

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1875	Date: December 14, 2009
	Change Request 6740

SUBJECT: Revisions to Consultation Services Payment Policy

I. SUMMARY OF CHANGES: In the calendar year 2010 physician fee schedule final rule with comment period (CMS-1413-FC) CMS budget neutrally eliminated the use of all consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation G-codes. CMS increased the work relative value units (RVUs) for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our practice expense PE and malpractice calculations. CMS also increased the incremental work RVUs for the evaluation and management (E/M) codes that are built into the 10-day and 90-day global surgical codes. All references (both text and code numbers) in IOM Publication 100-04 (CP), Chapter 12 §30.6 that pertain to the use of the AMA CPT consultation codes (ranges 99241-99245 and 99251-99255) are removed by this transmittal.

NEW / REVISED MATERIAL

EFFECTIVE DATE: *January 1, 2010

IMPLEMENTATION DATE: January 4, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	12/30/30.6.1/ Selection of Level of Evaluation and Management Service
R	1230/30.6.8/ Payment for Hospital Observation Services (Codes 99217 - 99220) and Observation or Inpatient Care Services (Including Admission and Discharge Services - (Codes 99234 - 99236)
R	1230/30.6.9.1/ Payment for Initial Hospital Care Services (Codes 99221 - 99223) and Observation or Inpatient Care Services (Including Admission and Discharge Services) (Codes 99234 - 99236)
R	12/30/30.6.10/ Consultation Services (Code 99241 - 99255)
R	12/30/30.6.11/ Emergency Department Visits (Codes 99281 - 99285)
R	12/30/30.6.13/ Nursing Facility Services (Codes 99304 - 99318)

R	12/30/30.6.15.1/ Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes)
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III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1875	Date: December 14, 2009	Change Request: 6740
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SUBJECT: Revisions to Consultation Services Payment Policy

EFFECTIVE DATE: January 1, 2010

IMPLEMENTATION DATE: January 4, 2010

I. GENERAL INFORMATION

- A. Background:** In the calendar year 2010 physician fee schedule final rule with comment period (CMS1413-FC) CMS budget neutrally eliminated the use of all consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation G-codes. CMS increased the work relative value units (RVUs) for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our practice expense and malpractice calculations. CMS also increased the incremental work RVUs for the evaluation and management (E/M) codes that are built into the 10-day and 90-day global surgical codes. All references (both text and code numbers) in Pub 100-04 (CP), Chapter 12, §30.6 that pertain to the use of the AMA CPT consultation codes (ranges 99241-99245 and 99251-99255) are removed by this transmittal.
- B. Policy:** Effective January 1, 2010, the consultation codes are no longer recognized for Medicare Part B payment. Physicians shall code patient evaluation and management visit with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. In the inpatient hospital setting and the nursing facility setting all physicians (and qualified nonphysicians where permitted) who perform an initial evaluation and management may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304-99306). As a result of this change, multiple billings of initial hospital and nursing home visit codes could occur even in a single day.

Modifier “-AI,” defined as “Principal Physician of Record,” shall be used by the admitting or attending physician who oversees the patient’s care, as distinct from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier “-AI” in addition to the initial visit code. All other physicians who perform an initial evaluation on this patient shall bill only the E/M code for the complexity level performed. NOTE: The primary purpose of this modifier is to identify the principal physician of record on the initial hospital and nursing home visit codes. It is not necessary to reject claims that include the “-AI” modifier on codes other than the initial hospital and nursing home visit codes (i.e., subsequent care codes or outpatient codes). Follow-up visits in the facility setting may be billed as subsequent hospital care visits and subsequent nursing facility care visits as is the current policy. In all cases, physicians shall bill the available code that most appropriately describes the level of the services provided.

Method II Critical Access hospitals (CAHs) may bill on type of bill (TOB) 85X with revenue code (RC) 96X, 97X or 98X, using the appropriate new or established visit code (99201 – 99215) for those physician and non-physician practitioners who have reassigned their billing rights, depending on the relationship status between the physician and patient.

