

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2282	Date: AUGUST 26, 2011
	Change Request 7405

SUBJECT: Clarification of Evaluation and Management Payment Policy

I. SUMMARY OF CHANGES: In the Calendar Year (CY) 2010 Physician Fee Schedule (PFS) final rule with comment period (CMS-1413-FC), the Centers for Medicare and Medicaid Services (CMS) eliminated the payment of all Current Procedural Terminology (CPT) consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation Healthcare Common Procedure Coding System (HCPCS) G-codes. In the CY 2011 PFS final rule with comment period (CMS-1503-FC), CMS recognized the newly created CPT subsequent observation care codes (99224-99226). All references to billing consultation codes in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 and Pub. 100-04, Medicare Claims Processing Manual, chapter 12 are revised to reflect the current policy on consultation codes. References to billing observation care codes in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.6 are revised to account for the new subsequent observation care codes (99224-99226).

EFFECTIVE DATE: January 1, 2011

IMPLEMENTATION DATE: November 28, 2011

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/Table of Contents
R	12/30.6.8/Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services)
R	12/30.6.9/Payment for Inpatient Hospital Visits - General
R	12/30.6.9.1/Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services)
R	12/30.6.10/Consultation Services

R	12/30.6.13/Nursing Facility Services
R	12/30.6/15.1/Prolonged Services With Direct Face-to-Face Patient Contact Service (ZZZ codes)

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

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

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: 2282	Date: August 26, 2011	Change Request: 7405
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SUBJECT: Clarification of Evaluation and Management Payment Policy

Effective Date: January 1, 2011

Implementation Date: November 28, 2011

I. GENERAL INFORMATION

A. Background: In the Calendar Year (CY) 2010 Physician Fee Schedule (PFS) final rule with comment period (CMS-1413-FC), the Centers for Medicare & Medicaid Services (CMS) eliminated the payment of all Current Procedural Terminology (CPT) consultation codes (inpatient and office/outpatient codes) for various places of service except for telehealth consultation Healthcare Common Procedure Coding System (HCPCS) G-codes. In the CY 2011 PFS final rule with comment period (CMS-1503-FC), CMS recognized the newly created CPT subsequent observation care codes (99224-99226). All references to billing CPT consultation codes in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 and Pub. 100-04, Medicare Claims Processing Manual, chapter 12 are revised to reflect the current policy on reporting evaluation and management (E/M) services that would otherwise be described by CPT consultation codes. References to billing observation care codes in Pub. 100-04, chapter 12, section 30.6 are revised to account for the new subsequent observation care codes (99224-99226).

B. Policy: Effective January 1, 2010, CPT consultation codes were no longer recognized for Medicare Part B payment. As explained in CR 6740, Transmittal 1875, Revisions to Consultation Services Payment Policy, issued on December 14, 2009, 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. CMS instructed providers billing under the PFS to use other applicable E/M codes to report the services that could be described by CPT consultation codes. CMS also provided that, in the inpatient hospital setting, physicians (and qualified nonphysicians where permitted) who perform an initial E/M service may bill the initial hospital care codes (99221 – 99223).

CMS is aware of concerns pertaining to reporting initial hospital care codes for services that previously could have been reported with CPT consultation codes and for which the minimum key component work and/or medical necessity requirements for CPT codes 99221 through 99223 are not documented. Providers may report CPT code 99221 for an E/M service if the requirements for billing that code, which are greater than CPT consultation codes 99251 and 99252, are met by the service furnished to the patient.

In situations where the minimum key component work and/or medical necessity requirements for initial hospital care services are not met, subsequent hospital care CPT codes (99231 and 99232) could potentially meet requirements to be reported for an E/M service that could be described by CPT consultation code 99251 or 99252. Contractors shall expect changes to physician billing practices accordingly. Medicare contractors shall not find fault with providers who report a subsequent hospital care code (99231 and 99232) in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

The general policy of billing the most appropriate visit code, following the elimination of payments for consultation codes, shall also apply to billing initial visits provided in skilled nursing facilities (SNFs) and nursing facilities (NFs) by physicians and nonphysician practitioners (NPPs) who are not providing the federally mandated initial visit. If a physician or NPP is furnishing that practitioner’s first E/M service for a Medicare beneficiary in a SNF or NF during the patient’s facility stay, even if that service is provided prior to the federally mandated visit, the practitioner may bill the most appropriate E/M code that reflects the services the practitioner furnished, whether that code be an initial nursing facility care code (CPT codes 99304-99306) or a subsequent nursing facility care code (CPT codes 99307-99310) when documentation and medical necessity do not meet the requirements for billing an initial nursing facility care code.

