



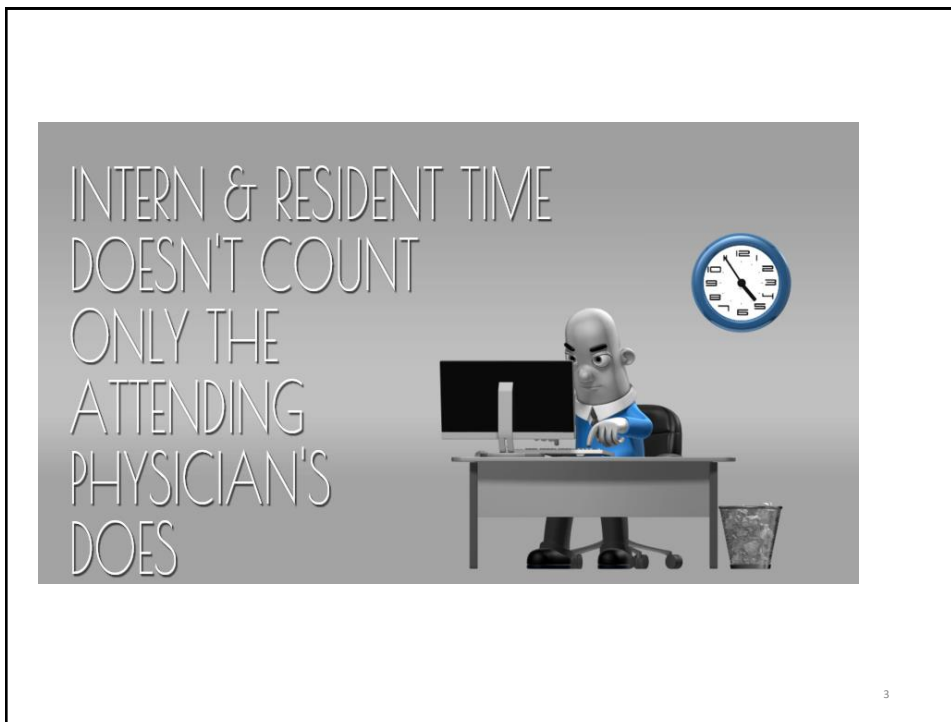
TIME BASED CODING

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Disclaimer

- This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational a guide and should not be considered a legal/consulting opinion



Time with House Staff

- Only the time the attending is working with or on the patient
- Do not count teaching time
- May use documentation of resident/fellow in their note
 - Only their time counts toward quantity of minutes being coded

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Face to Face



- CPT defines *with the patient and/or family*
- Medicare requires presence of patient
 - Exception
 - Observing interaction between family members
 - Assessing capability of family members to aid in the management of the patient

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Unit Floor – CPT[®] definition

- CPT - Includes time present on the patient's hospital unit and at the bedside rendering services for the patient. This includes time to establish and/or review the patient's chart, examine the patient, write notes and communicate with other professionals and the patient's family
- Pre-and Post time includes time spent off the patient's floor performing such tasks as reviewing pathology and radiology findings in another part of the hospital .
 - This time is NOT included in the time component

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Unit Floor - CMS

- CMS - Time must be spent at the immediate bedside or elsewhere on the floor or unit so long as the physician is immediately available to the patient.
 - For example, time spent reviewing medical records, reading x-rays, laboratory test results, **charting** or discussing the patient's care with other medical staff in the unit or at the nursing station on the floor may be reported
 - The physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

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Counseling & Coordination of Care

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CPT - Time

- When counseling and/or coordination of care constitute more than 50% of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or unit/floor time in the hospital or nursing facility) time may be considered the key or controlling factor to qualify for a particular level of E/M service.”



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CPT Assistant – August 2004 CPT 2018

- “Counseling is a discussion with a patient and/or family concerning one or more of the following areas:
 - Diagnostic results, impressions and/or recommended diagnostic studies
 - Prognosis
 - Risks and benefits of management (treatment) options
 - Instructions for management (treatment) and/or follow-up
 - Importance of compliance with chosen management (treatment options)
 - Risk factor reduction
 - Patient and family education”



CPT Assistant – August 2004

- This includes time spent with those who have assumed responsibility for the care of the patient or decision making, regardless of whether they are family members (eg, child's parents, foster parents, person acting in locum parentis, legal guardian). “

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CPT Assistant – August 2004

- “The documentation requirements when using time with counseling and/or coordination of care are twofold
 - First, the physician must include a record of total time of the visit as well as the time spent in the specific counseling or coordination of care activities.
 - Secondly, the note should include a summary of the content of the counseling that occurred.

