Internal Medicine Coding Alert

Mythbusters: Bust These Myths, Extend Your Prolonged E/M Coding Knowledge

Take this expert advice to buy extra time the right way.

We all want to be given credit where credit is due, and that's especially true for providers when they put in extra time with patients who need that little bit more.

But when you document any extra time your internist spent working on complex conditions, counseling, record reviews or research, it's important that you know how to report such extended services correctly. To help, we've busted the four most common myths that surround the prolonged evaluation and management (E/M) codes, so you can report additional time accurately and clearly.

Mark the Codes to Know

In primary care, four codes cover most, but not all, prolonged service situations:

- +99354 - Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service) »
- +99355 - ...each additional 30 minutes (List separately in addition to code for prolonged service)
- 99358 - Prolonged evaluation and management service before and/or after direct patient care; first hour
- +99359 - ... each additional 30 minutes (List separately in addition to code for prolonged service).

The first two are add-on codes for a number of face-to-face E/M services, including 99201-99215, while the second two do not require face-to-face interaction between provider and patient.

MYTH 1: If the prolonged service goes for up to 30 minutes, you can report +99354.

Reality: This is a big no-no. CPT® regulations clearly state that "prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes."

Or, as **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians, puts it, coders should "be aware of the different time thresholds. Prolonged time of less than 30 minutes (physician codes) or 45 minutes (clinical staff codes, which are discussed later)," Moore stresses, "is not separately reportable."

Consequently, **Mary I. Falbo, MBA, CPC**, CEO of Millennium Healthcare Consulting Inc. in Lansdale, Pennsylvania, offers this timely piece of advice to coders: "When reporting prolonged services, time needs to be precise. Documentation should detail important clinical matters," Falbo reminds coders, "and it should also support coding."

MYTH 2: Any time your physician performs a prolonged E/M service that is not face-to-face, you can report 99358/+99359.

Reality: Again, CPT® guidelines are very strict when reporting these codes. Most important, they must "relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management."

CPT® also stresses that you cannot use the codes for "time spent in care plan oversight services ... home and outpatient INR monitoring ... medical team conferences ... on-line medical evaluations ... or other non-face-to-face services that have more specific codes and no upper time limit."

So, Falbo adds, per the Centers for Medicare & Medicaid Services (CMS), you can report 99358/+99359 providing you can document "prolonged communication consulting with other health care professionals related to ongoing management of the patient, prolonged review of extensive health record and diagnostic tests regarding the patient." You must also document the additional 30-74 minutes for 99358 and 15-44 minutes for +99359. The same rules as +99354-+99355 apply, only you don't have to substantiate direct patient contact.

MYTH 3: Time spent on E/M services, whether face-to-face or without the patient, has to be continuous in order to qualify for a prolonged service code.

Reality: CPT® guidelines for all the prolonged services codes state that they are used to report the total duration of face-to-face or non-face-to-face time spent by a physician or other qualified healthcare professional on a given date "even if the time spent by the physician or other qualified health care professional on that date is not continuous."

This is especially true of 99358/+99359. Moore reminds coders that they can report prolonged services such as these on a different date providing the services meet the CPT® guideline of relating "to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management." CPT® guidelines explicitly state, "This prolonged service may be reported on a different date than the primary service to which it is related."

MYTH 4: Only services provided by a physician or qualified health care professional can qualify for prolonged service codes.

Reality: Actually, there are two other specific prolonged service codes that are intended for such circumstances:

- +99415 - Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
- +99416 - ... each additional 30 minutes (List separately in addition to code for prolonged service).

The codes differ from the others in two very important ways: first, "a physician or qualified health professional" must be present "to provide direct supervision of the clinical staff," and second, the minimum time threshold for these codes is 45 minutes.

The Bottom Line

Falbo reminds coders that the prolonged service codes "must be used for unusual circumstances," that go above and beyond "the typical or average time of the documented visit code." To do that, Falbo concludes, "it is important that you record the times for these time-based codes in the medical record."