In the CY 2011 PFS final rule with comment period (CMS-1503-FC), CMS recognized the newly created CPT subsequent observation care codes (99224-99226). For the new subsequent observation care codes, the current policy for initial observation care also applies to subsequent observation care. Payment for a subsequent observation care code is for all the care rendered by the ordering physician on the day(s) other than the initial or discharge date. 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. In the rare circumstance when a patient receives observation services for more than 2 calendar dates, the physician shall bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility is indicated by an “X” in each applicable column)									
		A/B M A C	D M M A C	F I	C A R I E R	R H R I	Shared-System Maintainers				Other
						F I S S	M C S	V M S	C W F		
7405-04.1	Contractors shall be in compliance with the instructions found in Pub 100-04, Medicare Claims Processing Manual, chapter 12 and Pub. 100-02, Medicare Benefit Policy Manual, chapter 15.	X		X	X	X					
7405-04.2	Contractors shall allow providers to bill for a subsequent hospital care code even if it is for the provider’s first evaluation and management service to the inpatient during the hospital stay.	X		X	X	X					
7405-04.3	Contractors shall allow providers to bill for an initial nursing facility care code or subsequent nursing facility care code, even if it is provided prior to the initial federally mandated visit.	X		X	X	X					
7405-04.4	As with all E/M services, contractors shall monitor subsequent observation care codes (99224-99226) to prevent payment for two or more E/M services by the same physician/nonphysician practitioner (or	X		X	X	X					

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)									
		A/B M A C	D M E M A C	F I	C A R I E R	R H I	Shared-System Maintainers				Other
							F I S S	M C S	V M S	C W F	
	physician/nonphysician practitioner of the same specialty from the same group practice), unless an appropriate modifier is appended.										
7405-04.5	Contractors shall not search their files to adjust claims already processed, but shall adjust claims brought to their attention within a timely period.	X		X	X	X					

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	C A R I E R	R H I	Shared-System Maintainers				OTH ER
							F I S S	M C S	V M S	C W F	
7405-04.6	<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	X					

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	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): For payment policy questions contact Erin Smith at (410) 786-0763 (e-mail: erin.smith@cms.hhs.gov)

For Part A claims processing questions, contact Wendy Tucker at (410) 786-3004 (email: wendy.tucker@cms.hhs.gov)

For Part B claims processing questions, contact Kathleen Kersell at (410) 786-2033 (e-mail: kathleen.kersell@cms.hhs.gov) or Joscelyn Lissone at (410) 786-5116 (e-mail: Joscelyn.lissone@cms.hhs.gov)

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *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)*, 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.

Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev. 2282, Issued: 08-26-11)

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

30.6.8 - Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services)

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

A. Who May Bill Observation Care *Codes*

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 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 *and subsequent* observation care codes. 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

Similar to initial observation codes, payment for a subsequent observation care code is for all the care rendered by the treating physician on the day(s) other than the initial or discharge date. 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.

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. *On the rare occasion when a patient remains in observation care for 3 days, the physician shall report an initial observation care code (99218-99220) for the first day of observation care, a subsequent observation care code (99224-99226) for the second day of observation care, and an observation care discharge CPT code 99217 for the observation care on the discharge date. When observation care continues beyond 3 days, the physician shall report a subsequent observation care code (99224-99226) for each day between the first day of observation care and the discharge date.*

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)

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 *observation services* furnished *on day(s) other than the initial or discharge date* using *subsequent observation care* 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 *or subsequent* 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, 99220, *99224, 99225, 99226*, 99234, 99235, *and* 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 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 - Payment for Inpatient Hospital Visits - General

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

A. Hospital Visit and Critical Care on Same Day

When a hospital inpatient or office/outpatient evaluation and management service (E/M) are furnished on a calendar date at which time the patient does not require critical care and the patient subsequently requires critical care both the critical Care Services (CPT codes 99291 and 99292) and the previous E/M service may be paid on the same date of service. Hospital emergency department services are not paid for the same date as critical care services when provided by the same physician to the same patient.

During critical care management of a patient those services that do not meet the level of critical care shall be reported using an inpatient hospital care service with CPT Subsequent Hospital Care using a code from CPT code range 99231 – 99233.

Both Initial Hospital Care (CPT codes 99221 – 99223) and Subsequent Hospital Care codes are “per diem” services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.

Physicians and qualified nonphysician practitioners (NPPs) are advised to retain documentation for discretionary contractor review should claims be questioned for both hospital care and critical care claims. The retained documentation shall support claims for critical care when the same physician or physicians of the same specialty in a group practice report critical care services for the same patient on the same calendar date as other E/M services.

