Disclaimer

This material is designed to offer basic information for coding and billing and is presented based on the experience, training and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the presenter does not accept any responsibility or liability with regards to errors, omissions, misuse, or misinterpretation. This presentation and handout is intended as an education guide only.

Presentation Outline

1. E/M Services
2. Critical Care Services
3. Prolonged Care Services
4. Psychotherapy
5. Infusions
6. Smoking Cessation
7. Physical Therapy
8. Resources & Links
E/M Visits

Established Office Visit:
- Total E/M visit = 55 min
- Counseling Time = 30 minutes (more than 50% of total) .......(description).

What should be billed and documented?
- EM code?
- Both E/M & Prolonged Care (CPT 99354-99355)?
- Extra time Monitoring versus Counseling?
- What if Resident & Teaching Physician?

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time For E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>5</td>
</tr>
<tr>
<td>99212</td>
<td>10</td>
</tr>
<tr>
<td>99213</td>
<td>15</td>
</tr>
<tr>
<td>99214</td>
<td>25</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
</tr>
</tbody>
</table>

Using time as controlling factor for E/M when counseling or coordination of care dominates the visit.

Discharge management includes:
- Final exam of patient
- Discussion of hospital stay
- Discharge instructions (including time to instruct family or other caregivers)
- Preparation of discharge records, prescriptions and referral forms

CPT 99238 Hospital discharge day management; 30 min or less
CPT 99239 Hospital discharge day management; more than 30 min
- Must document time
- Include all time even if not continuous on the same date

Do not confuse: reporting requirements for physician coding and hospital requirements
Discharge Services
Nursing Facility

› CPT 99315  Nursing Facility Discharge, day management; **30 minutes or less**

› CPT 99316  Nursing Facility Discharge, day management; **more than 30 minutes**
  - **Must document time**

Discharge Documentation

› Reason for hospitalization
› Significant findings
› Summary of procedures and treatment provided
› Patient’s discharge condition
› Patient and family instructions (as appropriate)
› Attending physician’s signature

› **Time, if more than 30 minutes**
  - “40 minutes spent in D/C management”
  - “More than 30 minutes spent in D/C management”

Death Pronouncement

› Use Discharge Day Management codes (CPT 99238-99239)
  - Only physician who performs the pronouncement
  - Use date pronouncement occurred even if the paperwork is delayed to a subsequent date
  - Completion of the death certificate alone is not sufficient for billing
  - Physician must “examine” the patient, thus satisfying the “face to face” visit requirement

› **Document the cumulative time when reporting 99239 or 99316 (greater than 30 minutes)**

Source: CMS’ Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, §30.6.9.2E
Hourly codes (CPT 99291-99292) used for:
- Over 71 months of age
- Outpatient pediatric/neonates

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptions</th>
<th>Fee Office (POS 11)</th>
<th>Fee Facility (POS 22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99291</td>
<td>Critical care, E/M of the critically ill or critically injured patient; first 30-74 minutes</td>
<td>$272.18</td>
<td>$217.75</td>
</tr>
<tr>
<td>99292</td>
<td>Critical care, each additional 30 minutes (Separately in addition to CPT 99291)</td>
<td>$120.78</td>
<td>$109.55</td>
</tr>
</tbody>
</table>

Neonate & Pediatric Critical Care Codes (Daily)
- Used as long as the neonate/infant/young child qualifies for critical care services during the hospital stay

Neonate Critical Care Codes (28 days of age or younger):
- 99468-99469: Inpatient critical care services provided to neonates 28 days of age or younger

Pediatric Critical Care Codes (29 days of age to 71 months):
- 99471-99476: Inpatient critical care services provided to infants 29 days through 71 months of age

Note: These codes have specific guidelines, not covered in this presentation.
Critical Care Requirements

1. Reasonable and medically necessary;
2. Clinical condition – critically ill;
3. Critical care work; and
4. Documentation of time

- If the services are reasonable and medically necessary but do not meet the criteria for Critical Care services, they should be coded as another appropriate E/M service (e.g., subsequent hospital care, CPT codes 99231–99233)

(Critical Care is defined in Medicare Claims Processing Manual: Pub. 100-04, Ch.12,30.6.12)

Critically Ill

The criteria for defining a critical care condition:

- High probability of sudden, clinically significant or life threatening deterioration in the patient’s condition
- The condition requires the highest level of physician preparedness for urgent intervention.

Critical Care Work

- Require a physician’s direct personal supervision and management of life- and organ-supporting interventions that may require frequent 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.

