Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Look Out--Prolonged-Services Switch Just Around the Corner

Learn how these CMS changes will affect your E/M coding and reimbursement

Coding for prolonged services can be daunting. But thanks to Medicare changes coming down the pike, CMS-expectations will be a little clearer.

Today we will tell you what's in store and how these changes can help you ratchet up your practice's reimbursement.

1. Document Start and Stop Time, CMS Says

Keep an eye on the clock: According to Medicare Transmittal 1490, effective July 1, -When reporting prolonged services, the provider shall document both the visit start and end time in the medical record along with the date of service,- says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO**, with **MJH Consulting.** You can find the transmittal online at www.cms.hhs.gov/transmittals/downloads/R1490CP.pdf.

Why it matters: -The medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show that the physician or qualified NPP personally furnished the direct face-to-face time with the patient specified in the CPT code definitions,- the transmittal states.

But don't forget: Prolonged service codes 99354-99357 require -face-to-face- patient care. That doesn't mean, however, that the time must be continuous. The encounter doesn't have to be one long face-to-face session, says **Mary Falbo, MBA, CPC**, president of **Millennium Healthcare Consulting** in Lansdale, Pa.

Example: A physician visits a patient in the morning and, upon reviewing all of the patient's clinical information, decides that the patient needs another diagnostic study. The patient leaves to get the test and comes back that afternoon to discuss treatment options with the physician, who reviews the test results.

You may be able to report a prolonged service code in this case even though the time the physician spent with the patient wasn't continuous, Falbo says. Just be sure the start and stop times are included in the documentation.

2. Avoid Rounding for Time-Based E/M Choices

Warning: When you choose an E/M code level based on time spent on counseling and/or coordination of care (C/C), remember that Medicare has its own prolonged service rules.

Rule: Transmittal 1490 clarifies that when you report prolonged services as an add-on to E/M codes based on C/C (time-based), -the time approximation for the E/M service must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the evaluation and management code) and should not be -rounded- to the next higher level,- Hammer says.

What it means: If you base the E/M service level on time spent in C/C, the total face-to-face time has to meet or exceed the -typical time threshold- for that service level, Hammer says. You can't -round up- after meeting a halfway point as you can with many other time-based codes (such as physical therapy services), Hammer says.

She cites this example: A patient sees your physician with a total face-to-face time of 35 minutes. The established

office visit level is based on time spent in C/C.

Per Medicare, you can't -round up- a level-four service--99214 (Office or other outpatient visit -)--to a level-five service such as 99215 because the service doesn't meet CPT's -typical time threshold- of 40 minutes for a level-five service, Hammer says.

This holds true despite the face-to-face time--35 minutes--being at a point more than halfway between the times typically associated with these codes (25 minutes for 99214 and 40 minutes for 99215), Hammer says. The Medicare transmittal indicates that -rounding up- after meeting -more than the halfway- point is not applicable for determining E/M service level based on counseling and/or coordination of care.

3. Watch for Highest Code Level for C/C Coding

Rule: This new Medicare transmittal also states that when the level of service is based on time spent in counseling/coordination of care, you may report prolonged services only with the highest code level in that E/M code category.

What it means: If your provider bases the E/M level of service on time spent in C/C, then you may report prolonged services only if the E/M service level is the highest level in the applicable code category, such as 99205, 99245 or 99215.

Example: An established patient sees your physician in the office with a total face-to-face time of 65 minutes. Again, you base the visit level on time spent in C/C. In this case, you meet the time criteria for billing 99215 (typical time threshold of 40 minutes).

But the actual face-to-face time (65 minutes) minus the 40 minutes required for 99215 leaves you with 25 extra minutes, Hammer says. She notes that this does not meet the required threshold of 70 minutes--99215 threshold + 30 minutes--for you to bill 99215 plus 99354. For Medicare, reporting a lower E/M service level (such as 99214) with a prolonged service code (such as 99354) would not be compliant when you base the E/M service level on C/C time.

The bottom line: When you determine the level of service based on time spent in C/C, Hammer says, you may bill prolonged services only if the total time meets the threshold of the highest level's typical time plus 30 minutes. -However, this would not be the case if the E/M level of service is based on meeting the key component requirements,- she says.