

CMS Manual System	Department of Health & Human Services (DHH)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1490	Date: April 11, 2008
	Change Request 5972

SUBJECT: Prolonged Services (Codes 99354 - 99359)

I. SUMMARY OF CHANGES: This transmittal updates Chapter 12, §§30.6.15.1 and 30.6.15.2. Several code changes, code deletions, and typical/average time units have changed in the American Medical Association Current Procedural Terminology (CPT) coding system since the manual section was first written. Physician visits for counseling and/or coordination of care are based on typical/average time units necessitating a section explaining current Medicare policy. The time approximation must meet or exceed the typical/average time of a specific code and shall not be "rounded" to the next higher level. Prolonged services may only be reported with the highest code level in a code family for counseling and/or coordination of care services based on time. The tables for threshold times are corrected and updated.

New / Revised Material

Effective Date: June 2, 2008

Implementation Date: July 7, 2008

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-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	12/30/30.6.15.1/Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes)
R	12/30/30.6.15.2/Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359)

III. FUNDING:

SECTION A: For Fiscal Intermediaries and 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):

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: 1490	Date: April 11, 2008	Change Request: 5972
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SUBJECT: Prolonged Services (Codes 99354 – 99359)

Effective Date: June 2, 2008

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: This transmittal updates Chapter 12, §30.6.15.1 and §30.6.15.2. Several code changes, code deletions and typical/average time units have changed in the American Medical Association Current Procedural Terminology (CPT) coding system since the manual section was first written. Physician visits for counseling and/or coordination of care are based on typical/average time units necessitating a section explaining current Medicare policy.

B. Policy: The Prolonged Services definition and required evaluation and management companion codes are explained. The explanations are in keeping with current Medicare payment policy for physician presence, supporting documentation and in recognition of code changes that have occurred since last revised. The tables for threshold times are corrected and updated to reflect code changes and current typical/average time units associated with the CPT levels of care in code families. A new subsection (30.6.15.1 (H) is added to explain how to report physician visits for counseling and/or coordination of care when the visit is based on time, and when the counseling and/or coordination service is prolonged. The time approximation must meet or exceed the typical/average time of a specific CPT code billed and shall not be “rounded” to the next higher level. Prolonged Services may only be reported with the highest code level in a code family for counseling and/or coordination based on time. New examples are provided.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B M A C	D M M A C	F I	C A R E R	R H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
5972.1	Contractors shall instruct physicians and qualified nonphysician practitioners (NPPs) on the definition and correct use of prolonged services for direct face-to-face patient contact with codes 99354 – 99357 as explained in §30.6.15.1 (A) and (E).	X			X						
5972.2	Contractors shall instruct physicians and qualified NPPs on the required evaluation and management companion	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H I S S	Shared-System Maintainers				OTHER
						F I S	M C S	V M S	C W F		
	codes to use with prolonged services codes, 99354 – 99357 as explained in §30.6.15.1 (B).										
5972.3	Contractors shall instruct physicians and qualified NPPs that time spent reviewing charts or a discussion of the patient with house medical staff and not with direct face-to-face patient contact does not meet the requirement for prolonged hospital services as explained in §30.6.15.1 (C).	X			X						
5972.4	Contractors shall instruct physicians and qualified NPPs that the medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show direct face-to-face patient contact and enter the dated start and end times of the prolonged service as explained in §30.6.15.1 (D).	X			X						
5972.5	Contractors shall instruct physicians and qualified NPPs to apply the threshold times for codes 99354 and 99355 for the office or outpatient setting as identified in the table in §30.6.15.1 (F).	X			X						
5972.6	Contractors shall instruct physicians and qualified NPPs to apply the threshold times for codes 99356 and 99357 for the inpatient setting as identified in the table in §30.6.15.1 (G).	X			X						
5972.7	Contractors shall instruct physicians and qualified NPPs that for prolonged services for counseling and/or coordination of care based on typical/average time units the time approximation must meet or exceed the specific CPT code typical/average time unit billed and shall not be “rounded” to the next higher level.	X			X						
5972.7.1	Contractors shall instruct physicians and qualified NPPs that 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, as shown in Example 3 of the Nonbillable Prolonged Services in §30.6.15.1(J).	X			X						
5972.8	Contractors shall instruct physicians and qualified NPPs that prolonged services without direct face-to-face patient contact, CPT codes 99358 and 99359, are not	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
		M A C	M A C				I S S	M S	V M S	C W F	
	separately payable and are included in the payment for other billable services.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTH ER
		M A C	M A C				I S S	M S	V M S	C W F	
5972.9	<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						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