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CPT Assistant – August 2004

- Therefore, in order to select the appropriate E/M code, the first question to ask is “Did counseling or coordination of care dominate the visit?”
- This is true whether the E/M service involves a new or an established patient visit.

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CPT Assistant – August 2004

- If counseling and/or coordination of care did not constitute more than 50% of the face-to-face physician/patient encounter in the office or other outpatient setting or floor/unit time in the hospital or nursing facility setting, then the level of service is selected on the basis of the key components (ie, history, examination, and medical decision making).”



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MCM Chapter 12: Section 30.6.1.C



- “The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but **that estimate**, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.”

1995 & 1997 Evaluation & Management Guidelines

- In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.
- *The E&M code is selected based on the total time of the visit*
AND
- *Medical necessity*

1995 & 1997 Evaluation & Management Guidelines

- *DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.*

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Prolonged Services

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Prolonged Services

- Prolonged Service With Direct Patient Contact
 - + 99354
 - + 99355
- Prolonged Service Without Direct Patient Contact
 - + 99358
 - + 99359
- Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision
 - +99415
 - +99416

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Prolonged Service Codes

- Add-on time-based codes require that the primary E/M service have a typical or specified time included in their descriptors*
- Time standards for reporting prolonged services require that the services occur on one date
- Time does not need to be continuous
- The total amount of service time beyond the typical time of the primary E&M service would be used to select the appropriate prolonged service code

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Prolonged Clinical Staff Services
with Physician or Other Qualified
Health Care Professional

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Prolonged Clinical Staff Services-
Code Combinations
99415-99416

- Office New Patient
 - 99201-99205

- Office Established Patient
 - 99211-99215

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Prolonged Clinical Staff Services with Physician Or Other Qualified Health Care Professional Supervision

- +99415 - Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour
- (List separately in addition to code for outpatient Evaluation and Management service)
- +99416 - each additional 30 minutes
- (List separately in addition to code for prolonged service)

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Prolonged Clinical Staff Services with Physician Or Other Qualified Health Care Professional Supervision

- Used when a prolonged evaluation and management (E/M) service provided in the office or outpatient setting that involved prolonged clinical staff face-to-face time beyond the typical face to face time of the E/M service as stated in the code description.
- Physician or other qualified health care professional is present to provide direct supervision
- Reported in addition to the designated E/M service

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Prolonged Clinical Staff Services with Physician Or Other Qualified Health Care Professional Supervision

- Only for use in outpatient settings
 - Facilities may not report codes
- Physician is responsible for the care of the patient
 - Does not require face-to-face time by the physician or other qualified health care professional.
- 99415-99416 may be reported for no more than 2 simultaneous patients

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Prolonged Clinical Staff Services with Physician Or Other Qualified Health Care Professional Supervision

- Physician code is selected based on documentation
 - That typical published time is the base time
- Clinical staff must first meet that base time (face to face with patient) BEFORE clock starts on the Prolonged Clinical Staff time

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Prolonged Clinical Staff Services with Physician Or Other Qualified Health Care Professional Supervision

- Minimum time to report Clinical Staff time is 45 minutes (beyond time of physician code)
- Time does not need to be contiguous
- For a 99214 (published time 25 minutes)
 - After 25 minutes *of Clinical Staff* face to face with patient clock starts
 - After another 45 minutes of face to face time with patient – 99415 is possible to bill
 - 70 minutes required in this example to consider billing 99415

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Prolonged Clinical Staff Services with Physician or Other Qualified Health Care Professional Supervision

| Total Duration of Prolonged Services | Code(s) |
|--------------------------------------|-----------------------------------|
| Less than 45 minutes | Not billable |
| 45-74 Minutes | 99415 x 1 |
| 75-104 | 99415 x 1 and 99416 x 1 |
| 105 or more | 99415 x 1 and 99416 x 2 (or more) |

- 99415 – First Hour
 - Threshold is 45 minutes
- 99416 – Each additional 30 Minutes
 - Threshold is 15 minutes

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Documentation

- Specifics on why extra time was needed

- Physician Codes
 - Documentation must support code selected
 - Bullet points
 - Counseling and Coordination of care
- Clinical Codes
 - What was happening
 - What was being monitored

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Prolonged Service Without Direct Patient Contact

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Prolonged Service Without Direct Patient Contact

- Prolonged evaluation and management service before and/or after direct patient contact
 - + 99358 – first hour
 - + 99359 – each additional 30 minutes

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Prolonged Service Without Direct Patient Contact

- Must relate to a service or patient where (face-to-face) patient care as occurred or will occur
- AND
- Relate to ongoing patient management.

