Part B Insider (Multispecialty) Coding Alert

E/M Coding: This MAC Reveals The Top Prolonged Service Errors

Follow these tips so you can avoid making these mistakes.

Part B practices need to keep a close eye on the clock when reporting prolonged service codes. That's the word from Part B MAC National Government Services (NGS), which identified the top errors in this category via a news article that the carrier published last week.

Check out the following errors that most often impact codes 99354-99357, as well as tips on how to avoid making the same errors.

1. Missing or Illegible Signature. NGS found that the most common error among prolonged service claims was a missing or illegible provider signature. Although a practitioner's signature can be electronic or handwritten, it cannot be stamped, so ensure that your provider signs each prolonged service note before you submit the claim.

2. Incomplete or Missing Beneficiary Information. If you're going to the trouble of calculating how much time was spent with a patient and how much of that can go toward a prolonged service code, you absolutely should be sure to include a legible beneficiary name on the claim. You should also have a date of service and the patient's Part B identification number on the claim.

3. Failure to Document Total Visit Time. Billing a prolonged service code tells a payer that you've exceeded the amount of time included in a standard E/M visit but the MAC has no way of verifying that if you don't tell them how long you were with the patient overall.

For example: Your physician provided a 72 minute E/M service, most of which was spent on counseling, so you reported 99215 and one unit of +99354 (Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour...). This is correct coding because 99354 applies to an extra 30 to 74 minutes beyond the typical time of 40 minutes allotted for 99215. In this case, the physician spent a total of 72 minutes on the service, with 32 of those minutes counting toward 99354.

However, even if you know that you met the rules for billing these codes, you have to ensure that the essentials regarding timing are in the documentation, including the total time spent with the patient. If the doctor spent the time but forgot to document it, you cannot report the codes.

4. Lack of Documentation to Establish Face-to-Face Contact by the Provider. You can't report prolonged service codes for a patient who doesn't have a face-to-face visit with the provider for the total time that you're reporting. Even if the time with the patient isn't continuous, you can count it as long as the visit is face-to-face, but otherwise the prolonged service codes won't apply.

For example: Suppose a patient presents for a 50 minute E/M service and then the physician leaves the room as the asthma patient sits with a nebulizer. When the nebulizer treatment ends 20 minutes later, the nurse puts away the nebulizer supplies and the patient checks out. In this case, the physician may be tempted to report a prolonged service code to represent the total 70 minutes that the patient was in the office, but the reality was that the face-to-face service ended at the 50 minute mark and therefore the prolonged service codes don't apply.

5. Lack of an E/M Companion Code. You cannot report a prolonged service code unless you're also billing an E/M code on that date of service. The prolonged service codes are considered add-ons and won't be reimbursed without an E/M service. For instance, our example in number three (above) demonstrates a scenario when 99215 and +99354 are the appropriate codes based on the time spent with the patient, assuming the physician documented the time

appropriately.