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B M A C	D M E M A C	F I I E R	C A R R I E R	R H I I S S	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
6740.4	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X		X	X					
6740.5	Contractors shall employ the "MLN Matters" article to educate all physicians and (qualified nonphysician practitioners where permitted) who perform an initial evaluation shall in the inpatient hospital setting and nursing facility setting bill an initial hospital care visit code (CPT code 99221 – 99223) or nursing facility care visit code (CPT99304 – 99306).	X		X	X					
6740.6	Contractors shall employ the "MLN Matters" article, to educate physicians that the physician who oversees the patient’s care, as distinct from other physicians who may be furnishing specialty care, shall append modifier “-AI” Principal Physician of Record, to the initial hospital or nursing home visit code when billed (CPT codes 99221 – 99223 and 99304 – 99306).	X		X	X					
6740.7	Contractors shall employ the "MLN Matters" article to educate all physicians and qualified nonphysician practitioners to bill the appropriate new or established visit code (CPT codes 99201 – 99205 or 99211 – 99215), in the office and other outpatient settings, depending on the relationship status between the physician and patient.	X		X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I I E R	C A R I E R	R H H I	Shared-System Maintainers				OTH ER
						F I S S	M C S	V M S	C W F		

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
 Use "Should" to denote a recommendation.

X-Ref Requirement Number	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): James Hart: James.Hart@cms.hhs.gov; 410-786-9520

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers, use only one of the following statements:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For Medicare Administrative Contractors (MACs), include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and

immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

30.6.1 - Selection of Level of Evaluation and Management Service

(Rev.1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

A. Use of CPT Codes

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

B. Selection of Level Of Evaluation and Management Service

Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C.

Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the carrier at the appropriate physician fee schedule amount based on the rendering UPIN/PIN.

"Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met (refer to sections 60.1, 60.2, and 60.3, chapter 15 in IOM 100-02).

SPLIT/SHARED E/M SERVICE

Office/Clinic Setting

In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician's UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

Hospital Inpatient/Outpatient/Emergency Department Setting

When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face

portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NPP's UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

EXAMPLES OF SHARED VISITS

1. If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.
2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's UPIN/PIN.

In the rare circumstance when a physician (or NPP) provides a service that does not reflect a CPT code description, the service must be reported as an unlisted service with CPT code 99499. A description of the service provided must accompany the claim. The carrier has the discretion to value the service when the service does not meet the full terms of a CPT code description (e.g., only a history is performed). The carrier also determines the payment based on the applicable percentage of the physician fee schedule depending on whether the claim is paid at the physician rate or the non-physician practitioner rate. CPT modifier -52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier -52 for this purpose.

C. Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling

Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient's care after the patient has left the office or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

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.

D. Use of Highest Levels of Evaluation and Management Codes

Contractors must advise physicians that to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT's definition of a comprehensive history).

The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient's medical, family, and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.

The comprehensive examination may be a complete single system exam such as cardiac, respiratory, psychiatric, or a complete multi-system examination.

30.6.8 - Payment for Hospital Observation Services (Codes 99217 - 99220) and Observation or Inpatient Care Services (Including Admission and Discharge Services – (Codes 99234 – 99236))

(Rev.1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

A. Who May Bill Initial Observation Care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

Contractors pay for initial observation care billed by only the physician who *ordered* hospital *outpatient* observation *services* and was responsible for the patient during his/her observation *care*. A physician who does not have inpatient admitting privileges but who is authorized *to furnish hospital outpatient* observation *services* may bill these codes.

For a physician to bill the initial observation care codes, there must be a medical observation record for the patient which contains dated and timed physician's orders regarding the *observation services* the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient *received* observation *services*. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter.

Payment for an initial observation care code is for all the care rendered by the *ordering* physician on the date the patient's observation *services* began. *All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.*

For example, if an internist *orders* observation *services* and asks *another physician to additionally evaluate the patient, only the internist may bill the initial observation care code. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate.*

For information regarding hospital billing of observation services, see Chapter 4, §290.

B. Physician Billing for Observation Care Following *Initiation of Observation Services*

When a patient *receives* observation care for less than 8 hours on the same calendar date, the Initial Observation Care, from CPT code range 99218 – 99220, shall be reported by the physician. The Observation Care Discharge Service, CPT code 99217, shall not be reported for this scenario.

When a patient is admitted for observation care and then *is* discharged on a different calendar date, the physician shall report Initial Observation Care, from CPT code range 99218 – 99220, and CPT observation care discharge CPT code 99217.

When a patient *receives* observation care for a minimum of 8 hours, but less than 24 hours, and *is* discharged on the same calendar date, Observation or Inpatient Care Services (Including Admission and Discharge Services) from CPT code range 99234 – 99236 shall be reported. The observation discharge, CPT code 99217, cannot also be reported for this scenario.

