Internal Medicine Coding Alert

CPT Update:Expert Cheers Revisions to +99356, +99357

Medicare still to comment on 'beautiful' revision to inpatient prolonged service codes.

There is a lot of buzz around the deletion of modifier 21 (Prolonged evaluation and management services) and the revision of prolonged services codes coming in CPT 2009. The impact of these changes on coders and practices should be mostly positive, especially when reporting inpatient prolonged services.

The CPT revisions are "a beautiful clarification that will allow physicians to see their patients more than once a day in the inpatient setting, and use prolonged services codes if the compilation of visits during the course of the day allows it," offers **Joan Gilhooly, CPC, CHCC,** president of Medical Business Resources in Chicago.

Caveat: Medicare's current policy for reporting inpatient prolonged is at odds with the AMA's CPT 2009 definitions. Look for CMS to comment on the new codes some time before the New Year.

CPT: Labs, Order-Writing Part of Inpatient E/M Time

The CPT 2009 descriptors for inpatient prolonged services substitute "direct [face-to-face] patient contact" with "unit/floor time." Gilhooly says this will usher in an easier way to report prolonged services -- and open doors to greater reimbursement, as CPT 2009 lifts the "face time" restriction on inpatient prolonged services.

For example: "I have followed physicians on rounds in the hospital, and at times they literally spent about two minutes face-to-face with the patient," she explains. But that does not mean the internist only spent about two minutes providing the patient with E/M; it's just that a lot of the service was "floor/unit time."

"The typical flow of these inpatient encounters started with the physician catching the patient's nurse and getting info about patient," she says. He might then spend time at the computer checking studies, lab results, vitals, overnight changes in condition, etc.

"Once the internist had that information, he would go see the patient; ask a few questions, do a physical, and then tell the patient what was going to happen in terms of treatment. These [face-to-face interactions] were relatively short encounters, for the most part," Gilhooly explains.

Then, the internist would leave the patient and go to the nursing station or dictating area to write orders, call consulting physicians, etc. Very little E/M time was face-to-face with patient -- though the physician was still providing E/M service.

Before CPT 2009, you could have only counted the "face time" toward total E/M service minutes in the above example. But with the new codes +99356 (Prolonged physician 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]), you can consider all of the internist's actions in the example part of the overall E/M -- in CPT's eyes, at least.

Medicare Yet to Weigh in on CPT Changes

At press time, the new CPT language for +99356 and +99357 was not consistent with Medicare's policy for these codes. According to MLN Matters article MM5972, "Medicare will pay for prolonged physician services [code 99356] with direct face-to-face patient contact, which require one hour beyond the usual service." The article also states you cannot count any time not spent face-to-face with the patient toward prolonged service coding in the hospital setting.

The feds should offer their opinion on the AMA's changes to +99356 and +99357 before the end of the year; look for

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more information on this topic in future issues of Internal Medicine Coding Alert.

(Check out the article at www.cms.hhs.gov/MLNMattersArticles/downloads/MM5972.pdf.)

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