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Internal Medicine Coding Alert

Prolonged Services FAQs: Value Your Extra Time

Don't let the abundance of guidelines for codes 99354-99357 deter you from properly reporting prolonged services they may be your only means of receiving additional reimbursement for the extra time your physician spends with a patient.

The prolonged services codes represent the face-to-face physician-patient time "that is beyond the usual service in either the inpatient or outpatient service," according to CPT, which is why these services are add-on codes, reported only in addition to other E/M codes that include a reference to time, without which, there is no way to determine when a service can be classified as "prolonged."

Sherry Wilkerson, RHIT, CCS, CCS-P, director of coding and compliance for Esse Health in St. Louis, explains how they work. Let's say an internist sees an established patient who has been having trouble sleeping. The internist provides an E/M service that measured by the key components of history, examination and medical decision-making qualifies as a level-four outpatient visit, 99214, which has a 25-minute physician-to-patient time allotment. But the internist spends one hour, 35 minutes more than the allotted 25 minutes discussing management of the insomnia. The internist may report 99214 and 99354 to account for the additional time he spent discussing the patient's condition. If the internist had spent less than 55 minutes total time with the patient, or fewer than 30 minutes more than the E/M's allotted 25 minutes, the internist would not have been able to account for that additional time using the prolonged services codes.

Getting reimbursed for your internist's time and navigating through the prolonged services guidelines can be a snap if you use these answer to frequently asked questions about the following codes:

+99354 Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting); first hour (list separately in addition to code for office or other outpatient evaluation and management service)
+99355 each additional 30 minutes (list separately in addition to code for prolonged physician service)
+99356 Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (e.g., maternal fetal monitoring for high-risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient); first hour (list separately in addition to code for inpatient evaluation and management service)
+99357 each additional 30 minutes (list separately in addition to code for prolonged physician service).

Q: Are there any evaluation and management codes that the prolonged services codes can't be reported with?

For Medicare carriers and the vast majority of non-Medicare carriers, the prolonged service codes can't be billed with the following:

Hospital observation services
Observation of inpatient care service, including admissions and discharges
Critical care service
Emergency department service, unless the physician is providing an outpatient consultation that goes beyond the typical time spent with a patient.

Another way to look at it is that the outpatient prolonged services codes 99354 and 99355 can only be reported in addition to outpatient visit codes 99201-99205 and 99212-99215, and outpatient consultation codes 99241-99245. And

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the inpatient prolonged services codes 99356 and 99357 can only be reported with initial hospital care codes 99221-99223, subsequent hospital care codes 99231-99233, initial inpatient consultation codes 99251-99255, follow-up inpatient consultation codes 99261-99263, comprehensive nursing facility assessment codes 99301-99303, and subsequent nursing facility care codes 99311-99313.

Q: Can I use the prolonged services codes if the internist exceeds the allotted E/M time with a patient by more than 30 minutes, but that documented time was not all in one sitting?

While it isn't necessary for the time counted toward prolonged services to be continuous, it is important that all of the time intervals spent with the patient be documented, Wilkerson says. The Medicare Carriers Manual, section 15511.1, instructs carriers to "Advise physician that to support billing for prolonged services, the medical record must document the duration and content of the E/M code billed ..." You should also check for documentation showing that the extra time spent with the patient was necessary. You don't have to go so far as to have documented start and stop times to be reimbursed, but the more detailed the documentation the better.

Q: If the internist meets the requirements for reporting a prolonged services code and he also meets the requirements for increasing the level of the E/M service because he spent more than 50 percent of his time counseling the patient and coordinating care, should we upcode the E/M level or use the prolonged services codes?

The good news is that either way you decide to code, you should be compensated for the extra time your internist spent with the patient as long as the internist's documentation clearly identifies the time spent with the patient and what was accomplished in that time.

The bad news is that neither CPT nor CMS offers guidance on whether you should report a higher-level E/M service or use the prolonged services codes when, for instance, the internist spends 35 minutes of a 50-minute (face-to-face time) established patient office visit. It would not be improper to use either method of coding.

"You have to weigh what is in your best interest," when you have the option of using either method of coding, Wilkerson says. If you decide to bill a higher-level E/M service based on time, you have to make sure you document the time and a summary of what transpired during the visit. "You can't just say that over 50 percent of the time was spent counseling you have to say exactly how much time and what happened and what was discussed during that counseling." And in either case, you must provide documentation of the time and service in the medical record.

If fewer than 30 additional minutes were spent face-to face with the patient, and counseling and coordination of care still exceeded 50 percent of the time allotted to the E/M visit, you cannot use the prolonged services codes and should report a higher E/M level based on time. On the other hand, Wilkerson says, if you are working with an E/M service that starts at 99215, the highest level, and you have spent more than 50 percent of the time performing counseling and coordination of care, the prolonged services codes are your only option for reporting the additional time.You are shortchanging your practice if you don't use the prolonged services codes and the physician has spent more than 30 minutes with the patient on top of the time allotted for 99215, she warns.

Q: Can the internist get paid for more than 30 minutes of additional time spend not face-to-face with the patient but spent discussing the patient's condition with other healthcare professional or arranging treatment in the patient's absence?

The short answer to your question is "no." Even though CPT does include two codes for prolonged services without direct patient contact +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) and +99359 (each additional 30 minutes) you'll be hard-pressed to find a payer that reimburses for them, Wilkerson says. Most insurance companies just don't want to pay for the non-face-to-face time the physician spends doing things like talking to other doctors, checking records, or talking to the family, she explains.

Medicare has not assigned relative value units to these add-on codes, and instructs Medicare carriers not to reimburse for these services. CMS'reasoning: "Payment for these services is included in the payment for direct face-to-face services that physicians bill" (i.e., the services are considered "bundled" into any E/M services provided). Therefore, you cannot

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bill any Medicare patients for these services even if the patient has signed an advance beneficiary notice (ABN). You can report these codes for the sake of coding accuracy, just don't expect to see any reimbursement from Medicare.

You may get lucky and find that some third-party payers recognize and reimburse for non-face-to-face prolonged services, but check with the carrier before getting your hopes up.

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