C. Documentation Requirements for Billing Observation or Inpatient Care Services (Including Admission and Discharge Services (Codes 99234 – 99236))

The physician shall satisfy the E/M documentation guidelines for *furnishing* observation care or inpatient hospital care. In addition to meeting the documentation requirements for history, examination, and medical decision making documentation in the medical record shall include:

Documentation stating the stay for observation care or inpatient hospital care involves 8 hours, but less than 24 hours;

Documentation identifying the billing physician was present and personally performed the services; and

Documentation identifying the *order for observation services, progress notes*, and discharge notes were written by the billing physician.

In the rare circumstance when a patient *receives observation services* for more than 2 calendar dates, the physician shall bill a visit furnished before the discharge date using the outpatient/office visit codes. The physician may not use the subsequent hospital care codes since the patient is not an inpatient of the hospital.

D. Admission to Inpatient Status *Following Observation Care*

If the same physician who *ordered hospital outpatient observation services* also admits the patient to inpatient status before the end of the date on which the patient *began receiving hospital outpatient observation services*, pay only an initial hospital visit for the evaluation and management services provided on that date. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill an initial observation care code for services on the date that he or she admits the patient to inpatient status. If the patient is admitted to inpatient status from *hospital outpatient observation care* subsequent to the date of *initiation of observation services*, the physician must bill an initial hospital visit for the services provided on that date. The physician may not bill the hospital observation discharge management code (code 99217) or an outpatient/office visit for the care provided *while the patient received hospital outpatient observation services* on the date of admission to inpatient status.

E. Hospital Observation *Services* During Global Surgical Period

The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, and 99220, 99234, 99235, 99236) services unless the criteria for use of CPT modifiers “-24,” “-25,” or “-57” are met. Contractors must pay for these services in addition to the global surgical fee only if both of the following requirements are met:

- The hospital observation service meets the criteria needed to justify billing it with CPT modifiers “-24,” “-25,” or “-57” (decision for major surgery); and
- The hospital observation service furnished by the surgeon meets all of the criteria for the hospital observation code billed.

Examples of the decision for surgery during a hospital observation period are:

- *An emergency department physician orders hospital outpatient observation services for a patient with a head injury. A neurosurgeon is called in to evaluate the need for surgery*

while the patient is *receiving* observation *services* and decides that the patient requires surgery. The surgeon would bill *a new or established office or other outpatient visit code as appropriate* with the “-57” modifier to indicate that the decision for surgery was made during the *evaluation*. The surgeon must bill *the office or other outpatient visit code* because the patient *receiving hospital outpatient* observation *services* is not an inpatient of the hospital. Only the physician who *ordered* hospital *outpatient* observation *services* may bill for initial observation care.

- A neurosurgeon *orders* hospital *outpatient* observation *services* for *a patient with* a head injury. During the observation period, the surgeon makes the decision for surgery. The surgeon would bill the appropriate level of hospital observation code with the “-57” modifier to indicate that the decision for surgery was made while the surgeon was providing hospital observation care.

Examples of hospital observation services during the postoperative period of a surgery are:

- A *surgeon orders hospital outpatient observation services for a patient with abdominal pain from a kidney stone on* the 80th day following a TURP (*performed by that surgeon*). The surgeon decides that the patient does not require surgery. The surgeon would bill the observation code with CPT modifier “-24” and documentation to support that the observation services are unrelated to the surgery.
- A *surgeon orders hospital outpatient observation services for a patient with abdominal pain on* the 80th day following a TURP (*performed by that surgeon*). While the patient is *receiving* hospital *outpatient* observation *services*, the surgeon decides that the patient requires kidney surgery. The surgeon would bill the observation code with HCPCS modifier “-57” to indicate that the decision for surgery was made while the patient was *receiving* hospital *outpatient* observation *services*. The subsequent surgical procedure would be reported with modifier “-79.”
- A *surgeon orders hospital outpatient observation services for a patient with abdominal pain on* the 20th day following a resection of the colon (*performed by that surgeon*). The surgeon determines that the patient requires no further colon surgery and discharges the patient. The surgeon may not bill for the observation services furnished during the global period because they were related to the previous surgery.

An example of a billable hospital observation service on the same day as a procedure is *when a physician repairs a laceration of the scalp in the emergency department for a patient with a head injury and then subsequently orders hospital outpatient observation services for that patient*.

The physician would bill the observation code with a CPT modifier 25 and the procedure code.

