COMMERCIAL REIMBURSEMENT POLICY

Prolonged Services

Active

Section: Evaluation and Management
Policy Number: 006
Effective Date: 02/01/24

Description

This policy addresses coding and reimbursement for prolonged services.

Definitions

Prolonged Services with Direct Patient Contact: when a physician or other qualified healthcare professional provides prolonged services beyond the usual service in either the inpatient or outpatient setting. 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. This service is reported in addition to the designated evaluation and management (E/M) services at any level and any other services provided at the same session as evaluation and management services.

Prolonged Services without Direct Patient Contact: when a prolonged service is provided that is neither face-to-face time in the office or outpatient setting, nor additional unit/floor time in the hospital or nursing facility setting during the same session of an evaluation and management service and is beyond the usual physician or other qualified health care professional service.

Policy Statement

Blue Cross and Blue Shield of Minnesota (Blue Cross) will separately reimburse for prolonged services with direct patient contact.

Current Procedural Terminology (CPT) codes 99415, 99416 are used to report the total amount of face-to-face time spent with the patient and/or family/caregiver by clinical staff in the office or other outpatient setting, on a given date of service even if the time is not continuous. The physician or qualified health care professional is present to provide direct supervision of the clinical staff. Codes 99415, 99416 should not be used for prolonged services of less than 30 minutes total duration on a given date.

Codes 99415, 99416 are not separately reimbursed when submitted with code 99417.

CPT codes 99417, 99418 are used when the primary service has been selected using time alone as the basis and only after the minimum time required to report the highest-level service (i.e., 99205, 99215) has been exceeded by 15 minutes. Codes 99417, 99418 should not be used for time increments of less than 15 minutes.

Codes 99417, 99418 are not separately reimbursed when submitted with codes 90833, 90836, 90838, 99358, 99359, 99415, or 99416.

Healthcare Common Procedure Coding System (HCPCS) code G2212 may be used instead of code 99417. This code is only used when the office or other outpatient primary service has been selected using time alone as the basis and only after the minimum time required to report the highest-level service (i.e., 99205, 99215) has been exceeded by 15 minutes.

Code G2212 is not separately reimbursed when submitted with codes 99358, 99359, 99415, or 99416.

HCPCS codes G0316, G0317, and G0318 may be used instead of code 99418. Use only when the primary service has been selected using time and the service has been exceeded by 15 minutes.

Code G0316 is not separately reimbursed when submitted with codes 99358, 99359, 99415, 99416, or 99418. Code G0317 is not separately reimbursed when submitted with codes 99358, 99359, or 99418. Code G0318 is not separately reimbursed when submitted with codes 99358, 99359, or 99417.

Time spent performing separately reported services other than the E/M service is not counted toward the prolonged service time.

CPT codes 99358, 99359 are not separately reimbursed (prolonged services without direct patient contact) and will be denied as provider liability.

Documentation Submission

Documentation must identify and describe the procedures performed. The time in prolonged care with the patient must be noted. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.
All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	N/A					
ICD-10 Diagnosis:	N/A					
ICD-10 Procedure:	N/A					
CPT/HCPCS:	99358	99359	99415	99416	99417	99418
	G0316	G0317	G0318	G2212		
Revenue Codes:	N/A					

Resources

Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
CY 2023 Physician Fee Schedule Final Rule

Policy History

03/24/2015	Initial Committee Approval
06/09/2016	Annual Policy Review
08/30/2017	Annual Policy Review
01/01/2018	Code Update
06/15/2020	Annual Policy Review
01/26/2021	Code Update
07/27/2021	Annual Policy Review
01/24/2023	Annual Policy Review and Code update
11/28/2023	Revised
01/23/2024	Annual Policy Review