X-Ref Requirement Number	Recommendations or other supporting information:

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

The American Medical Association Current Procedural Terminology (CPT), 2008, Evaluation and Management Section, pp. 9 – 29.

V. CONTACTS

Pre-Implementation Contact(s): Kit Scally (Cathleen.Scally@cms.hhs.gov)

Post-Implementation Contact(s): Appropriate Regional Office staff

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHs)* use only one of the following statements:

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)*, use 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.

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev.1490, 04-11-08)

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30.6.15.1 - Prolonged Services *With Direct Face-to-Face Patient Contact Service* (Codes 99354 - 99357) (ZZZ codes)

(Rev.1490, Issued: 04-11-08, Effective: 06-02-08, Implementation: 07-07-08)

A. Definition

Prolonged *physician* services (CPT code 99354) *in the office or other outpatient setting with direct face-to-face patient contact which require one 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 one 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 Office or Other Outpatient Consultation codes (99241 – 99245), 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 (99221 - 99223, 99231 – 99233), the Inpatient Consultation codes (99251 – 99255); 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 all 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 outpatient consultation services and 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 and Consultation Codes**

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
99241	15	45	90
99242	30	60	105
99243	40	70	115
99244	60	90	135
99245	80	110	155
<i>99324</i>	<i>20</i>	<i>50</i>	<i>95</i>
<i>99325</i>	<i>30</i>	<i>60</i>	<i>105</i>
<i>99326</i>	<i>45</i>	<i>75</i>	<i>120</i>
<i>99327</i>	<i>60</i>	<i>90</i>	<i>135</i>
<i>99328</i>	<i>75</i>	<i>105</i>	<i>150</i>
<i>99334</i>	<i>15</i>	<i>45</i>	<i>90</i>
<i>99335</i>	<i>25</i>	<i>55</i>	<i>100</i>

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
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
99233	35	65	110
99251	20	50	95
99252	40	70	115
99253	55	85	130
99254	80	110	155
99255	110	140	185
<i>99304</i>	<i>25</i>	<i>55</i>	<i>100</i>
<i>99305</i>	<i>35</i>	<i>65</i>	<i>110</i>
<i>99306</i>	<i>45</i>	<i>75</i>	<i>120</i>
<i>99307</i>	<i>10</i>	<i>40</i>	<i>55</i>
<i>99308</i>	<i>15</i>	<i>45</i>	<i>60</i>
<i>99309</i>	<i>25</i>	<i>55</i>	<i>70</i>
<i>99310</i>	<i>35</i>	<i>65</i>	<i>80</i>
<i>99318</i>	<i>30</i>	<i>60</i>	<i>75</i>

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.

30.6.15.2 - Prolonged Services Without *Direct* Face-to-Face *Patient Contact* Service (Codes 99358 - 99359)

(Rev.1490, Issued: 04-11-08, Effective: 06-02-08, Implementation: 07-07-08)

Contractors may not pay prolonged services codes 99358 and 99359, which do not require any direct patient *face-to-face* contact (*e.g., telephone calls*). Payment for these services is included in the payment for direct face-to-face services that physicians bill. The physician cannot bill the patient for these services since they are Medicare covered services and payment is included in the payment for other billable services.