Payment Policy | Prolonged Physician Services

EFFECTIVE DATE: 01|01|2021
POLICY LAST UPDATED: 01|06|2021

OVERVIEW
Prolonged service codes are add-on codes that are used when a physician or other qualified healthcare professional provides prolonged service that is provided beyond the usual service in either the inpatient or outpatient setting.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Not applicable

POLICY STATEMENT
Medicare Advantage Plans and Commercial Products
Claims filed for prolonged services are covered when the documentation submitted with the claim validates the extended time and documentation requirements have been met.

Claims filed for prolonged services (CPT Codes 99354-99359, 99417 and G2212) will automatically suspend for individual consideration review. The supporting documentation must be filed with the claim at the time of submission. BCBSRI will not request documentation if not submitted with the initial claim and any claim submitted without documentation will be denied as documentation required.

The use of the time-based prolonged services add-on codes requires that the primary evaluation and management (E/M) service have a typical or specified time published in Current Procedural Technology.

Effective 01/01/2021:
Claims filed for professional outpatient prolonged services (**both** 99417 and G2212) will be considered for reimbursement as described by Centers for Medicare & Medicaid Services' (CMS) Prolonged Office Outpatient Evaluation and Management Reporting Times whereby,

> *"…the time of the reporting practitioner is used to select the office/outpatient E/M visit level, HCPCS code G2212 could be reported when the maximum time for the level 5 office/outpatient E/M visit is exceeded by at least 15 minutes on the date of the service."*

BCBSRI will not be following the coding guidance from the AMA for Commercial members related to code 99417, which allows for submission and reimbursement consideration for the code within the first 15 min of extended time.

The supporting documentation is reviewed to determine that all of the following are met:

- Documentation reflects the physician time spent having direct patient contact, including additional non-face-to-face time (excluding telephone encounters), such as time spent on the patient's floor or unit in the hospital or nursing facility setting.
- Documentation includes the start time and end time of the visit or the total time spent having direct patient contact and non-face-to-face time, such as time spent on the patient's floor or unit in the

hospital or nursing facility setting. Please note that start and end time needs to be documented for each component of time. e.g. if there is face-to-face time and then non-face-to-face time that occurs several times during the date of service each component of the total time needs to be documented.

- Sufficient documentation must be included in the medical record to support that the provider personally furnished the prolonged service time with the patient or non-face-to-face time as specified in the CPT code definitions. Services provided by another provider and/or support staff will not be considered for reimbursement.
- The documentation should also meet the coding guidelines for the E/M service being provided. If time is used as a basis for selecting the appropriate level of E/M, then the medical record must indicate that counseling was the dominant service provided.
- Prolonged service CPT codes 99358 and 99359 may be used during the same session of an E/M service, except office or other outpatient services (99202-99205 and 99212-99215). Prolonged service CPT codes 99358 and 99359 may be used on a different date of service than the primary service. When prolonged service codes 99358 and 99359 are filed, the supporting documentation must include medical records supporting the prolonged service, as well as the service to which the prolonged service is related.

It is not appropriate to bill prolonged services for any the following:

- Prolonged Service (99354-99357) of less than 30 minutes total duration on a given date should not be reported separately because the work involved is included in the total work of the E&M codes.
- Prolonged Service (99417 and G2212) of less than 15 minutes beyond the maximum time for the level 5 office/outpatient E/M visit (99205 and 99215) on a given date should not be reported separately. because the work involved is included in the total work of the E&M codes.
- In the office setting, for time spent by office staff with the patient, or time the patient remains unaccompanied in the office even if such patient is being supervised periodically during that timeframe.
- 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 conditions, for end of a therapy, or for use of facilities.
- With Preventive Medicine codes, 99381-99397
- With Emergency Medicine Department codes, 99281-99285
- With critical care codes, 99291-99292
- With Neonatal Intensive care codes, 99295-99298
- With anticoagulation service codes, 99363-99364
- With care plan oversight codes, 99339-99340, 99374-99380
- With other indirect services that have a more specific code and no upper time limit in the code description.
- With patient management services during same time frame as 99487-99489, 99495-99496
- With time spent in medical team conference, 99366-99368
- Use of code more than one time per date of service
- Telephone Encounters with patient or family

Note: Claims for services rendered in the Hospital Based Clinic by a physician or other qualified healthcare professional, must be filed in accordance with BCBSRI's Hospital Based Clinical Policy. See Related Policies section.