  - The physician must devote his or her full attention to the patient and therefore cannot render E/M services or other services to another patient during the same time period.
Special Considerations

- Warranted versus unwarranted Critical Care
- Chronic Illness & Critical Care
- Bundled Procedures*
- Separately Billable Procedures (Unbundled)*
- Covered versus non covered activities
- Family Discussion
- Teaching Time
- Non Physician Practitioners & Shared Visits
- Medical Students

*See Resource section

Time

- Physician must document time (per date/calendar day)
  - Start/Stop times vs. Total time?

- Time counted:
  - Must be exclusively devoted to patient
  - Does not have to be continuous
  - Includes time spent on bundled procedures
  - Excludes teaching time

- Critical Care Services are not restricted to a fixed number of days

Best Practices – Documentation

- Time-based service, must include the total time spent performing critical care services:
  - “Total critical care time, excluding procedures, 1 hour and 40 minutes”

- Additionally, each daily note should include:
  - Specific diagnoses supporting critical illness
  - Details of the patient’s condition and critical care work to support the ongoing critical illness and the high complexity of decision-making
CPT 99291 (Critical Care, first hour) is used to report physician services that provide constant attention to a critically ill patient for a total of 30–74 minutes on a given day.

A physician may bill only one unit of CPT code 99291 for a patient on a given date.

If the total duration of Critical Care provided by the physician on a given day is less than 30 minutes, the appropriate E/M code should be used. (Usually 99221-99223 – initial encounter or 99231-99233 – subsequent encounters)

Additional Critical Care services over 74 minutes should be billed with CPT add on code of 99292 for each additional 30 minutes beyond 75 minutes.

### Counting Units

<table>
<thead>
<tr>
<th>Total Duration CC (minutes)</th>
<th>Total Duration CC (hr &amp; min)</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 minutes</td>
<td>30 min – 1hr 14 min</td>
<td>99232 or 99233</td>
</tr>
<tr>
<td>30–74 minutes</td>
<td></td>
<td>99291 x 1</td>
</tr>
<tr>
<td>75–104 minutes</td>
<td>1 hr 15 min – 1 hr 44 min</td>
<td>99291 x 1 and 99292 x 1</td>
</tr>
<tr>
<td>105–134 minutes</td>
<td>1 hr 45 min – 2 hr 14 min</td>
<td>99291 x 1 and 99292 x 2</td>
</tr>
<tr>
<td>135–164 minutes</td>
<td>2 hr 15 min – 2 hr 44 min</td>
<td>99291 x 1 and 99292 x 3</td>
</tr>
<tr>
<td>165–194 minutes</td>
<td>2 hr 45 min – 3 hr 14 min</td>
<td>99291 x 1 and 99292 x 4</td>
</tr>
<tr>
<td>195 minutes or longer</td>
<td>3 hr 15 min – etc.</td>
<td>99291–99292 as appropriate (per above illustrations)</td>
</tr>
</tbody>
</table>

The initial Critical Care service (CPT 99291) must be met by a single physician or qualified NPP.

Physicians in group practice of the same specialty:
- Considered single physician for billing and reporting
- Should not each report CPT 99291 on the same date

Physicians in group practice of different specialty:
- Considered without regard to membership in same group
- Can each report 99291, if providing care that is unique to specialty and managing at least one of the patient’s critical illnesses
- Cannot report 99291, if providing “staff coverage” or “follow up”
CPT 99292
Each Additional 30 Minutes

- Subsequent Critical Care services performed on the same calendar date:
  - Report CPT code 99292 (Critical Care, each additional 30 minutes)
  - 15–30 minutes beyond the first 75 minutes of critical care on a given day.

- The service may represent aggregate time met by a single physician or physicians in the same group practice with the same medical specialty in order to meet the duration of minutes required for CPT code 99292.

Prolonged Care

- Beyond the usual service & reported in addition to another service
  - Initial (CPTs 99354, 99356, 99358)
    - First hour once per day (30-60 min)
    - Less than 30 min total duration is not reported (included in E/M code)
  - Add on (CPTs 99355, 99357, 99359)
    - Each additional 30 min beyond first hour (and final 15-20 min on a given date)
    - Less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.
Prolonged Care
With Face-to-Face Care

- Office / Other Outpatient Setting (99354-99355):
  - CPT 99354: Prolonged service in the office or other outpatient setting required direct patient contact beyond the usual service; first hour
  - +99355 each additional 30 minutes

- Inpatient / Observation Setting (99356-99357):
  - CPT 99356: Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour
  - +99357 each additional 30 minutes

Prolonged Care
Without Face-to-Face Care

- CPTs 99358 and 99359 are used when a physician provides prolonged service not involving direct (face-to-face) care that is beyond the usual service in either the inpatient or outpatient setting.
  - CPT 99358 is used to report the first hour of prolonged service on a given date
  - CPT 99359 is used to report each additional 30 minutes beyond the first hour

Medicare only allow providers to report Inpatient codes (CPTs 99356 & 99357) if the time was spent face-to-face with the patient.