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Prolonged Service Without Direct Patient Contact

- Services generally but not limited to
 - Prolonged communication consulting with other health care professionals related to ongoing management of patient
 - Evaluation and Management service performed earlier on the patient
 - Prolonged review of extensive health record and diagnostic tests regarding the patient

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Prolonged Service Without Direct Patient Contact

- No place of service shown with code
- Intended for practitioner's time spent and not clinical staff time
- Time does not have to be continuous
- Generally provided
 - Not traditional office setting
 - Not traditional unit floor setting


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Prolonged Service Without Direct Patient Contact

- Do not report if time spent in non-face-to-face care described by more specific codes having no upper time limit
- CMS would expect that only time spent in excess of typical times published would be reported under 99358-99359
- Codes 99358 and 99359 can only be used to report extended qualifying time of the billing physician or other practitioner (not clinical staff).

Prolonged Service Without Direct Patient Contact

- Do not report codes with
 - 99487, 99489 – Complex Chronic Care
 - 99490 – Chronic Care
 - G0502, G0503, G0504 - Psychiatric Collaborative Care Model
 - G0507 – Behavioral Health Integration



Prolonged Service With Direct Patient Contact

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Prolonged Service With Direct Patient Contact

- When a physician or other qualified health care professional provides prolonged service(s) involving direct patient contact that is provided beyond the usual service in either the inpatient or outpatient setting.
- The use of the time based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook.

• CPT 2018

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Prolonged Service with Direct Patient Contact

Guidelines

- Used to report total duration of face-to-face time spent by a physician or other qualified health care professional on a given date:
 - In the office or other outpatient setting
 - At the bedside and on the patient's floor or unit in hospital or nursing facility
 - Direct patient contact is face-to-face and includes additional non-face-to-face services on the patient's floor or unit in the hospital or nursing facility during the same session.
- The time does not have to be continuous

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Prolonged Service with Direct Patient Contact

Guidelines

- This service is reported in addition to the primary procedure (i.e., the designated evaluation and management[E&M] services at any level or code 90837 psychotherapy, 60 minutes with patient and/or family member) and any other services provided at the same session.
- Appropriate codes should be selected for supplies provided or other procedures performed in the care of the patient during this period

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Prolonged Service with Direct Patient Contact

Guidelines

- Time spent performing separately reported services other than the E/M or psychotherapy service is not counted toward the prolonged services time.
- Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service.
- Either code should be used only once per date, even if the time spent by the physician or other qualified health care professional is not continuous on that date.

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Prolonged Service with Direct Patient Contact

Guidelines

- Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management or psychotherapy codes.
- For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, use 99415, 99416.

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Prolonged Service with Direct Patient Contact

| Total Duration of Prolonged Services | Code(s) |
|--------------------------------------|-----------------------------------|
| Less than 30 minutes | Not billable |
| 30-74 Minutes | 99354 x 1 |
| 75-104 | 99354 x 1 and 99355 x 1 |
| 105 or more | 99354 x 1 and 99355 x 2 (or more) |

| Total Duration of Prolonged Services | Code(s) |
|--------------------------------------|-----------------------------------|
| Less than 30 minutes | Not billable |
| 30-74 Minutes | 99356 x 1 |
| 75-104 | 99356 x 1 and 99357 x 1 |
| 105 or more | 99356 x 1 and 99357 x 2 (or more) |

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99354 & 99356 – First Hour – (threshold is 30 minutes)
 99355 & 99357 –Each additional 30 Min (threshold is 15 minutes)

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Prolonged Services Office or other Outpatient Setting

+ 99354 - Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient **Evaluation and Management or psychotherapy** service

+ 99355 - each additional 30 minutes (List separately in addition to code for prolonged service)

- Face to Face time (CPT & CMS)

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Prolonged Care Office

- Not Billable under prolonged office services
 - Time spent by office staff with the patient
 - Time the patient remains unaccompanied in the office

Office – 45 Minute Service

- If the dominate service has traditional elements of History, Exam and Medical Decision making.
 - 99213 (2.06) + prolonged service (3.66) = 5.72 RVU
- If the dominant service is counseling and time is the basis of the code selection
 - 99215
 - TOTAL 4.08 RVU

Bill Based on Documentation
don't

"just bump up the code"



Only The Provider Knows What Went on in the Room

PROLONGED CARE

- Code selected based on requirements of elements of E&M visit
 - History, Exam, MDM
- Additional time spent face to face beyond published time for code
 - Minimum 30 minutes beyond
- E&M code billed and also prolonged care code