Prolonged Behavioral Health Services Provided to Children Under the Age of 18
BCBSRI recognizes that the evaluation of children/adolescents often takes longer than adults and requires additional collateral contacts that further differentiate this population. Effective, for dates of service on or after January 1, 2013, BCBSRI allows providers to file with a modifier "TU" Special Payment Rate, Overtime

for extended psychiatric diagnostic interview examination (90791-TU and 90792-TU) for children under the age of 18. Extended services are defined as psychiatric diagnostic interview/examinations that extend longer than 75 minutes for our members under 18 years of age.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for the applicable doctors' hospital visits and office visits benefits/coverage.

BACKGROUND

Blue Cross & Blue Shield of Rhode Island (BCBSRI) has created this policy to document the coding guidelines for reimbursement of prolonged services. These codes are used when a physician or other qualified healthcare professional provides prolonged service involving direct patient contact, expect for codes 99417 and G2212, that is provided beyond the usual service in either the inpatient or outpatient setting.

Prolonged service in the office or other outpatient setting require documentation of the entire time spent having direct patient contact, except for codes 99417 and G2212 beyond the usual service.

Prolonged services supplied in the inpatient setting requires that direct patient contact is face-to-face and includes additional non-face-to-face services on the patient's floor or unit in the hospital or nursing facility during the same session. Direct patient contact also includes time spent providing indirect contact services by the physician or other qualified health care professional in relation to patient management where face-to-face services have occurred or will occur on a different date. Additionally, included in the prolonged service codes is the time spent providing prolonged services performed on a date of service (which may be other than the date of the primary service) that are not continuous. These services are reported in addition to the designated E/M services at any level.

Time spent performing separately reported services is not counted toward the prolonged services time.

CPT codes 99358 and 99359 may not be reported during the same service period as complex chronic care management (CCM) services or transitional care management services. These codes are not reported for time spent in non-face-to-face care described by more specific codes having no upper time limit in the CPT code set.

CODING

Medicare Advantage Plans and Commercial Products

The following codes are covered **and separately reimbursed** when documentation requirements are met:

99354 Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service, first hour (list separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215)

99355 each additional 30 minutes (List separately in addition to code for prolonged service)

99356 Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation Evaluation and Management service)

99357 Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)

99358 Prolonged evaluation and management service before and/or after direct patient care; first hour

99359 Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)

Commercial Products
The following codes are covered and separately reimbursed when documentation requirements are met:

99417 Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time, with or without direct patient contact beyond the usual service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services).

Medicare Advantage Plans
The following codes are covered and separately reimbursed when documentation requirements are met:

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 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)

Medicare Advantage Plans and Commercial Products
Administration of medication requiring observation of the patient should be filed with CPT codes 99415, 99416. It is incorrect coding to file prolonged physician services for time spent by clinical staff observing a patient and monitoring vital signs as part of medication administration.

The following codes are covered, but not separately reimbursed:

99415 Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)

99416 Each additional 30 minutes (list separately in addition to code for prolonged service)

RELATED POLICIES
Mid-Level Practitioners
Behavioral Health Services
Hospital Based Clinic

PUBLISHED
Provider Update, February 2021
Provider Update, September 2019
Provider Update, March 2018
Provider Update, March 2017
Provider Update, July 2016

REFERENCES
1. American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

2. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

3. Change Request 12071. Retrieved January 6, 2021 at https://www.cms.gov/files/document/r10505cp.pdf