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Internal Medicine Coding Alert

Prolonged Service Codes Get Subsequent Hospital Visit Pay Up

Subsequent hospital care visits (99231-99233) are the evaluation and management (E/M) services where an interval history is one of the key components for determining the level of visit reported. They are unusual in that CPT suggests that the patients stable, nonresponsive or unstable condition can be used to determine the level of visit billed. But confusion regarding the use of interval history and patient status may result in some internists underreporting the level of visit that was performed. In addition, there are situations when an internist may appropriately attach a prolonged services code (99356-99359) to the subsequent hospital care visit to indicate that an amount of time above and beyond the level normally required was spent managing the patients care.

Subsequent care visit codes are used by an internist to report E/M services provided on the days following a hospital admission. The internist must be the patients attending physician, says **Dea Robinson Genth,** legislative liaison for the Colorado chapter of the Medical Group Management Association (MGMA) and a practice administrator at Inpatient Medicine Service, a four-physician internal medicine hospital practice in Englewood, Colo. These codes may also be used by an internist who is filling in for the patients attending physician or by an internist who is taking over a patients care for a specific problem after an initial evaluation was performed during an inpatient consultation.

Level of Initial History Affects Interval History

One of the unusual features of these codes is that interval history is one of the key components along with examination and medical decision-making in determining the level of subsequent hospital care that should be reported. HCFA (the Health Care Financing Administration) and CPT have not really defined an interval history, Genth says. Our practice defines it as what has changed with the patient in the last 24 hours or the last time we saw him or her.

Because there are no specific guidelines for documenting an interval history, internists are often confused concerning what constitutes the difference in levels of interval history. The difference between the problem-focused interval history (which is required for 99231, subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem-focused interval history; a problem-focused examination; medical decision-making that is straightforward or of low complexity) and an expanded problem-focused interval history (a requirement of 99232, subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem-focused interval history; an expanded problem-focused examination; and medical decision-making of moderate complexity) seems to be the review of systems, says **Michael Haynes, MD, FACP,** an internist and pulmonologist who is also the compliance director at University Medical Associates in Augusta, Ga. The problem is that the review of systems and personal, family and social history are not part of an interval history. Not much is going to change for those two elements from day to day. Its not likely that the patients mother has been diagnosed with a new ailment within the past 24 hours.

One of the keys to documenting and determining the level of interval history is to start with the level of history that was performed during the patients hospital admission, which can be carried over to a subsequent hospital care visit. Most internists will take a detailed or comprehensive history of the patient when he or she is admitted to the hospital, says **Catherine A. Brink, CMM, CPC,** president of Healthcare Resource Management Inc., a physician practice management consulting firm in Spring Lake, N.J. That level of history can be carried forward to subsequent hospital care visits as long as the internist reviews the history during the subsequent visit and notes in detail any changes or the lack of change.

A dated entry in the patients medical record should note the change or lack of change in symptoms, additional details about current or new symptoms, the status of other ailments or risk factors, and additional information about the patients history not included in the admitting history.

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Complexity of Condition May Override Patient Status

Another source of confusion when determining the overall level of the visit is the note at the end of each subsequent care CPT definition regarding the patients condition. For code 99231, the CPT manual states that the patient will usually be stable, recovering or improving. For code 99232, it states that the patient will usually be responding inadequately to therapy or developing a minor complication.

Internists who code strictly on the basis of the patients status may be underreporting their services for patients who are stable but have multiple conditions that require more time and complex medical decision-making. For example, a patient is not responding adequately to treatment for pneumonia, and the internist decides to order a new or additional treatment based on the patient examination and a review of test results, such as a chest x-ray and sputum culture. That E/M service probably would be a level two (99232) visit, Haynes says.

But what about the patient who has been admitted with pneumonia and is stable at the time of the visit, but also has asthma, diabetes and hypertension? Most internists will probably spend more time with this patient than one who is receiving potassium because they now have to consider all three conditions when looking at the patients charts and test results, Haynes says.

The patients problem or problems ultimately determine the medical necessity of the visit. If the patient is responding to treatment, medical necessity would not support a higher-level subsequent hospital care visit, Brink says. Multiple conditions or risk factors, however, could increase the level of medical decision-making to moderate (99232) even when the patient is stable.

Level of Visit Can Also Be Based on Time

The internist can also code the visit based on the time spent with the patient, Brink suggests. When more than 50 percent of the total encounter with the patient is spent on counseling and coordination of care, the internist can report the visit based on the element of time, she says. The internist can be counseling the patient on his or her medical problems or talking with other providers. Both services are considered part of counseling and coordination of care.

Internists may want to record beginning and ending times for a visit if it is going to be billed based on the time spent counseling and coordinating care, Brink recommends. The internist should also include a brief synopsis of what was discussed with the patient or other providers, she says.

Some Visits in ICU May Be Subsequent Care

Most internists have no problem differentiating between a level-two and level-three subsequent care visit, but may have problems determining whether to report a critical care code or subsequent visit code. The level three subsequent care visit is usually easy to delineate from the other levels of subsequent care, Haynes says. The patient is acutely ill and probably will be in the intensive care unit (ICU).