30.6.9.1 - Payment for Initial Hospital Care Services (Codes 99221 - 99223) and Observation or Inpatient Care Services (Including Admission and Discharge Services) (Codes 99234 – 99236)

(Rev.1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

A. Initial Hospital Care From Emergency Room

Contractors pay for an initial hospital care service if a physician sees a patient in the emergency room and decides to admit the person to the hospital. They do not pay for both E/M services.

Also, they do not pay for an emergency department visit by the same physician on the same date of service. When the patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician's office, nursing facility), all services provided by the physician in conjunction with that admission are considered part of the initial hospital care when performed on the **same date** as the admission.

B. Initial Hospital Care on Day Following Visit

Contractors pay both visits if a patient is seen in the office on one date and admitted to the hospital on the next date, even if fewer than 24 hours has elapsed between the visit and the admission.

C. Initial Hospital Care and Discharge on Same Day

When the patient is admitted to inpatient hospital care for less than 8 hours on the same date, then Initial Hospital Care, from CPT code range 99221 – 99223, shall be reported by the physician. The Hospital Discharge Day Management service, CPT codes 99238 or 99239, shall not be reported for this scenario.

When a patient is admitted to inpatient initial hospital care and then discharged on a different calendar date, the physician shall report an Initial Hospital Care from CPT code range 99221 – 99223 and a Hospital Discharge Day Management service, CPT code 99238 or 99239.

When a patient has been admitted to inpatient hospital care for a minimum of 8 hours but less than 24 hours and discharged on the same calendar date, Observation or Inpatient Hospital Care Services (Including Admission and Discharge Services), from CPT code range 99234 – 99236, shall be reported.

D. Documentation Requirements for Billing Observation or Inpatient Care Services (Including Admission and Discharge Services), CPT codes 99234 - 99236

The physician shall satisfy the E/M documentation guidelines for admission to and discharge from inpatient observation or hospital care. In addition to meeting the documentation requirements for history, examination and medical decision making documentation in the medical record shall include:

Documentation stating the stay for hospital treatment or observation care status involves 8 hours but less than 24 hours;

Documentation identifying the billing physician was present and personally performed the services; and

Documentation identifying the admission and discharge notes were written by the billing physician.

E. Physician Services Involving Transfer From One Hospital to Another; Transfer Within Facility to Prospective Payment System (PPS) Exempt Unit of Hospital; Transfer From One Facility to Another Separate Entity Under Same Ownership and/or Part of Same Complex; or Transfer From One Department to Another Within Single Facility

Physicians may bill both the hospital discharge management code and an initial hospital care code when the discharge and admission do not occur on the same day if the transfer is between:

Different hospitals;

Different facilities under common ownership which do not have merged records; or

Between the acute care hospital and a PPS exempt unit within the same hospital when there are no merged records.

In all other transfer circumstances, the physician should bill only the appropriate level of subsequent hospital care for the date of transfer.

F. Initial Hospital Care Service History and Physical That Is Less Than Comprehensive

When a physician performs a visit that meets the definition of a Level 5 office visit several days prior to an admission and on the day of admission performs less than a comprehensive history and physical, he or she should report the office visit that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code 99221) for the initial hospital admission. Contractors pay the office visit as billed and the Level 1 initial hospital care code.

All physicians who provide an initial visit to a patient during hospital care shall report an initial hospital care code (99221-99223). The principal physician of record shall append modifier “-AI”, Principal Physician of Record, to the claim with the initial hospital care code. This modifier will identify the physician who oversees the patient’s care from all other physicians who may be furnishing specialty care.

G. Initial Hospital Care Visits by Two Different M.D.s or D.O.s When They Are Involved in Same Admission

In the inpatient hospital setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306). Contractors consider only one M.D. or D.O. to be the principal physician of record (sometimes referred to as the admitting physician.) The principal physician of record is identified in Medicare as the physician who oversees the patient’s care from other physicians who may be furnishing specialty care. Only the principal physician of record shall append modifier “-AI”, Principal Physician of Record, in addition to

the E/M code. Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.

30.6.10 - Consultation Services (Codes 99241 - 99255)

(Rev.1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

A. Consultation Services versus Other Evaluation and Management (E/M) Visits

Effective January 1, 2010, the consultation codes are no longer recognized for Medicare part B payment. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. In the inpatient hospital setting and the nursing facility setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306). The principal physician of record is identified in Medicare as the physician who oversees the patient's care from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier “-AI”, Principal Physician of Record, in addition to the E/M code. Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.). In the CAH setting, those CAHs that use method II shall bill the appropriate new or established visit code for those physician and non-physician practitioners who have reassigned their billing rights, depending on the relationship status between the physician and patient.

