Family conferences: Whether to bill, and when?

A patient's relative makes an appointment to discuss the patient's condition and course of treatment. The doctor spends as much time with the relative as he would to provide care to a patient. Can this service be billed?

In brief, the answer will depend on the payer - Medicare holds fast to its rule that E/M codes must be conducted face-to-face, while some commercial insurers follow CPT, which allows for conversations with the patient or family members subsequent to a patient encounter. While your physicians won't like it, insurance companies usually won't reimburse for a family conference if the patient is not present.

A possible exception: children, who are usually private pay. Even if the child is not present, since it involves the care of a minor patient, some coders say they bill payers for an E/M service anyway, usually level 3 or below. Even then, the policy among payers varies, so the best advice is to check with your payer in advance.


It specifically says, "In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported." [The rule also can be found in the old Medicare Carrier's Manual (MCM), section 15501(C.)]

CPT, on the other hand, notes in its introduction to E/M codes that, "Counseling is a discussion with a patient and/or family..." So those payers that follow CPT guidelines should allow these visits, as long as it doesn't contradict anything in their policy or managed care contract.

Medicaid's stance depends on the state or region you live in. In Wisconsin, for instance, the carrier requires face-to-face time.

Although most coders acknowledge they normally don't charge for telephone consultations with a patient's family members, coders differ on whether to bill when it comes to face-to-face time with the physician. Obviously, if the patient is present and the discussion includes his or her care, the service is billable to Medicare and most commercial payers. Some practices follow a simple set of guidelines for billing family conferences to Medicare and other payers: 1) the patient is present and 2) it is necessary to have the conversation for the care of the patient.

Medicare, in particular, requires patient contact for reimbursement, except when the physician needs to contact an outside source (e.g., a relative) to "secure background information to assist in diagnosis and treatment planning," according to the Medicare Coverage Manual (MCM), section 35-14.

Payment for the one code available for counseling services, 90887, has been bundled into other medical services under Medicare and is not billable to anyone - the patient or the family member, even with a signed waiver of liability. Code 90887 (consultation with family) provides for the "interpretation or explanation of results of psychiatric, other medical examinations and procedures...to family or other responsible persons, or advising them how to assist patient." CMS's stance is that when billing for counseling, the main focus has to be the treatment of the illness of the Medicare beneficiary, although Medicare will pay the appropriate E/M code with documentation under two exceptions:

* observing the interaction between family members; and
* A visit assessing and assisting the physician in determining the capability of family members to aid in the management of the patient. (e.g., home dialysis).
Medicare may also pay if the patient is physically or mentally unable to communicate with the physician and a family conference is necessary before the physician can proceed with a treatment plan.

Two other codes, 90847 (family psychotherapy, conjoint, with patient present) and 90846 (family psychotherapy, without the patient present), have been assigned a "restricted" rating, which means that their coverage is restricted by Medicare.

A CMS official explains that IOM Pub. 100-4, Chapter 12, section 30.6.1(B), the section that addresses the selection of level of E/M service, also stresses the importance of face-to-face contact. "The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50% of the face-to-face time (for non-inpatient services) or more than 50% of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C."

Although the CMS official says this section specifically addresses how to bill for time for counseling and coordination of care, she adds, "it does address the reasonable fact that the visit is a face-to-face encounter between the provider and the patient. In the inpatient setting the provider will generally have a face-to-face encounter with the patient and then complete the encounter out on the unit floor documenting the findings, assessment and plan, writing orders. In either case there is a face-to-face encounter."

"AMA CPT addresses the intra-service time as face-to-face for the office/outpatient setting and for floor time for the inpatient setting," she adds.

Other physician practices say they bill for the service with the appropriate E/M code and if it's rejected by Medicare, the claim is resubmitted to secondary payers, such as Medigap plans. Still other offices consider family conferences without the patient present to be a non-covered service and bill the family member directly.

Family members often want face-to-face contact. In a lot of cases, there may be 3 or 4 family members, so trying to do a phone consult is not particularly practical.

The charge is to the person who is requesting the service - not the patient. You cannot bill any other E/M service because the patient will not be present.

Try hard, when the appointment is made, to inform the relatives that this is not a covered service, this cannot be billed to Medicare and they will be responsible for paying for it, preferably at the time of service. Some consultants recommend billing family conferences as a "conference" under CPT 99499. The diagnosis code most likely would be V65.1, person consulting on behalf of a nonattending person. However, be careful not to overuse the code. Some other options to consider:

* Nursing home services are based on unit floor time, versus physician face-to-face time, which means that if the physician were to meet with the patient's relatives at the nursing home instead of in the office setting, the time spent in discussion would roll into the total time for the visit with the patient on that date. Time spent in counseling/coordination of care as well as the total time of the visit must be documented in the medical record, then the service could be billed using the appropriate code from the +99304-99310 series if the counseling dominated the patient/family encounter.

* When billing commercial insurers, office codes based on time may be more effective because of the counseling involved.

Tip: Send the claim hard copy, and use the carrier's acceptance or denial as a precedent for future such claims. If the entire conversation involves counseling, it would meet the 50%-of-visit criteria to be able to bill based on time alone. The CPT descriptor language says, "Physicians typically spend (#) minutes face-to-face with the patient and/or family," which for non-Medicare carriers may allow office codes to apply to family members without the patient present. But if a private carrier wants you to bill on time, get the policy in writing and go ahead and bill that way.
There are times when it doesn't really matter because the absence of the patient won't affect reimbursement. (For instance, when the conversation with others is so brief that time is not the key element for choosing the E/M level.) But when the conversation might be extensive - exploring options for a patient with dementia, for instance, it's significant. You'll be able to bill Medicare for the level of E/M represented by your encounter with the patient, but the time spent with the family will be pro bono.