B. Two Hospital Visits Same Day

Contractors pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not. The inpatient hospital visit descriptors contain the phrase “per day” which means that the code and the payment established for the code represent all services provided on that date. The physician should select a code that reflects all services provided during the date of the service.

C. Hospital Visits Same Day But by Different Physicians

In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, *contractors* do not pay physician B for the second visit. The hospital visit descriptors include the phrase “per day” meaning care for the day.

If the physicians are each responsible for a different aspect of the patient’s care, pay both visits if the physicians are in different specialties and the visits are billed with different diagnoses. There are circumstances where concurrent care may be billed by physicians of the same specialty.

D. Visits to Patients in Swing Beds

If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply.

30.6.9.1 - Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services) *(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)*

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)

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.

Physicians who provide an initial visit to a patient during inpatient hospital care that meets the minimum key component work and/or medical necessity requirements 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 for 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.

Physicians may bill initial hospital care service codes (99221-99223), for services that were reported with CPT consultation codes (99241 – 99255) prior to January 1, 2010, when the furnished service and documentation meet the minimum key component work and/or medical necessity requirements. Physicians must meet all the requirements of the initial hospital care codes, including “a detailed or comprehensive history” and “a detailed or comprehensive examination” to report CPT code 99221, which are greater than the requirements for consultation codes 99251 and 99252.

Subsequent hospital care CPT codes 99231 and 99232, respectively, require “a problem focused interval history” and “an expanded problem focused interval history.” An E/M service that could be described by CPT consultation code 99251 or 99252 could potentially meet the component work and medical necessity requirements to report 99231 or 99232. Physicians may report a subsequent hospital care CPT code for services that were reported as CPT consultation codes (99241 – 99255) prior to January 1, 2010, where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay.

Reporting CPT code 99499 (Unlisted evaluation and management service) should be limited to cases where there is no other specific E/M code payable by Medicare that describes that service.

Reporting CPT code 99499 requires submission of medical records and contractor manual medical review of the service prior to payment. Contractors shall expect reporting under these circumstances to be unusual.

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

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

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, physicians (and qualified nonphysician practitioners where permitted) *may bill the most appropriate initial hospital care code (99221-99223), subsequent hospital care code (99231 and 99232), initial nursing facility care code (99304-99306), or subsequent nursing facility care code (99307-99310) that reflects the services the physician or practitioner furnished. Subsequent hospital care codes could potentially meet the component work and medical necessity requirements to be reported for an E/M service that could be described by CPT consultation code 99251 or 99252. Contractors shall not find fault in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay. Unlisted evaluation and management service (code 99499) shall only be reported for consultation services when an E/M service that could be described by codes 99251 or 99252 is furnished, and there is no other specific E/M code payable by Medicare that describes that service. Reporting code 99499 requires submission of medical records and contractor manual medical review of the service prior to payment. CMS expects reporting under these circumstances to be unusual.* 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.

30.6.13 - Nursing Facility Services

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

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 *federally mandated* visits in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4) *and* (f)). 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 *or qualified NPPs* who perform an initial evaluation in the *NF or SNF* may bill the initial nursing facility care code. The initial *federally mandated* visit is defined in S&C-04-08 (see www.cms.hhs.gov/medlearn/matters) as the initial comprehensive 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), *in a SNF* 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 *federally mandated comprehensive* visit in a SNF.

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. 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 *federally mandated* visit. Only a physician may report these codes for an initial *federally mandated* 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 *federally mandated* 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. *A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-*

99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

SNF Setting--Place of Service Code 31

Following the initial *federally mandated* 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 *federally mandated* 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 *federally mandated* visit by the physician *or qualified NPP where permitted*, 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 *federally mandated* visit by the physician in a SNF.

Qualified NPPs in the NF setting, who are not employed by the NF *and who are working in collaboration with a physician*, may perform federally mandated physician visits, at the option of the State.

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 *federally mandated* 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. *A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.*

SNF Setting--Place of Service Code 31

Following the initial *federally mandated* 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 *federally mandated* 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 *as* 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 *the* 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. *Multiple 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 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 (ZZZ codes)

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

A. Definition

Prolonged physician services (CPT code 99354) in the office or other outpatient setting with direct face-to-face patient contact which require 1 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 1 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.

B. Required Companion Codes

The companion evaluation and management codes for 99354 are the Office or Other Outpatient visit codes (99201 - 99205, 99212 – 99215), 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); 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 *the* 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**

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

Code	Typical Time for Code	Threshold Time to Bill Code 99356	Threshold Time to Bill Codes 99356 and 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100

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.