COUNSELING & COORDINATION OF CARE

- More than 50% of face to face time spent in discussions with patient
- E&M Code selected based on total time of visit
- Documentation total time and % of time spent C&C
- May have elements of E&M in documentation

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Prolonged Services Inpatient or Observation Setting

+ 99356 - Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service, first hour

+ 99357 - each additional 30 minutes (List separately in addition to code for prolonged service)

- Face to Face time (CMS)*
- Unit Floor (CPT)
- 2.60 RVU both codes



Prolonged Care Hospital

- “In the case of prolonged hospital services, time spent reviewing charts or discussion of a patient with house medical staff and **not with direct face-to-face contact** with the patient, or waiting for test results, for changes in the patient’s condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services. “

Documentation Requirements

MCM Chapter 12:Sec 30:6:151D

- Documentation is required in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services billed.
- 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.

Documentation Requirements

MCM Chapter 12:Sec 30:6:15.1D *(cont'd)*

- The start and end times of the visit shall be documented in the medical record along with the date of service.

TIME BASED CODES

Prolonged Care

- Code selected based on requirements of elements of E&M visit
 - History, Exam, MDM
- Additional time spent face to face beyond published time for code
 - Minimum 30 minutes beyond
- E&M code billed and also prolonged care code

Counseling and Coordination of Care (C&C)

- More than 50% of face to face time spent in discussions with patient
- E&M Code selected based on total time of visit
- Documentation total time and % of time spent C&C
- May have elements of E&M in documentation

| CPT CODE | TYPICAL TIME (Used for C&C) | THRESHOLD TO BILL PROLONGED |
|----------------------------|--------------------------------|-----------------------------------|
| Office New Patient | | |
| 99201 | 10 | 40 |
| 99202 | 20 | 50 |
| 99203 | 30 | 60 |
| 99204 | 45 | 75 |
| 99205 | 60 | 90 |
| Office Established Patient | | |
| 99212 | 10 | 40 |
| 99213 | 15 | 45 |
| 99214 | 25 | 55 |
| 99215 | 40 | 70 |

| CPT CODE | TYPICAL TIME (Used for C&C) | THRESHOLD TO BILL PROLONGED |
|--------------------------|--------------------------------|-----------------------------------|
| Hospital Initial Care | | |
| 99221 | 30 | 60 |
| 99222 | 50 | 80 |
| 99223 | 70 | 100 |
| Subsequent Hospital Care | | |
| 99231 | 15 | 45 |
| 99232 | 25 | 55 |
| 99233 | 35 | 65 |

Prolonged Physician Services

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Prolonged Care Hospital

- Day Prior to Discharge –
- Patient is stable
 - Service 99231 or 99232
- Extra time is spent
 - Visit is not counseling and coordination of care
 - Visit is bullet points of 99231 or 99232
 - Medical necessity is only met for these two codes
- Total Visit time 99231 - 45 minutes 99232 - 55 minutes

| | |
|-----------------------|-----------------------|
| RVU: 1.11 | RVU: 2.06 |
| Prolonged | Prolonged |
| <u>Care RVU: 2.61</u> | <u>Care RVU: 2.61</u> |
| TOTAL: 3.72 | TOTAL: 4.67 |

99233 RVU = 2.95

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CRITICAL CARE

- “Direct delivery by a physician of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of *imminent or life threatening deterioration* in the patient’s condition.”



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CRITICAL CARE - CMS

- “*Providing medical care to a critically ill patient should not be automatically determined to be a critical care service for the sole reason that the patient is critically ill.*
- *The physician service must be medically necessary and meet the definition of critical care services as described above to be considered covered”*

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CRITICAL CARE

- 1. Clinical Condition Criterion
 - There is a high probability of sudden, clinically significant, or life threatening deterioration in the patient's condition that requires the highest level of physician preparedness to intervene urgently
- 2. Treatment Criterion
 - Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or **life threatening deterioration** in the patient's condition.

Program Memoranda Carriers PM Rev. B-99-43, December 1999 ⁵⁷

CPT Assistant – December 1998

- The care of such patients typically involve decision making of **high complexity** to assess, manipulate and support circulatory, respiratory, central nervous, metabolic or other vital system functions to prevent or treat single or multiple vital organ system failure. It often also requires extensive interpretation of multiple databases and the application of advance technology to manage the patient.