In the office or other outpatient setting where an evaluation is performed, physicians and qualified nonphysician practitioners shall use the CPT codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician. All physicians and qualified nonphysician practitioners shall follow the E/M documentation guidelines for all E/M services. These rules are applicable for Medicare secondary payer claims as well as for claims in which Medicare is the primary payer.

30.6.11 - Emergency Department Visits (Codes 99281 - 99288)

(Rev.1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

A. Use of Emergency Department Codes by Physicians Not Assigned to Emergency Department

Any physician seeing a patient registered in the emergency department may use emergency department visit codes (for services matching the code description). It is not required that the physician be assigned to the emergency department.

B. Use of Emergency Department Codes In Office

Emergency department coding is not appropriate if the site of service is an office or outpatient setting or any other site of service other than an emergency department. The emergency department codes should only be used if the patient is seen in the emergency department and the services described by the HCPCS code definition are provided. The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.

C. Use of Emergency Department Codes to Bill Nonemergency Services

Services in the emergency department may not be emergencies. However the codes (99281 - 99288) are payable if the described services are provided.

However, if the physician asks the patient to meet him or her in the emergency department as an alternative to the physician's office and the patient is not registered as a patient in the emergency department, the physician should bill the appropriate office/outpatient visit codes. Normally a lower level emergency department code would be reported for a nonemergency condition.

D. Emergency Department or Office/Outpatient Visits on Same Day As Nursing Facility Admission

Emergency department visit provided on the same day as a comprehensive nursing facility assessment are not paid. Payment for evaluation and management services on the same date provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date as the nursing facility admission.

E. Physician Billing for Emergency Department Services Provided to Patient by Both Patient's Personal Physician and Emergency Department Physician

If a physician advises his/her own patient to go to an emergency department (ED) of a hospital for care and the physician subsequently is asked by the ED physician to come to the hospital to evaluate the patient and to advise the ED physician as to whether the patient should be admitted to the hospital or be sent home, the physicians should bill as follows:

- If the patient is admitted to the hospital by the patient's personal physician, then the patient's regular physician should bill only the appropriate level of the initial hospital care (codes 99221 - 99223) because all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The ED physician who saw the patient in the emergency department should bill the appropriate level of the ED codes.
- *If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only advises the emergency department physician by telephone, then the patient's personal physician may not bill.*

F. Emergency Department Physician Requests Another Physician to See the Patient in Emergency Department or Office/Outpatient Setting

If the emergency department physician requests that another physician evaluate a given patient, the other physician should bill *an emergency department visit code*. *If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.*

30.6.13 - Nursing Facility Services (Codes 99304 - 99318)

(Rev.1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

The distinction made between the delegation of physician visits and tasks in a skilled nursing facility (SNF) and in a nursing facility (NF) is based on the Medicare Statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs. For further information refer to Medlearn Matters article number SE0418 at www.cms.hhs.gov/medlearn/matters

The initial visit in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4)). *The principal physician of record must append the modifier “-AI”, Principal Physician of Record, to the initial nursing facility care code. This modifier will identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care. All other physicians who perform an initial evaluation in the nursing facility may bill the initial nursing facility care code.* The initial visit is defined in S&C-04-08 (see www.cms.hhs.gov/medlearn/matters) as the initial comprehensive assessment visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, a visit must occur no later than 30 days after admission.

Further, per the Long Term Care regulations at 42 CFR 483.40 (c) (4) and (e) (2), the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C-04-08 the physician may not delegate the initial visit in a SNF. This also applies to the NF with one exception.

The only exception, as to who performs the initial visit, relates to the NF setting. In the NF setting, a qualified NPP (i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS), who is not employed by the facility, may perform the initial visit when the State law permits this. The evaluation and management (E/M) visit shall be within the State scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration and physician supervision shall be met.

Under Medicare Part B payment policy, other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit. A qualified NPP may perform medically necessary E/M visits prior to and after the initial visit if all the requirements for collaboration, general physician supervision, licensure and billing are met.

