EFFECTIVE DATE: 01|01|2023
POLICY LAST UPDATED: 08|16|2023

OVERVIEW
Prolonged service codes are add-on codes that are used when a physician or other qualified healthcare professional provides prolonged service beyond the usual time of 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.

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."*

Providers are expected to follow appropriate coding for 99417, which allows for submission of these codes once the end time in the primary E/M code has been surpassed. **However, the first unit billed for 99417 will not be reimbursed, consistent with the CMS Prolonged Evaluation and Management Reporting Times** shown directly above**.** BCBSRI will reimburse additional units beyond the first unit.

Effective 01/01/2023:
Claims filed for professional outpatient prolonged services (99417, 99418 and G0316, G0317, G0318) will be considered for reimbursement as described by Centers for Medicare & Medicaid Services' (CMS) Prolonged Evaluation and Management Reporting Times whereby,

> *"…the time of the reporting practitioner is used to select the E/M visit level, HCPCS codes G3016, G3017, G3018 could be reported when the maximum time for the highest-level E/M visit is exceeded by at least 15 minutes on the date of the service."*

Providers are expected to follow appropriate coding for 99417 and 99418, which allows for submission of these codes once the end time in the primary E/M code has been surpassed. **However, the first unit billed for 99417 and 99418 will not be reimbursed, consistent with the CMS Prolonged Evaluation and**

Management Reporting Times shown directly above**.** BCBSRI will reimburse additional units beyond the first unit.

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 time with or without direct patient contact, that is provided beyond the usual service in either the inpatient or outpatient setting.

BCBSRI expects supporting documentation in medical records to contain all applicable information required for review as defined above and reserves the right to audit all supporting documentation to ensure policy adherence.

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. The non-face-to-face prolonged care codes 99358 and 99359 are used when the services are performed on a date other than a face-to-face visit.

CODING

Medicare Advantage Plans and Commercial Products
The following codes are covered **and separately reimbursed** when documentation requirements are met:
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 not separately reimbursed for the first unit of 15 minutes and covered and separately reimbursed for all units billed after the first unit:

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)

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

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

G0317 Prolonged nursing facility 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

G0318 Prolonged home or residence 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

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
Advanced Practice Providers Hospital Based Clinic

PUBLISHED

Provider Update, October 2023
Provider Update, February 2023
Provider Update, February 2022
Provider Update, February 2021
Provider Update, September 2019
Provider Update, March 2018
Provider Update, March 2017

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