Good News: Prolonged Services May Add Revenue to Your Bottom Line

Frustrated by long patient encounters that lower your productivity? Take heart—they can be billable in the right circumstances.

By Mary McDermott

Physicians frequently ask how they can get compensated for the increasing amount of time they must spend with patients in their office. Neurologists in particular are spending more time with an increasingly aged and chronically ill patient population, counseling them about their condition. It's a classic case of "working more but earning less" that seems inevitable in most medical fields. But there's good news: in certain circumstances, physicians may be able to use the prolonged services codes to report the significant increased time spent directly, face-to-face with the patient. These prolonged services are reimbursed by CMS and most third-party payers.

How it Works

CPT developed the prolonged services codes 99354-99357 "to be used when a physician provides prolonged service involving direct, (face-to-face) patient contact that is beyond the usual services in either the inpatient or outpatient setting." These codes are designed to be used in addition to your evaluation and management code for the basic E/M service rendered that day. Other services such as testing may also be reported with these codes, but it is important to understand that these prolonged service codes must be reported in addition to an evaluation and management code, and may not be billed as stand alone services.

These are time-based codes, and you must meet certain time threshold requirements in order to bill them. Codes 99354-99355 (outpatient) and 99356-99357 (inpatient) are used to report the total duration of face-to-face time spent by the physician providing prolonged services and are based on the site of service where the services were rendered—even if the time on that date is not continuous. If for instance you see a patient four or five times during a given day on the ward of the hospital, you would aggregate all of the prolonged service face-to-face time spent during the course of the day to come up with the codes to be billed providing prolonged services. In this situation, you need to make sure that the total face-to-face time is documented in each medical record entry throughout the day. This is the only way you'll be sure to capture the appropriate amount of billable time in your documentation so that it will withstand the scrutiny of a third-party auditor. Codes 99354 and 99356 are each billed once per calendar day, and codes 99355 and 99357 are add on codes each representing an additional 30 minutes.

In order to correctly bill prolonged face-to-face services, you must first have at least an additional 30 minutes of face-to-face time over and above the average time associated with your evaluation and management code on that date. For a level 4 follow-up outpatient visit (CPT 99214) with an associated average time of 25 minutes, you would have to spend at least an additional 30 minutes in providing direct face-to-face services in order to be able to also bill code 99354. This means that the provider (not the staff, not your RN) would need to spend at least 65 minutes face–to-face with the patient to bill the additional code. Don't count time your patient spends in the office when the provider of care is not in direct face-to-face contact with the patient. It's also important to remember that prolonged services lasting less than 30 minutes are *not* billable. The intent of the codes is that the provider spent face-to-face time actively treating or interacting with the patient on a care issue. You must make this very clear in your documentation.

These services can be billed direct by CRNPs and PAs as well, or as split shared services providing that the companion evaluation and management code is eligible to be billed as a split shared service. (Remember: for CMS, consultations can never be billed as split/shared services, which means when billing a consult together with the prolonged service codes, all of the services must be fully provided and billed by the same provider.)

Potential Dealbreakers

Documentation is critical when providing these services. In order to withstand third-party payer scrutiny, it will be important for you to have documented your total face-to-face time spent directly with the patient. Time spent on the floor of the hospital *cannot* be counted towards prolonged services with direct patient contact, even if:

- it is related to the patient's case
- time spent speaking with relatives about the condition of the patient when the patient is not present and able to be a part of the discussion, or
- time spent discussing the case with other providers of care when the patient

is not able to take part in the discussion. While this time represents valuable and important service to the patient, it cannot be reported using the direct face-to-face prolonged service codes because they are not direct face-to-face services.

CMS has some unique rules of its own when it comes to billing for extended services, and these rules will affect neurologists' ability to bill for prolonged services involving direct face-to-face services. In addition to meeting the time threshold requirement above, CMS requires that the *entire time* spent with the patient must be direct face-to-face time, including the evaluation and management service time that is being billed on the same day. CPT instructions tell you that you must provide 30 minutes above and beyond the average time associated with your evaluation and management code in order to bill for prolonged services. As an example, for a level 3 subsequent daily care service (CPT 99233), if you meet the level of the code based on work, and you are able to count floor time to achieve this code and you then spend an additional 30 minutes over and above the 35 minutes associated with the level three subsequent daily care code (CPT 99233), providing additional direct face-to-face services, you can bill 99233 and 99356 to report these services.

From CMS's standpoint, you must spend 65 minutes providing direct face-to-face services to be able to bill both the 99233 and the 99356 codes. Floor time in this example will not count toward getting you to the 65-minute threshold. So if you spent 15 minutes of the time associated with the 99233 in reviewing the patient's medical records and labs in the physician work area on the floor, do not count this time toward meeting your threshold time, as it was not a direct face-to-face service. For CMS, you must document total time spent face-to-face providing prolonged services and you must describe what was done during the prolonged service. It's best to be very descriptive of what's being done and why the prolonged services were necessary. This will ensure you get to keep the revenue generated from this service if you are audited.

Physicians are often at odds over how to bill for services that take an inordinate amount of time, such as discussing the care of a sick patient with relatives, consoling the family during end of life care, or making phone calls to the patient's family because the family was not around when the physician was available to speak with them during the day. Bear in mind that these types of services cannot be billed using the prolonged service codes with direct (face-to-face) patient contact. There are, however, codes developed for the purpose of reporting Prolonged Physician Service without direct, face-to-face patient contact. Codes, 99358-99359 have the same time threshold guidelines that govern the use of these codes as the direct, face-to-face codes, but simply speaking, they are not reimbursed by CMS and are not recognized by many third-party payers. CMS warns you not to bill the patient for these types of services because they are considered bundled to the face-to-face services provided within your evaluation and management code.

Knowing the ins and outs of how to correctly bill for prolonged services with direct (face-to-face) patient contact can mean additional revenue for your practice. Knowing the rules, what they mean, and how to adhere to them will make your practice audit proof when payers review your documentation. **PN**

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