The CPT Nursing Facility Services codes shall be used with place of service (POS) 31 (SNF) if the patient is in a Part A SNF stay. They shall be used with POS 32 (nursing facility) if the patient does not have Part A SNF benefits or if the patient is in a NF or in a non-covered SNF stay (e.g., there was no preceding 3-day hospital stay). The CPT Nursing Facility code definition also includes POS 54 (Intermediate Care Facility/Mentally Retarded) and POS 56 (Psychiatric Residential Treatment Center). For further guidance on POS codes and associated CPT codes refer to §30.6.14.

Effective January 1, 2006, the Initial Nursing Facility Care codes 99301– 99303 are deleted.

Beginning January 1, 2006, the new CPT codes, Initial Nursing Facility Care, per day, (99304 – 99306) shall be used to report the initial visit. Only a physician may report these codes for an initial visit performed in a SNF or NF (with the exception of the qualified NPP in the NF setting who is not employed by the facility and when State law permits, as explained above).

A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.

A physician who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment. An NPP who is employed by the SNF or NF may perform and bill Medicare Part B directly for those services where it is permitted as discussed above. The employer of the PA shall always report the visits performed by the PA. A physician, NP or CNS has the option to bill Medicare directly or to reassign payment for his/her professional service to the facility.

As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. CPT codes, Subsequent Nursing Facility Care, per day (99307 - 99310), shall be reported for these E/M visits even if the visits are provided prior to the initial visit by the physician.

SNF Setting--Place of Service Code 31

Following the initial visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting--Place of Service Code 32

Per the regulations at [42 CFR 483.40 \(f\)](#), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial visit by the physician, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

Effective January 1, 2006, the Subsequent Nursing Facility Care, per day, codes 99311– 99313 are deleted.

Beginning January 1, 2006, the new CPT codes, Subsequent Nursing Facility Care, per day, (99307 – 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.

Carriers shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service. The Nursing Facility Services codes represent a “per day” service.

The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The physician/qualified NPP shall bill only one E/M visit. Beginning January 1, 2006, the new CPT code, Other Nursing Facility Service (99318), may be used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. For Medicare Part B payment policy, an annual nursing facility assessment visit code may substitute as meeting one of the federally mandated physician visits if the code requirements for CPT code 99318 are fully met and in lieu of reporting a Subsequent Nursing Facility Care, per day, service (codes 99307 – 99310). It shall not be performed in addition to the required number of federally mandated physician visits. The new CPT annual assessment code does not represent a new benefit service for Medicare Part B physician services.

Qualified NPPs, whether employed or not by the SNF, may perform alternating federally mandated physician visits, at the option of the physician, after the initial visit by the physician in a SNF.

Qualified NPPs in the NF setting, who are not employed by the NF, may perform federally mandated physician visits, at the option of the State, after the initial visit by the physician.

Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes. E/M visits, prior to and after the initial physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.

C. Visits by Qualified Nonphysician Practitioners

All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs. General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. CPT codes, Subsequent Nursing Facility Care, per day (99307 - 99310), shall be reported for these E/M visits even if the visits are provided prior to the initial visit by the physician.

SNF Setting--Place of Service Code 31

Following the initial visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting--Place of Service Code 32

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

D Medically Complex Care

Payment is made for E/M visits to patients in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are reasonable and medically necessary and documented in the medical record. Physicians and qualified NPPs shall report initial nursing facility care codes for their first visit with the patient. The principal physician of record must append the modifier “-AI” Principal Physician of Record, to the initial nursing facility care code when billed to identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care. Follow-up visits shall be billed subsequent nursing facility care visits.

E Incident to Services

Where a physician establishes an office in a SNF/NF, the “incident to” services and requirements are confined to this discrete part of the facility designated as his/her office. “Incident to” E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B. Thus, visits performed outside the designated “office” area in the SNF/NF would be subject to the coverage and payment rules applicable to SNF/NF setting and shall not be reported using the CPT codes for office or other outpatient visits or use place of service code 11.

F Use of the Prolonged Services Codes and Other Time-Related Services

Beginning January 1, 2008, typical/average time units for E/M visits in the SNF/NF settings are reestablished. Medically necessary prolonged services for E/M visits (codes 99356 and 99357) in a SNF or NF may be billed with the Nursing Facility Services in the code ranges (99304 – 99306, 99307 – 99310 and 99318).

Counseling and Coordination of Care Visits

With the reestablishment of typical/average time units, medically necessary E/M visits for counseling and coordination of care, for Nursing Facility Services in the code ranges (99304 – 99306, 99307 – 99310 and 99318) that are time-based services, may be billed with the appropriate prolonged services codes (99356 and 99357).

