medicaid Services (CMS) has provided waivers to ensure that virtual visits are paid at the same rate as in-person visits. It is important to code all visits correctly and to ensure the documentation reflects what happened in the visit, either in-person or virtual. Title X agencies should monitor telehealth payer policy as payment parity and other policies were implemented during the public health emergency and may be different in the future.

Q: Should there be a written consent for telehealth visits?

- **A:** During the public health emergency, some states suspended the use of the consent form. It is important to check with the payer on its policy and documentation for telehealth visits. Telehealth services informed consent samples can be found on rhntc.org.

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