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CRITICAL CARE



- “Time spent with the individual patient should be recorded in the patient’s record.”
- “Also, when the patient is unable or clinically incompetent to participate in discussions, time spend on the floor or unit with family members or surrogate decision makers obtaining a medical history, reviewing the patient’s condition or prognosis or discussing treatment or limitation(s) of treatment may be reported as critical care, provided that the conversation bears directly on the management on the patient.”

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Critical Care Time

- Total time of critical care should be documented
 - No particular format required
 - Recommend start and stop times
- Includes any time the physician devotes their full attention to the critical patient on the unit floor*



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Critical Care Time

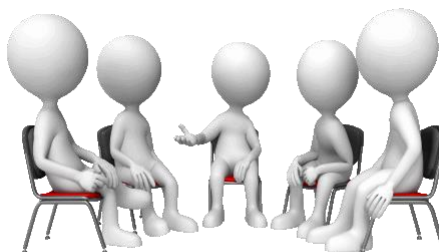
- Only one physician may bill for critical care services during any one single period of time even if more than one physician is providing care to a critically ill patient.
- Time may be aggregated throughout the day
 - Must show this in documentation



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Family Discussions

- For family discussions, the physician should document:
 - The patient is unable or incompetent to participate in giving history and/or making treatment decisions
 - The necessity to have the discussion (e.g., "no other source was available to obtain a history" or "because the patient was deteriorating so rapidly I needed to immediately discuss treatment options with the family",
 - Medically necessary treatment decisions for which the discussion was needed, and



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Family Discussions

- For family discussions, the physician should document:
 - A summary in the medical record that supports the medical necessity of the discussion
 - All other family discussions, no matter how lengthy, may not be additionally counted towards critical care. Telephone calls to family members and or surrogate decision-makers may be counted towards critical care time, but only if they meet the same criteria as described in the aforementioned paragraph.
- MCM 30.6.12.E



Importance of Diagnosis Coding

- Reflects patient condition(s) being managed **that day**
- Used in hospitals determination of DRG
- Can separate critical care service from other specialty services, helping to eliminate concerns regarding concurrent care
- General guideline: Code all conditions which exist at the time of the encounter that require or affect patient treatment or management
- Code in order of importance or severity

Subjective Data NOT Indicative of Patient's Critical Illness

- "Alert and awake" and "feeling good today"
- "Did not sleep because of diarrhea"
- "Pt has no complaints"
- "Eating breakfast"
- "In no acute distress"



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PLAN NOT indicative of pt's critical illness

- "patient has been stable overnight"
- "PFT show severe COPD"
- "patient c/o upper abdominal pain and is having diarrhea"
- "patient was extubated yesterday and is breathing without efforts. He is oxygenating well on 2L nasal cannula."

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CRITICAL CARE

- Critical care, evaluation and management of the critically ill or critically injured patient;
 - 99191 - first 30-74 minutes
 - 99292 - each additional 30 minutes (add-on)

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Reporting of Critical Care Services

| Total Duration of Critical Care | Appropriate CPT Codes |
|---------------------------------|--|
| Less than 30 minutes | 99232 or 99233 or other appropriate E/M code |
| 30 - 74 minutes | 99291 x 1 |
| 75 - 104 minutes | 99291 x 1 and 99292 x 1 |
| 105 - 134 minutes | 99291 x1 and 99292 x 2 |
| 135 - 164 minutes | 99291 x 1 and 99292 x 3 |
| 165 - 194 minutes | 99291 x 1 and 99292 x 4 |

MedLearn Matters 5993

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Proper Use of 99292 “Block of time”

- “Code 99292 is used to report additional block(s) of time up to 30 minutes each beyond the first 74 minutes of critical care.”
 - Defined by CMS & CPT®



Clarified in Transmittal 1548 Dated July 9, 2008

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Proper use of 99291



- The initial critical care time (billed as CPT code 99291) must be met by a single physician or qualified NPP. This may be performed in a single period of time or be cumulative by the same physician on the same calendar date.
- A history or physical examination performed by one group partner for another group partner in order for the second group partner to make a medical decision would not represent critical care services.

Medlearn 5993

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Hospital Discharge Services

- 99238 and 99239
- Based on time
 - ≤30 minutes
 - >30 minutes
- Includes
 - Examination of patient
 - Discussion of hospital stay/counseling
 - Instructions for continuous care to patient and caregivers
 - Writing prescriptions and referral forms
 - Preparing discharge records-including dictation



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Hospital Discharge Services

- Can be billed on a day other than the discharge day
- Cannot bill date of death
 - Unless you are pronouncing physician
- Can be billed as a split shared visit

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THANK YOU!!



Questions???

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