Commercial Reimbursement Policy

Subject: **Prolonged Services - Professional**	
Policy Number: **C-08011**	Policy Section: **Coding**
Last Approval Date: **12/16/2020**	Effective Date: **01/01/2021**

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem Blue Cross and Blue Shield (Anthem) benefit plan. The determination that a service, procedure, item, etc., is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Our policies apply to both participating and non-participating professionals and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. Anthem reserves the right to review and revise these policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Except as described in this policy, prolonged services are not eligible for separate reimbursement. The recording of patient history, review of past records, physical exam, medical decision making, treatment plan discussions, and counseling are all services included in the Evaluation and Management (E/M) code reported. The Health Plan considers the time spent providing these services as part of the overall E/M service provided and is not eligible for separate reimbursement.

The Health Plan requires providers to follow CPT coding guidelines when reporting prolonged services.

- Prolonged service codes 99354-99355 are add-on codes and should not be reported with prolonged office or other outpatient E/M services or prolonged clinical staff services with physician or other qualified health care professional supervision. Prolonged services must be at least 30 minutes or longer beyond the typical time of the base E/M
- Prolonged services should not be reported with E/M codes that do not have stated times within their CPT definitions
- Documentation must support the reporting of prolonged services. The content and duration of the provider's service must be stated with start and stop times clearly indicated

- Time spent unaccompanied, accompanied with office staff, or accompanied with clinical staff other than the physician or other qualified health care professionals, should not be included as prolonged service

Correct coding should be used when reporting prolonged services; and the medical record documentation with content and timeframes are required for consideration of possible reimbursement. Prolonged Services will be denied as included in the primary E/M service provided and will not be eligible for separate reimbursement for most typical case scenarios and when all of the criteria listed above are not met.

Related Coding

Code	Description	Comment
99354	Prolonged Service in the Office or other Outpatient Setting: May be eligible for separate reimbursement when the E/M service performed and reported is based on the required component factors (which are history and/or examination, and decision making, but not counseling or coordination of care), is not based on time and the medical record clearly documents the content of the specific face-to-face service provided, beyond what is typically included in the E/M services. Start and stop times are noted and are at least 30 minutes or more beyond the typical time of the reported E/M. Anything less than 30 minutes is considered part of the work effort of the base E/M.	Covered; Do not report in conjunction with the following: • New/established office or other outpatient services E/M codes 99202 – 99205, 99211- 99215, • Prolonged office or other outpatient codes 99417 or G2212 • Prolonged clinical staff services with physician or other qualified health care professional supervision E/M codes 99416 and 99417
99355	For additional 30 minute increments, documented service and time frames need to be at least 15 minutes or more to be reported	Covered; Do not report in conjunction with the following: • Office or other outpatient services E/M codes 99202 – 99205, 99211- 99215, 99417 or G2212 • Prolonged clinical staff services with physician or other qualified health care professional supervision E/M codes 99416 and 99417

99356 99357	Prolonged Service in the Inpatient or Observation Setting are not eligible for separate reimbursement. Time spent as floor time, coordinating patient care on the unit and/or counseling a patient or patient's family is considered part of the primary care rendered and is not eligible for separate reimbursement. Each additional 30 minutes	Not Separately Reimbursable
99358 99359	Prolonged Service Without Direct Patient Contact is non-face-to-face services performed before and/or after direct patient care, are not eligible for separate reimbursement. Each additional 30 minutes	Not Separately Reimbursable
99415 99416	Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision is supervised face-to-face time spent by clinical staff with the patient in the office or outpatient setting after an E/M service provided by physician or other qualified health care professional, are not eligible for separate reimbursement. Each additional 30 minutes	Not Separately Reimbursable
99417 G2212	Prolonged office or other outpatient evaluation and management service(s) (beyond the total 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, on the date of the primary service; each additional 15 minutes	Eligible for separate reimbursement when billed in addition to CPT new/established level 5 Evaluation and Management codes 99205/ 99215 for office or other outpatient E/M services. The level 5 office or other outpatient E/M code must be selected using **only** time as the basis of selection and after the total time has been exceeded.

Prolonged Services ICD-10 List

Prolonged services codes 99354, 99355, 99417, and G2212 will be eligible for reimbursement when reported with one or more of the following:

ICD-10 Codes

Exemptions

None

Policy History

01/01/2021	Review request approved; Related coding section updated with new AMA CPT code 99417 and G2212, reimbursement rules for 99354 and 99355 have been updated; effective 1/1/2021
08/28/2020	Biennial review approved
08/15/2020	Allow 99354 and 99355 when reported with depression diagnosis codes F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.81, F32.89, F32.9,F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8 and F33.9
06/01/2019	New policy template: ICD-10 list added; removed description section and added definition section
09/07/2018	Biennial Review approved: redundancies removed, language clarified
11/01/2016	Revision: added new ICD-10 codes, removed ICD-9 codes
02/02/2016	Revision: added 99415-99416 as non-covered service
06/02/2015	Revision: added PTSD diagnosis
04/07/2015	Annual Review: no changes
03/04/2014	Annual Review: reordered paragraphs, added ICD-10 codes
03/05/2013	Annual Review: no changes
12/06/2011	Annual Review: CPT definition changes
12/07/2010	Annual Review: CPT definition changes
11/03/2009	Revision: coding sections updated with embedded Excel sheet of payable diagnosis codes
06/18/2009	Revision: language approved by Legal
04/01/2009	Policy language finalized
09/18/2008	Initial policy approved and effective date

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Association (AMA) *Current Procedural Terminology* (CPT) 2019 Professional
- Centers for Medicare & Medicaid Services (CMS)
- International Classification of Diseases (ICD-10-CM) 2019

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Bundled Services and Supplies

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.