- "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."

AMA's CPT description does not include "face-to-face" in description.

- CPT 2012 defines direct patient contact as face-to-face, but also counts "additional non face-to-face services on the patient's floor or unit of the hospital or nursing facility during the same session."
CPT 99354 & 99355
Times & Units

<table>
<thead>
<tr>
<th>Total Duration Prolonged Service</th>
<th>Codes Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>30–74 minutes</td>
<td>99354 x1</td>
</tr>
<tr>
<td>(1/2 hr – 1 hr 14 min)</td>
<td></td>
</tr>
<tr>
<td>75–104 minutes</td>
<td>99354 x1 and 99355 x1</td>
</tr>
<tr>
<td>(1 hr 15 min – 1 hr 44 min)</td>
<td></td>
</tr>
<tr>
<td>105–134 minutes</td>
<td>99354 x1 and 99355 x2</td>
</tr>
<tr>
<td>(1 hr 45 min – 2 hr 14 min)</td>
<td></td>
</tr>
<tr>
<td>135–164 minutes</td>
<td>99354 x1 and 99355 x3</td>
</tr>
<tr>
<td>(2 hr 15 min – 2 hr 44 min)</td>
<td></td>
</tr>
<tr>
<td>165–194 minutes</td>
<td>99354 x1 and 99355 x4</td>
</tr>
<tr>
<td>(2 hr 45 min – 3 hr 14 min)</td>
<td></td>
</tr>
</tbody>
</table>

CPT 99354 & 99355
Threshold Outpatient New Visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time For E/M</th>
<th>Threshold Time to Bill 99354</th>
<th>Threshold Time to Bill 99354 &amp; 99355</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>40</td>
<td>85</td>
</tr>
<tr>
<td>99202</td>
<td>20</td>
<td>50</td>
<td>95</td>
</tr>
<tr>
<td>99203</td>
<td>30</td>
<td>60</td>
<td>105</td>
</tr>
<tr>
<td>99204</td>
<td>45</td>
<td>75</td>
<td>120</td>
</tr>
<tr>
<td>99205</td>
<td>60</td>
<td>90</td>
<td>135</td>
</tr>
</tbody>
</table>

Prolonged Care –Documentation

- Can be billed with most E/M codes; consults, admits, new, established, subsequent, discharge day management.
- NPP's can also bill for prolonged care
- Documentation should include
  - Time spent above and beyond the documented level of E/M service
  - Total ALL time spent with the patient face-to-face
  - Medical necessity
  - Description of the reason for prolonged time (i.e. prolonged due to patient dementia)
When time is the controlling factor for billing the E/M service, then prolonged care should only be billed when the service has exceeded 30 minutes beyond the highest level of E/M in the appropriate category.

- The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the E/M code) and should not be “rounded” to the next higher level.

When the E/M service is billed based on the elements (history, exam & MDM) an indication of the time spent on the E/M is not required.

A physician performed a visit that met the definition of visit code 99233 and the total duration of the direct face-to-face contact (including the visit) was 115 minutes.

- The physician bills codes 99233, 99356, and 1 unit of code 99357

A physician performed an office visit to an established patient that was predominantly counseling, spending 75 minutes (direct face-to-face) with the patient.

- The physician should report CPT code 99215 and one unit of code 99354

Source: Medicare Claims Processing Manual (Pub.100-04, Ch12, Section 30.6.15.1.H)
Psychotepathy without E/M

• 90832: Psychotherapy, 30 minutes with patient and/or family member,

• 90834: Psychotherapy, 45 minutes with patient and/or family member, and

• 90837: Psychotherapy, 60 minutes with patient and/or family member

Psychotherapy with E/M

• +90833: Psychotherapy, 30 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure)

• +90836: Psychotherapy, 45 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure), and

• +90838: Psychotherapy, 60 minutes with patient and/or family member when performed with an E&M service (list separately in addition to the code for primary procedure).

Counting Time

Must document time

• 90832 and 90833 -- 16 to 37 minutes,

• 90834 and 90836 -- 38 to 52 minutes, and

• 90837 and 90838 -- 53 minutes or longer

NOTE: Document specific psychotherapy time not including E/M time for 90833, 90836 and 90838
**Medicare PHP Payments**

- Effective January 1, 2014, when E&M services are paid under Medicare’s Partial Hospitalization Program (PHP) and **not in the physician office setting**, the CPT outpatient visit codes 99201-99215 have been replaced with one Level II HCPCS code - G0463.

**Psychotherapy Services**

- CMS MLN Matters®Number: SE1407 (Jan2014):
- The Comprehensive Error Rate Testing (CERT) identified many improper payments for:
  - Failure to document the time spent on the E&M service separately from the time spent on the add-on psychotherapy service.

