Dynamic Chiropractic

Accounting for Extra Time Spent With the Patient

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Q: A patient complained of typical lower back pain, caused by overexertion while lifting a box. On the basis of this presented complaint and after examination, the patient was diagnosed with typical strain and sprain condition. However, I was required to spend an hour and 10 minutes on an examination with this new patient, due to a lengthy history involving not only this episode, but also two similar injuries within the past year and a half. Furthermore, the patient is diabetic, overweight and hypertensive, which complicated the history, creating several comorbidities. Typically, I would use 99203 for the level of exam for this service, but considering the time spent, would it be appropriate to bill a higher E&M code such as 99205 or some other code(s) to account for my time?

A: I understand your dilemma, as you wish to be compensated for the added time needed with this patient, but are concerned that a higher code may not be suitable. While time is one of the seven component factors in the choice of level of E&M service, it is not used to define the level of E&M service as the other six do. In fact, if time alone is used to determine the level, it can lead to two types of errors in coding and reimbursement: upcoding, which can be considered fraud or abuse, as it defines that a code for higher level of service was used for a lesser service; and the use of codes that indicate when additional time was needed beyond the typical time associated with the E&M service, although the use of such codes is not fraud or abuse. Respectively, these codes reimburse at a level commensurate with the added time required. Simply put, understanding the coding rules can ensure not only correct coding, but also potentially higher reimbursement.

To understand what must be done, the components of the E&M service must be understood. The six factors of choice for E&M codes are as follows, with the first three considered the key components and the last three used for selecting the level: (1) history, (2) examination, (3) medical decision-making, (4) counseling, (5) coordination of care, and (6) nature of presenting problem. Looking at these components, it can be readily observed that the severity of the condition would be the best indicator of the level of service utilized. As defined in *CPT 2006*, the two highest levels of E&M services require a risk of morbidity without treatment or a prolonged or severe functional impairment/disability from the condition. With these requirements, the two highest levels, 99204 or 99205, clearly would not be correct for a patient with the problem presented in your question. But time was a factor, and necessary, based on the prolonged and complicated history with the comorbidities present. Therefore, the most appropriate E&M code would be, as you noted, the mid-level 99203 (consistent with this severity), and for added time spent, code 99354 for prolonged physician service.

Code 99354 describes when a physician provides prolonged service involving direct, face-to-face patient contact that is beyond the usual E&M service. It does require that a minimum of 30 extra minutes be spent in addition to the time associated with the E&M code. In your case, 99203 is for 30 minutes and the additional 40 minutes (one hour and 10 minutes total) spent would be coded with 99354. When billing 99354, it must be used in addition to an E&M service and cannot stand alone.

Further, when using the code 99354 it requires no modifier. Fees for 99354 can range from a low of $95-$110, per the Medicare fee schedule, to as high as $245 for general health insurance and personal injury claims. Specifically, 99354 is for the first 30-74 minutes beyond the E&M service, while 99355 designates time above 75-104 minutes and in multiples thereafter, for each segment of additional periods of 30 minutes. If fewer than 30 additional minutes are spent, 99354 cannot be used.

If you were to use codes 99204 or 99205, it would not only be upcoding, but also would lessen the reimbursement you are entitled to considerably. In closing, I must emphasize that use of this code, while not uncommon, is not typical and should not be used if you routinely spend one hour or more with all patients. The use of that time level is likely one of style and personal preference, not of specific medical necessity. In my experience, only 5 percent of new patient exams qualify for the use of a prolonged service code. Moreover, be assured that claims using these codes are more prone to requests for documentation; as such, the documentation must not only indicate the time spent face to face, but also should include a fair amount of notes and other details, commensurate with the time indicated. Please refer to your CPT codebook for full details on the prolonged service codes.

FEBRUARY 2006