G Gang Visits

The complexity level of an E/M visit and the CPT code billed must be a covered and medically necessary visit for each patient (refer to §§1862 (a)(1)(A) of the Act). Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits. The E/M visit (Nursing Facility Services) represents a “per day” service per patient as defined by the CPT code. The medical record must be personally documented by the physician or qualified NPP who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient.

H Split/Shared E/M Visit

A split/shared E/M visit cannot be reported in the SNF/NF setting. A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes). The split/shared E/M policy does not apply to consultation services, critical care services or procedures.

I SNF/NF Discharge Day Management Service

Medicare Part B payment policy requires a face-to-face visit with the patient provided by the physician or the qualified NPP to meet the SNF/NF discharge day management service as defined by the CPT code. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date. The CPT codes 99315 – 99316 shall be reported for this visit. The Discharge Day Management Service may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.

30.6.15.1 - Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes)

(Rev.1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

A. Definition

Prolonged physician services (CPT code 99354) in the office or other outpatient setting with direct face-to-face patient contact which require one hour beyond the usual service are payable when billed on the same day by the same physician or qualified nonphysician practitioner (NPP) as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion evaluation and management service as noted in the CPT code. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99355.

Prolonged physician services (code 99356) in the inpatient setting, with direct face-to-face patient contact which require one hour beyond the usual service are payable when they are billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99357.

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 codes.

Code 99355 or 99357 may be used to report each additional 30 minutes beyond the first hour of prolonged services, based on the place of service. These codes may be used to report the final 15 – 30 minutes of prolonged service on a given date, if not otherwise billed. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Required Companion Codes

The companion evaluation and management codes for 99354 are the Office or Other Outpatient visit codes (99201 - 99205, 99212 – 99215), the Office or Other Outpatient Consultation codes (99241 – 99245), the Domiciliary, Rest Home, or Custodial Care Services codes (99324 – 99328, 99334 – 99337), the Home Services codes (99341 - 99345, 99347 – 99350);

The companion codes for 99355 are 99354 and one of the evaluation and management codes required for 99354 to be used;

The companion evaluation and management codes for 99356 are the Initial Hospital Care codes and Subsequent Hospital Care codes (99221 - 99223, 99231 – 99233), the Inpatient Consultation codes (99251 – 99255); Nursing Facility Services codes (99304 -99318) or

The companion codes for 99357 are 99356 and one of the evaluation and management codes required for 99356 to be used.

Prolonged services codes 99354 – 99357 are not paid unless they are accompanied by the companion codes as indicated.

C. Requirement for Physician Presence

Physicians may count only the duration of direct face-to-face contact between the physician and the patient (whether the service was continuous or not) **beyond** the typical/average time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable. In the case of prolonged office services, time spent by office staff with the patient, or time the patient remains unaccompanied in the office cannot be billed. 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.

D. Documentation

Documentation is not required to accompany the bill for prolonged services unless the physician has been selected for medical review. 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. The

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

E. Use of the Codes

Prolonged services codes can be billed only if the total duration of all physician or qualified NPP direct face-to-face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes). If the total duration of direct face-to-face time does not equal or exceed the threshold time for the level of evaluation and management service the physician or qualified NPP provided, the physician or qualified NPP may not bill for prolonged services.

F. Threshold Times for Codes 99354 and 99355 (Office or Other Outpatient Setting)

If the total direct face-to-face time equals or exceeds the threshold time for code 99354, but is less than the threshold time for code 99355, the physician should bill the evaluation and management visit code and code 99354. No more than one unit of 99354 is acceptable. If the total direct face-to-face time equals or exceeds the threshold time for code 99355 by no more than 29 minutes, the physician should bill the visit code 99354 and one unit of code 99355. One additional unit of code 99355 is billed for each additional increment of 30 minutes extended duration. *Contractors use the following threshold times to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings including domiciliary, rest home, or custodial care services and home services codes.*

***Threshold Time for Prolonged Visit Codes 99354 and/or 99355
Billed with Office/Outpatient and Consultation Codes***

<i>Code</i>	<i>Typical Time for Code</i>	<i>Threshold Time to Bill Code 99354</i>	<i>Threshold Time to Bill Codes 99354 and 99355</i>
<i>99201</i>	<i>10</i>	<i>40</i>	<i>85</i>
<i>99202</i>	<i>20</i>	<i>50</i>	<i>95</i>
<i>99203</i>	<i>30</i>	<i>60</i>	<i>105</i>
<i>99204</i>	<i>45</i>	<i>75</i>	<i>120</i>
<i>99205</i>	<i>60</i>	<i>90</i>	<i>135</i>
<i>99212</i>	<i>10</i>	<i>40</i>	<i>85</i>
<i>99213</i>	<i>15</i>	<i>45</i>	<i>90</i>

