Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Boost Prolonged Services Savvy With These Expert Tips

Warning: Don't add prolonged service codes to service levels calculated by MDM.

If you find navigating CPT® prolonged services challenging, you're not alone. In fact, many coders have struggled with coding and billing prolonged services since Medicare introduced a new code in the 2021 fee schedule. Read on for more background information and an expert's take on what to do.

Reminder: Last December, the Centers for Medicare & Medicaid Services' (CMS) published the 2021 Medicare Physician Fee Schedule (MPFS) in the Federal Register, creating a whole set of headaches for medical billers and coders.

Their disagreement with CPT® over when service times for 99205 (Office or other outpatient visit for the evaluation and management of a new patient ... 60-74 minutes of total time is spent on the date of the encounter) or 99215 (Office or other outpatient visit for the evaluation and management of an established patient ... 40-54 minutes of total time is spent on the date of the encounter) enter prolonged territory set up two different ways of billing the same scenario.

Understand How CPT® Views Prolonged Services

As a part of their 2021 revisions to the office/outpatient E/M codes, CPT® introduced a new prolonged service code: +99417 (Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services).

CPT® instructed you to add one unit of the code when time documented hits 15 minutes beyond the minimum for the 99205/99215 time ranges - 75 minutes for a new patient visit and 55 for an established patient - and additional units for every 15 minutes beyond those times.

CPT® Example: Your provider sees an established patient for 90 minutes. You would bill 99215 for the first 40 minutes, and +99417 x 3 for the additional 50 minutes.

Know New CMS-Created Code

In the 2021 final rule, CMS argued that +99417 should be used when the total time for visits hits 15 minutes beyond the maximum time range for 99205 (i.e., 89 minutes) and 99215 (i.e., 69 minutes).

To avoid potential confusion with CPT® guidelines, CMS replaced +99417 with a new prolonged service code now recognized by Medicare and payers following Medicare payment rules: G2212 (Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) ... (do not report G2212 for any time unit less than 15 minutes)).

Medicare example: Your provider sees an established Medicare patient for 90 minutes. Here, you would bill 99215 for

the first 54 minutes, but this time, you can only bill two units of G2212. That's because CMS does not allow the G2212 to be used until 69 minutes have passed. Adding another 15 minutes to 69 minutes would bring you to 84 minutes, which means a second unit of G2212 can be reported. The remaining 6 minutes is included in the second unit as a third cannot be reported unless at least 99 minutes are documented.

Take a Breather in These Situations

Fortunately, the following similarities illustrate the ways you can, and cannot, apply both +99417 and G2212 help make your life a little easier:

- You can apply both codes when the office/outpatient E/M service is coded based on total time. You cannot add prolonged service codes to service levels calculated by medical decision making (MDM).
- Times for the initial and prolonged service are times the provider spends with or without direct patient contact the same day as the encounter per the descriptors for +99417 and G2212. This means "you can count numerous activities, including any time the provider spends updating a patient's clinical information in the record, providing they occur on the day of the visit," notes **Mary I. Falbo, MBA, CPC**, CEO of Millennium Healthcare Consulting Inc. in Lansdale, Pennsylvania.
- You can only apply the codes to office/outpatient E/M codes 99205 and 99215, and you should not report them on the same date of service as +99354/+99355 (Prolonged service(s) in the outpatient setting requiring direct patient contact ...), 99358/+99359 (Prolonged evaluation and management service before and/or after direct patient care ...), or +99415/+99416 (Prolonged clinical staff service ... during an evaluation and management service in the office or outpatient setting ...).

Bottom Line: Bill Differently

In the end, CMS' adoption of G2212 "means practices will have to bill Medicare differently for prolonged office visits than they do payers who follow CPT®. That means more administrative complexity, which is the last thing your practice needs these days," notes **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians.