Eli's Rehab Report

Reader Question: Is Modifier -51 Required for Prolonged Services?

Question: Does **CPT 99359** need to be listed separately for each unit of time? And for Medicare, should modifier -51 (multiple procedures) be appended after the primary procedure?

Indiana Subscriber

Answer: The prolonged service codes are add-on codes, which should be appended to your E/M codes when the face-to-face services exceed the normal E/M services. Use code 99358 (prolonged E/M 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) for the first hour of prolonged service. It can be billed once per day for prolonged services that exceed the normal E/M service by 30 to 60 minutes, even if that extra 30 to 60 minutes is not continuous on that date.

Use 99359 (each additional 30 minutes) to report each additional 30 minutes beyond the first hour. You can bill multiple units of 99359 if your documentation warrants it, and modifier -51 is not required. Therefore, if you saw a patient with transient paralysis (781.4) whose E/M visit only fulfilled the requirements for a 99214, but lasted for two hours (120 minutes), your claim would read:

99214 (one unit)
99358 (one unit)
99359 (two units)

No Modifier is necessary, since these are add-on codes.

Note: For more information on billing prolonged services, see Use Prolonged Service Codes to Avoid Lost Revenue in the February 2000 Physical Medicine & Rehab Coding Alert.

Answers for Reader Questions and You Be the Coder provided by Catherine Brink, CMM, CPC, president of Healthcare Resource Management Inc., a practice management and reimbursement consulting firm in Spring Lake, N.J.; Cynthia Thompson, CPC, and Brenda Messick, CPC, senior consultants at Gates, Moore & Co., a physician reimbursement consulting firm in Atlanta; and Andrea Lamb, CPC, St. Josephs Medical Plaza, a multi-specialty practice in Buckhannon, W.Va.