<i>Code</i>	<i>Typical Time for Code</i>	<i>Threshold Time to Bill Code 99354</i>	<i>Threshold Time to Bill Codes 99354 and 99355</i>
99214	25	55	100
99215	40	70	115
99324	20	50	95
99325	30	60	105
99326	45	75	120
99327	60	90	135
99328	75	105	150
99334	15	45	90
99335	25	55	100
99336	40	70	115
99337	60	90	135
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

Add 30 minutes to the threshold time for billing codes 99354 and 99355 to get the threshold time for billing code 99354 and two units of code 99355. For example, to bill code 99354 and two units of code 99355 when billing a code 99205, the threshold time is 150 minutes.

G. Threshold Times for Codes 99356 and 99357

(Inpatient Setting) If the total direct face-to-face time equals or exceeds the threshold time for code 99356, but is less than the threshold time for code 99357, the physician should bill the visit and code 99356. Contractors do not accept more than one unit of code 99356. If the total direct face-to-face time equals or exceeds the threshold time for code 99356 by no more than 29 minutes, the physician bills the visit code 99356 and one unit of code 99357. One additional unit of code 99357 is billed for each additional increment of 30 minutes extended duration. Contractors use the following threshold times to determine if the prolonged services codes 99356 and/or 99357 can be billed with the inpatient setting codes.

***Threshold Time for Prolonged Visit Codes 99356 and/or 99357
Billed with Inpatient Setting Codes***

<i>Code</i>	<i>Typical Time for Code</i>	<i>Threshold Time to Bill Code 99356</i>	<i>Threshold Time to Bill Codes 99356 and 99357</i>
<i>99221</i>	<i>30</i>	<i>60</i>	<i>105</i>
<i>99222</i>	<i>50</i>	<i>80</i>	<i>125</i>
<i>99223</i>	<i>70</i>	<i>100</i>	<i>145</i>
<i>99231</i>	<i>15</i>	<i>45</i>	<i>90</i>
<i>99232</i>	<i>25</i>	<i>55</i>	<i>100</i>
<i>99233</i>	<i>35</i>	<i>65</i>	<i>110</i>
<i>99304</i>	<i>25</i>	<i>55</i>	<i>100</i>
<i>99305</i>	<i>35</i>	<i>65</i>	<i>110</i>
<i>99306</i>	<i>45</i>	<i>75</i>	<i>120</i>
<i>99307</i>	<i>10</i>	<i>40</i>	<i>85</i>
<i>99308</i>	<i>15</i>	<i>45</i>	<i>90</i>
<i>99309</i>	<i>25</i>	<i>55</i>	<i>100</i>
<i>99310</i>	<i>35</i>	<i>65</i>	<i>110</i>

<i>Code</i>	<i>Typical Time for Code</i>	<i>Threshold Time to Bill Code 99356</i>	<i>Threshold Time to Bill Codes 99356 and 99357</i>
<i>99318</i>	<i>30</i>	<i>60</i>	<i>105</i>

Add 30 minutes to the threshold time for billing codes 99356 and 99357 to get the threshold time for billing code 99356 and two units of 99357.

H. Prolonged Services Associated With Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)

When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management code is selected based on the typical/average time associated with the code levels. The time approximation 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.

In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.

I. Examples of Billable Prolonged Services

EXAMPLE 1

A physician performed a visit that met the definition of an office visit code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills code 99213 and one unit of code 99354.

EXAMPLE 2

A physician performed a visit that met the definition of a domiciliary, rest home care visit code 99327 and the total duration of the direct face-to-face contact (including the visit) was 140 minutes. The physician bills codes 99327, 99354, and one unit of code 99355.

EXAMPLE 3

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.

J. Examples of Nonbillable Prolonged Services

EXAMPLE 1

A physician performed a visit that met the definition of visit code 99212 and the total duration of the direct face-to-face contact (including the visit) was 35 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

EXAMPLE 2

A physician performed a visit that met the definition of code 99213 and, while the patient was in the office receiving treatment for 4 hours, the total duration of the direct face-to-face service of the physician was 40 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

EXAMPLE 3

A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354. The physician must bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.