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Prolonged Services (Codes 99354 - 99359)

Key Words

MM5972, CR5972, R1490CP, Prolonged

Provider Types Affected

Physicians and other qualified non-physician practitioners (NPP) whose services are billed to Medicare Carriers or Part A/B Medicare Administrative Contractors (A/B MAC)

Key Points

- The effective date of the instruction is July 1, 2008.
- The implementation date is July 7, 2008.
- Several code changes, code deletions, and typical/average time units have changed in the American Medical Association (AMA) Current Procedural Terminology (CPT) coding system since the *Medicare Claims Processing Manual,* Chapter 12 (Physicians/Nonphysician Practitioners), Section 30.6.15.1 (Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes)) and Section 30.6.15.2 (Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359) were first written.
- Change Request (CR) 5972 updates these sections that address prolonged services codes, in order to be consistent with the AMA CPT coding changes.

Summary of the Manual Changes

Prolonged Services with Direct Face-to-face Patient Contact

- In the office or other outpatient setting, Medicare will pay for prolonged physician services (CPT code 99354) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion E & M codes.
    - The time for usual service refers to the typical/average time units associated with the companion E&M service as noted in the CPT code.

  - Providers should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services by using CPT code 99355.

- In the inpatient setting, Medicare will pay for prolonged physician services (code 99356) (with direct face-to-face patient contact which require one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion E & M codes.
  - Providers should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services by using CPT code 99357.
- Providers should not separately report prolonged service of less than 30 minutes total duration on a given date because the work involved is included in the total work of the E&M codes.
- Providers may use code 99355 or 99357 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 services of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Required Companion Codes

- Prolonged services codes 99354 – 99357 are not paid unless they are accompanied by the companion codes as described below:
  - The companion E&M codes for 99354 are:
    - Office or Other Outpatient visit codes (99201 - 99205, 99212 – 99215);
    - Office or Other Outpatient Consultation codes (99241 – 99245);
    - Domiciliary, Rest Home, or Custodial Care Services codes (99324 – 99328, 99334 – 99337); and
    - Home Services codes (99341 - 99345, 99347 – 99350).
  - The companion E&M codes for 99355 are 99354 and one of the E&M codes required by 99354.
  - The companion E&M codes for 99356 are:
    - The Initial Hospital Care and Subsequent Hospital Care codes (99221 - 99223, 99231 – 99233),
    - Inpatient Consultation codes (99251 – 99255); and
    - Nursing Facility Services codes (99304 -99318).
  - The companion codes for 99357 are 99356 and one of the E&M codes required by 99356.

Requirement for Physician Presence

- Providers may count only the duration of direct face-to face contact with 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.
- Providers cannot bill as prolonged services:

- In the office setting, time spent by office staff with the patient, or time the patient remains unaccompanied in the office; or
- In the hospital setting, time spent reviewing charts or discussing the 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.

Documentation

- Unless providers have been selected for medical review, they do not need to send the medical record documentation with the bill for prolonged services.
- Documentation, however, is required to be in the medical record about the duration and content of the medically necessary E & M service and prolonged services that you bill.
  - Providers must appropriately and sufficiently document in the medical record that they personally furnished the direct face-to-face time with the patient specified in the CPT code definitions.
  - Providers should make sure that they document the start and end times of the visit, along with the date of service.

Use of the Codes

- Providers can only bill the prolonged services codes if the total duration of all physician or qualified NPP direct face-to-face service (including the visit) equals or exceeds the threshold time for the E & M service the physician or qualified NPP provided (typical/average time associated with the CPT E & M code plus 30 minutes).

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, provider should bill the E&M 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, provider 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.
- Table 1 (Threshold Time for Prolonged Visit Codes 99354 and/or 99355 Billed with Office/Outpatient and Consultation Codes) on page 5 of MLN Matters article MM5972 displays threshold times the carriers and A/B MACs use to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings, including outpatient consultation services and domiciliary, rest home, or custodial care services and home services codes.
  - The AMA CPT coding-derived changes are highlighted and noted in bolded italics.
  - To get to the threshold time for billing code 99354 and two units of code 99355, providers should add 30 minutes to the threshold time for billing codes 99354 and 99355. For example, when billing code 99205, in order to bill code 99354 and two units of code 99355, the threshold time is 150 minutes.

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, providers should bill the visit and code 99356.

- Medicare contractors will 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, provider should bill 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.
- Table 2 (Threshold Time for Prolonged Visit Codes 99356 and/or 99357 Billed with Inpatient Setting Codes) on pages 6 and 7 of MM5592 displays the threshold times that the Medicare contractors use to determine if the prolonged services codes 99356 and/or 99357 can be billed with the inpatient setting codes. The AMA CPT coding-derived changes are highlighted and noted in bolded italics.

Prolonged Services Associated With E&M Services Based Counseling and/or Coordination of Care (Time-Based)

- When an E&M 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 the qualified NPP, and the patient in the office/clinic or the floor time in the scenario of an inpatient service, then the E&M 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 E&M code) and should not be "rounded" to the next higher level.
- In E&M services in which the code level is selected based on time, providers may only report prolonged services with the highest code level in that family of codes as the companion code.

Billing Examples

Examples of billable and non-billable prolonged services are:

- Billable Prolonged Services

  EXAMPLE 1
  A physician performed a visit that met the definition of an office visit CPT code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills CPT 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 CPT code 99327 and the total duration of the direct face-to-face contact (including the visit) was 140 minutes. The physician bills CPT 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 bills CPT code 99215 and one unit of code 99354.

- Non-billable 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.

  Medicare contractors will not pay (nor can providers bill the patient) for prolonged services codes 99358 and 99359, which do not require any direct patient face-to-face contact (e.g., telephone calls). These are Medicare covered services and payment is included in the payment for other billable services.

Important Links

The related MLN Matters article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5972.pdf* on the CMS website.

The official instruction (CR5972) regarding this change may be viewed at *http://www.cms.hhs.gov/transmittals/downloads/R1490CP.pdf* on the CMS website.

Providers will find the updated *Medicare Claims Processing Manual* Chapter 12, Section 30.6.15.1 and Section 30.6.15.2 as an attachment to that CR.