Internal Medicine Coding Alert

CPT Update: Heed Medicare Clarification to Code Inpatient Prolonged Services Properly

Floor/unit time will not replace face time with feds.

The new CPT codes for inpatient prolonged services contradicted Medicare's longstanding rules for coding these encounters. At November's CPT and RBRVS 2009 Annual Symposium in Chicago, Medicare confirmed it will stick to its current

rules, leaving its policies at odds with CPT 2009's revisions.

The basics: The new descriptors for +99356 (Prolonged service in the inpatient setting, requiring unit/floor time beyond the usual service; first hour [List separately in addition to code for inpatient evaluation and management service]) and

+99357 (... each additional 30 minutes [List separately in addition to code for prolonged physician service) instruct coders to add up "unit/floor time" rather than "face-to-face time." This change implies that you can count services that your

internist provides on the unit/floor toward E/M time -- not just services he provides in person to the patient.

According to the Medicare Claims Processing Manual, Chapter 12, Section 30.6.15.1: "Prolonged Services With Direct Face-to-Face Patient Contact Service": "In the case of prolonged hospital services, time spent reviewing charts or discussion

of a patient with house medical staff and not with direct face-to-face contact with the patient, or waiting for test results, for changes in the patient's condition, for end of a therapy, or for use of facilities" can't be billed as prolonged services.

This makes it clear that Medicare still considers unit/floor time non-face-to-face, said **William J. Mangold, Jr., MD, JD,** medical director for Medicare Part B for Arizona and Nevada. Thus, any time the internist spends outside of the patient's

presence cannot be coded with +99356 or +99357.

Best bet: Check with your other payers to see if they allow you to count unit/floor time and face-to-face time when totaling inpatient prolonged service time.

Count Face Time, but Carve Out Floor Time

This change does not mean Medicare won't pay for inpatient prolonged services. "If a patient needs a second assessment from a physician within the same group later in the day, you can capture all this time with the E/M service code, plus the

prolonged service code," said **Peter A. Hollman, MD,** a practicing internal medicine and geriatrics physician and a medical director for Blue Cross Blue Shield of Rhode Island in the "Evaluation and Management Services" session at the

symposium. In 2009, physicians will still need to specify face-to-face minutes, not unit/floor time minutes, when coding for Medicare (and other payers that follow Medicare rules), Mangold reported.

Do this: When the physician provides prolonged inpatient services to a Medicare patient, carve the non-face-to-face time out of the prolonged service time, explains **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO,** consultant with

MJH Consulting in Denver. (Remember that you can only report prolonged service when the encounter lasts at least 30 minutes beyond the usual time parameter for your level of service.)

Example: Let's say the physician is providing a level-two initial hospital visit for a Medicare patient with an acute exacerbation of chronic obstructive pulmonary disease (COPD), insulin-dependent diabetes mellitus, and hypertension.

These visits typically take 50 minutes, but the notes indicate that the actual encounter time was 100 minutes. Further examination of the record reveals that 15 of those 100 minutes were spent counseling the family

in the waiting area; the rest of the time, the internist was providing direct medical services face-to-face with the patient. In this scenario, you should subtract the 15 minutes of counseling/coordination of care with the family (non-face to face time).

That leaves you with 85 minutes of face-to-face consult service, which still qualifies as a prolonged service (50 minutes for the initial hospital visit, 35 minutes of prolonged service).

On the claim, report 99222 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical.