Billing for Length of Time of Physician Services under Medicare

by Mary Lou Bowers, M.B.A., L.C.S.W.

Q: *When is it important for physicians to be alert to the length of time that they spend providing service to their patients?*

A: There are four scenarios in which length of time of physician services is important:

- When counseling or coordinating care is the major service
- When a visit is longer than expected
- During critical care
- When providing hospital discharge services.

Time is important in each of these instances, because 1) a higher level of service can be charged based on time or 2) an additional service can be charged.

Q: *When can education or counseling services provided by the physician be billed as part of the patient visit time?*

A: Oncologists often provide education or counseling services, particularly just prior to initiation of new treatment. Sometimes this service occurs on the same day as a high-level visit, but education and counseling can also be the only service provided.

When counseling consumes 50 percent or more of the total visit, time can be used to determine the visit level. For example, the physician provided a new patient consult yesterday and scheduled the patient to return today to start chemotherapy. The patient asked that the physician meet with herself and her daughter to review the treatment plan. Today's visit doesn't involve a history or physical exam, since comprehensive services were provided yesterday. The discussion takes 25 minutes. It would be appropriate to bill a level 4 established patient visit. The physician must document the reason for the visit, the discussion, and the medical decision making. In this case, the medical decision making might be to initiate treatment as planned. Total visit time and counseling time must also be documented.

Q: *What if that patient had brought the daughter the day before and the physician had the discussion after providing the new patient consult?*

A: The physician would bill the consult service, most likely CPT 99245, and a first hour prolonged visit, CPT 99354. The physician would document the same history, physical exam, and medical decision making visit information, adding major points of the counseling discussion and total time. Prolonged services can be billed by the physician for work done in the hospital or in the office. The CPT codes are specific to site of service: 99354 and 99355 for office, and 99356 and 99357 for hospital. If the visit is extended beyond another hour, the physician would bill the CPT code for each additional half-hour using the appropriate multiple to state units.

Q: *If the physician attends a patient in critical condition, using the definition for CPT code 99291-2, does the physician also need to record time?*

A: In my chart audits I often find that the physician has documented the critical care very adequately, but forgets to document time. This negates any charge that has been made. Critical care time and charges accumulate while the physician is attending the patient and include monitoring, assessing and documenting. These activities do not need to be continuous.

For example, an oncology patient comes to the office for routine chemotherapy treatment and experiences a severe anaphalactic reaction. The physician and nursing staff stabilize the patient and then send the patient to the hospital for admission. The physician attends to the patient at the hospital. The total time spent with the patient can be accumulated to charge for the first hour (CPT 99291) and subsequent half-hours (CPT 99292) of care. If the payer allows, an admission may also be billed, using a modifier, of course. But if both cannot be billed, the critical code accumulation will likely be more beneficial than billing for the admission. Medicare says that if the critical care is necessary following the E&M service, critical care may be billed in addition. However, if critical care precedes the E&M service, the E&M service may not be billed separately. So in the example above, Medicare would not allow the physician to bill for the admission.

Q: *How should the oncology patient discharge service be coded?*

A: The hospital discharge services may be reported using two different codes: one for service of 30 minutes or less (CPT 99238) and the other for more than 30 minutes (CPT 99239). Many oncology patient discharges take more than 30 minutes—coordination of care counts. Again, time must be documented, but does not have to be continuous. We find most oncologists don't even have both codes on their hospital encounter forms.

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