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Medicare Coverage of Prolonged Care Services CBT Script

Hello and welcome to our discussion on the proper billing of prolonged care services.

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Prolonged care services are those services that you provide which require patient care exceeding the amount of time described in the Current Procedural Terminology (CPT) codes for Evaluation and Management (E/M) services.

Medicare provides coverage for prolonged care services in the office or other outpatient settings or in the hospital, when direct face-to-face patient contact beyond the usual service is provided.

The prolonged care service must be provided on the same day by the same physician or qualified non-physician practitioner (NPP) as the companion E/M service.

The time for the usual service refers to the typical/average time units associated with the companion E/M service as noted in the CPT code description.

In the office or other outpatient setting, providers report the first 30 to 60 minutes of prolonged care services with procedure code 99354 and 99355 for each additional 30 minutes.

In the hospital setting, report the first 30 to 60 minutes of prolonged care services with procedure code 99356 and each additional 30 minutes using CPT code 99357.

Codes 99355 and 99357 may also be used to report the final 15 to 30 minutes of prolonged care services on a given date, if not otherwise billed.

Provider cannot bill separately any prolonged care services of less than 15 minutes beyond the first hour or the final 30 minutes.

Medicare will not pay, nor can providers bill the patient for prolonged care services, 99358 and 99359. because they do not require any direct face-to-face contact.

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Requirement for Physician Presence

Providers must bill prolonged care services on the same claim as the companion E/M code.

Prolonged care services of less than 30 minutes total duration on a given date are not billable separately because the work involved is included in the total work of the E/M codes. There must be at least 30 to 60 minutes of prolonged care services before the first hour can be billed.

To determine whether prolonged services are billable, providers may only count the duration of direct face-to-face contact with the patient beyond the typical/average time of the visit code billed. The face-to-face time does not have to be continuous.



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In the office, providers cannot bill time spent with the patient by office staff or time the patient remains unaccompanied as prolonged care services.

In the hospital, providers cannot bill as prolonged care services time spent:

- reviewing charts or discussing the patient with medical staff without direct face-to-face contact with the patient
- waiting for test results of changes in the patient's condition
- waiting for end of a therapy, or
- for the use of facilities

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Required Companion Codes

Prolonged care services are not payable unless they are accompanied by the E/M companion codes:

The companion E/M codes for 99354 are:

- Office or Other Outpatient visit codes,
- Office or Other Outpatient Consultation codes,
- Domiciliary, Rest Home, or Custodial Care Services codes; and
- Home Services codes

The companion codes for 99355 are 99354 and one of the required E&M codes.

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The companion E/M codes for 99356 are:

- The Initial Hospital Care and Subsequent Hospital Care codes,
- Inpatient Consultation codes; and
- Nursing Facility Services codes

The companion codes for 99357 are 99356 and one of the required E&M codes.

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Unless providers have been selected for medical review, they do not need to send the medical record documentation with the claim for prolonged care services.

However, documentation in the medical record must contain information about the duration and content of the medically necessary E/M service and prolonged care services billed.

Providers must appropriately and sufficiently document the medical record that they personally furnished the direct face-to-face time with the patient specified in the CPT code definitions.

Providers must also make sure 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 care codes if the total duration of all physician or qualified NPP direct face-to-face services, including the visit, equals or exceeds the



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threshold time for the E/M service the physician or qualified NPP provided. This means the typical/average time associated with the CPT E/M code plus 30 minutes of prolonged care.

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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, representing more than 50% of the total time with the patient, in a face-to-face encounter between the physician or the qualified NPP, 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 not “rounded” to the next higher level.

When the E/M services is chosen based on time, providers may only report prolonged care services with the highest code level in that family of codes as the companion code.

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Information on prolonged care services is contained in the Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.15 on CMS' Website at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

We hope that you found this information useful. Thanks for listening.