Monday, February 19, 2024

Making sense of the new coding-by-time rules for 2024

We all know that the new year brings changes (some years, more than others). As it turns out, no sooner had we gotten clinicians on track with how much time belongs to the E/M CPT code set than CMS issued new directives that make it harder to reach the prolonged care code 99417/G2212/G0316. CMS states that this CPT code can be billed—but only after exceeding the maximum time threshold by 15 minutes (with or without direct patient contact).

Due to CMS's disagreement with the CPT guidelines regarding the threshold time, the agency has introduced Healthcare Common Procedure Coding System (HCPCS) Level II codes with distinct reporting instructions. This dual system of codes, CPT and HCPCS, for prolonged E/M services has led to ongoing confusion. Nevertheless, CMS remains firm in its stance that the full 15 minutes beyond the maximum time threshold, not the minimum time threshold, must be achieved before reporting a prolonged services code.

So, what does that mean, exactly?

CPT 99417 goes by the LOWEST time threshold, and CMS G2212 goes by the HIGHEST time threshold in the 2023 guideline chart. The same rule applies for 99418/G0316, though these are codes for inpatient/observation hospital visits only.

Below is the best chart I have seen that shows the codes.[1]

Primary E/M Service (minimum time on date of encounter)	CPT Prolonged Services Codes	CPT Time Threshold	Medicare Prolonged Services Codes	Medicare Time Threshold
99205 New Patient Office Visit (60 minutes)	99417	75 minutes	G2212	90 minutes

[1] American College of Surgeons, New 2024 CPT Coding Changes Affect General Surgery, Related Specialties | ACS (facs.org)

99215 Established Patient Office Visit (40 minutes)	99417	55 minutes	G2212	70 minutes
99223 Initial Inpatient or Observation Visit (75 minutes)	99418	90 minutes	G0316	105 minutes
99233 Subsequent Inpatient or Observation Visit (50 minutes)	99418	65 minutes	G0316	80 minutes
99417 Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service).				
99418 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service).				
G2212 Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99358, 99359, 99415, 99416) (Do not report G2212 for any time unit less than 15 minutes).				
G0316 Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services) (Do not report G0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418, 99415, 99416) (Do not report G0316 for any time unit less than 15 minutes).				

Once clinicians know how to use the extended time CPT/HCPCS codes, how do they reach the time limits, even if it is rare that they would go over the normal time parameters for E/M office 99205/99215?

First, they should know that the time billable is for a 24-hour period.

Second, they can review the records sent by a specialist, ED, or former practice as long as these records (a) do not come from their own facility notes or (b) were not made on the day of the appointment. The dictation must expressly state the origin of the records reviewed.

Here are a few examples that could count toward the "total time" in a 24-hour period:

- The clinician spends extra time with a patient with major comorbidities, explaining treatments to them or to a relative who accompanies them to the office.
- The provider ran tests and told the patient she would contact them with the results—and would prescribe antibiotics if the results were positive.
- The physicians needed to stabilize a patient in the office and called for an ambulance.

In all cases, we recommend listing the breakdown in time so that you document every aspect of the patient encounter that resulted in the "total time." It's better to get in that habit of documenting the time breakdown now because you never know when the day will arrive when an insurance company will raise that question. Better safe than sorry!

Don't miss our "Ask the Experts" Q&A webinar on March 27!

Click here to register: https://zoom.us/webinar/register/WN_DR96lTB4QVWgI5b2wxmKuw

If you have an E/M coding question you'd like our experts to address during the webinar, please submit it here: https://survey.hsforms.com/1AI9VoMe-SK6MSUuAypFnmgnig0s

Michelle Sergei-Casiano
CPC, CFPC, CEMC, CPMA
Senior Manager, Regulatory and Coding Compliance