**Infusions**
IV Hydration Infusions

- 96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour
- + 96361 each additional hour

IV Infusions
Therapy, Prophylaxis or Diagnosis

- 96365 Intravenous infusion for therapy, prophylaxis or diagnosis; initial, up to 1 hour
- + 96366 each additional hour
- + 96367 additional sequential infusion of a new drug/substance, up to 1 hour

IV Infusions
Therapy, Prophylaxis or Diagnosis

- 96369 Subcutaneous infusion for therapy or prophylaxis; initial, up to 1 hour, including pump set-up and establishment of subcuraneous infusion site(s)
- + 96370 each additional hour
IV Infusions
Chemotherapy

› 96413  Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug

› + 96415  each additional hour

Documentation

› Document start time of infusion (do not include the time to establish the IV site)

› Document finish time of infusion (do not include the time to remove the IV needle)

› If new drug or same drug given as a “push” requiring 15 minutes or less, code with add-on CPT 96375 or 96376 as applicable

Smoking Cessation
Smoking Cessation

- 99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- 99407 intensive, greater than 10 minutes

Must document time
Best practices – document patient response to counseling and ordering of nicotine patch, etc.

Physical Therapy

Modalities – Constant Attendance

- 97032 – 97039
  - Each modality consists of 15 minutes per unit

Must document time
Reporting of total time/units depends on LCD of payer
Therapeutic Procedures – Direct one-on-one patient contact

- 97110 – 97124
- 97140
- 97530 – 97542
- Each procedure consists of 15 minutes per unit

- 97545 – Work hardening – initial 2 hours
- + 97546 each additional hour

Must document time

Reporting of total time/units depends on LCD of payer

Resources & Links

Critical Care Bundled & Unbundled Procedures
Critical Care Checklists & References
Prolonged Care References
CMS Provider News & Compliance News
Critical Care
Bundled Procedures

- Interpretations of cardiac output measures (93561, 93562)
- Chest x-rays, professional component (71010, 71015, 71020)
- Blood gases and information data stored in computers (93000, 99000, 82860–82810) (e.g., ECGs, blood pressures, hematologic data—CPT 99090)
- Pulse oximetry (94760, 94761, 94762)
- Gastric intubation (43752, 43753)
- Temporary transcutaneous pacing (92953)
- Ventilation management (94002–94004, 94660, 94662)
- Vascular access procedure (36000, 36410, 36415, 36591 36600)

Separately Billable Procedures
(Unbundled Procedures)

- Some of these separately billable services include:
  - Endotracheal intubation (31500)
  - Insertion/placement of Swan Ganz (93503)
  - Cardiopulmonary resuscitation (92950)
  - Central venous lines (36556)
  - Arterial lines (36620)

- The physician’s progress notes should document that time involved in the performance of separately billable procedures was not counted toward critical care time

Critical Care Checklist

<table>
<thead>
<tr>
<th>CRITICAL CARE SERVICES</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care (CPT 99221-99222) is the amount in &quot;no&quot; any of the operations do not report under 89.00-89.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time spent in the above procedures is the time that should be counted toward critical care time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care (CPT 99221-99222) is the amount in &quot;no&quot; any of the operations do not report under 89.00-89.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time spent in the above procedures is the time that should be counted toward critical care time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care (CPT 99221-99222) is the amount in &quot;no&quot; any of the operations do not report under 89.00-89.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time spent in the above procedures is the time that should be counted toward critical care time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care (CPT 99221-99222) is the amount in &quot;no&quot; any of the operations do not report under 89.00-89.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time spent in the above procedures is the time that should be counted toward critical care time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Care (CPT 99221-99222) is the amount in &quot;no&quot; any of the operations do not report under 89.00-89.05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time spent in the above procedures is the time that should be counted toward critical care time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Critical Care Checklist Cont.

Critical Care Services References

- CMS Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, §30.6.12
- CMS Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, §30E
- CMS Transmittal 1548, CR 5993, July 9, 2008:
- CMS Transmittal 2282, CR 7405, 8/26/11: “Clarification of Evaluation and Management Payment Policy”
- AMA’s CPT Assistant August 2012, Volume 22, Issue 8, Pages 3-5: “Prolonged E/M Services (99354-99359)”

Prolonged Care Services References

- CMS Medicare Claims Processing Manual 100-4, 12-§30.6.15.1 & §30.6.13F
- CMS Transmittal 2282, CR 7405, 8/26/11: “Clarification of Evaluation and Management Payment Policy”
- AMA’s CPT Assistant August 2012, Volume 22, Issue 8, Pages 3-5: “Prolonged E/M Services (99354-99359)”
Use this Link To sign up for CMS e-News:
https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819


Questions