Eli's Rehab Report

READER QUESTIONS: Prolonged Services Require Same Date

Question: Our group of physiatrists evaluates a patient on day one. The following day the patient returns for a review of condition by the therapist, but the therapist does not re-evaluate the patient. We usually bill an E/M code for the first day and prolonged services for the second, but I have recently been told that prolonged services must be performed on day one. What is proper coding for the second day?

Arizona Subscriber

Answer: According to CPT guidelines, prolonged services (99354-99357) are add-on codes used "to report the total duration of face-to-face time spent by a physician on a given date." Although time counted toward prolonged services need not be continuous, they must occur on the same date of service as the "base" E/M service.

In this case, the therapist sees the patient on the day after the physician provides the principal E/M service, and therefore the prolonged service codes are not appropriate.

Correct coding for the second day depends on the exact circumstances of the visit. If the therapist provides medically necessary services "incident-to" the primary physician, you should bill the follow-up visit as an established patient E/M service (99211-99215).

Medicare defines incident-to services as services provided by a nonphysician practitioner that are an integral part of the physician's personal professional services in the course of a diagnosis or treatment of an injury or illness.

You should report services provided incident-to using the appropriate CPT codes under the supervising physician's personal identification number. The insurer will reimburse your services at 100 percent of the Physician Fee Schedule.

You can find complete guidelines for billing incident-to services in section 2050 of the Medicare Carriers Manual.

If the therapist provides an evaluation under his own name as part of a physical therapy plan of care, the correct code is 97001 (Physical therapy evaluation).