But Haynes cautions that internists should not assume any ICU patient can be billed as critical care. I see a lot of internists who bill every patient that is in the ICU as a critical care visit, he says. Thats not right. A patient could be in the ICU for postoperative observation and might not even be a level-three subsequent care visit.

The level of severity distinguishes critical care from a level-three subsequent care visit. With critical care, you dont have a choice; you have to be there, says Haynes. A patient who is on a ventilator but not rapidly deteriorating would probably be a level-three subsequent hospital care visit. Although the patient is still very sick, whether the physician visits him or her in one hour or two wont make any difference to his or her condition.

Prolonged Services When Multiple Visits Are Made

An internist may visit an acutely ill patient more than once a day, according to Haynes, but can bill for only a single subsequent hospital care visit per day. The internist, however, might be able to bill for a prolonged care service in

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addition to the daily E/M service if the combined time of the visits exceeds the CPTs recommended time for the subsequent hospital care visit by more than 30 minutes.

For example, an internist visits an acutely ill patient twice in one day and spends a total of 75 minutes with the patient. The suggested time for 99233 (subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; and medical decision-making of high complexity) is 35 minutes, which means the internist spent an additional 40 minutes with the patient and can bill a prolonged care service in addition to the subsequent hospital care visit, depending on the nature of the service that was rendered.

Medicare Does Not Reimburse for Indirect Services

Two types of prolonged services can be billed with inpatient E/M services: direct or face-to-face patient contact, reported with 99356 (prolonged physician service in the inpatient setting, requiring direct [face-to-face] patient contact beyond the usual service; first hour) and 99357 (prolonged physician service in the inpatient setting, requiring direct [face-to-face] patient contact beyond the usual service; each additional 30 minutes).

Prolonged physician service without direct (face-to-face) patient contact is reported with 99358 (prolonged evaluation and management service before and/or after direct [face-to-face] patient care [e.g., review of extensive records and tests, communication with other professionals, and/or the patient/family]; first hour). Code 99359 (prolonged evaluation and management service before and/or after direct [face-to-face] patient care; each additional 30 minutes) is used to report 30-minute increments beyond the first hour of indirect prolonged service.

Although many Medicare carriers reimburse for direct prolonged service, Medicare has established a national policy of not covering indirect prolonged services. Therefore, it is important to distinguish between the two types of service, a task made more difficult because neither Medicare nor CPT has clearly defined either service. If the internist is in the room with the patient and directly managing the patients care by examining the heart and lungs or reviewing test results, then that would be considered face-to-face contact, Brink says. Also, if the family is gathered in the patients room and the internist is discussing end-of-life issues with them, then that could also be considered face-to-face.

But if the internist is discussing end-of-life issues with the family in the hospital lounge or the internists office, then those are considered indirect prolonged services, Brink continues. Any review of lab results or documentation, as well as phone calls made from the internists office, would be considered indirect services. And reviewing records by the patients bedside, but not actively managing the patients care, would be considered indirect prolonged care because the internist didnt have to be with the patient to do that.

The lack of a clear definition in this area often means that the payer has the final say regarding what is a direct and indirect prolonged service, according to Genth. Some payers may interpret face-to-face to mean time spent on the hospital unit in the vicinity of the patient, while others interpret it strictly to mean that the internist has to be in the patients room, she explains.

Although Medicare does not reimburse for indirect prolonged care services, some private payers may, according to Brink, who recommends that internists check with their payers to see if this is a covered service. Since most internists are dealing often with high-risk patients, it may be worthwhile for them to investigate whether their major payers will cover this service, she explains. Your only other alternative to getting paid for an indirect prolonged care service would be to have the patient sign a waiver in advance of any discussion, an option that not many internists will pursue.

Four Tips for Using Prolonged Service Codes

When using prolonged care codes with the subsequent hospital care visits, be aware of the following:

1. Documentation is crucial when it comes to prolonged care codes. The internist needs to record the start and stop times of the visit(s) and what services were provided.

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2. The time for a prolonged care code does not have to be continuous. It should represent the total time spent in prolonged service for the entire day.

3. Prolonged services represent the time spent in excess of the recommended time for an E/M service. Prolonged services of less than 30 minutes are not reported separately. Therefore, if an internist spends 50 minutes with an acutely ill patient and reports the E/M service as 99233, no prolonged service can be reported because it was only 15 minutes in excess of the 35 minutes recommended for a level-three subsequent hospital care visit.

4. Codes 99356 and 99358 are used to report up to the first hour of prolonged services and can be reported only once. Codes 99357 and 99359 are used to report prolonged services in excess of the first hour, in 30-minute increments, and can be reported more than once. If an internist spends a total of 155 minutes at the bedside of an acutely ill patient, then 99233 should be reported for the subsequent hospital care service, 99356 reported for the first hour of prolonged services, and 99357 reported twice for the next 60 minutes of prolonged services.

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