Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	MRP- 004		
Subject:	Prolonged Services		
Effective Date:	February 7, 2022	**End Date:**	
Issue Date:	January 1, 2023	**Revised Date:**	January 2023
Date Reviewed:	December 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY**	☐
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy outlines the general billing of Prolonged Services with Direct Face- to Face Member contact service and without Direct Face-to-Face Member Contact Service.

REIMBURSEMENT GUIDELINES:

Requirements for Physician Presence:

- Physicians may only count the duration of direct face to face contact between the physician and the member (whether the service was continuous or not) beyond the typical/average time of the E/M visit code billed. Reference E&M times should be used as the basis for determining whether prolonged services are appropriate to bill and determine the prolonged services codes allowable under this policy.

- Office Place of Service: In case of prolonged office services, time spent by office staff with the member, or time the member remains unaccompanied in the office cannot be billed.

- Facility Place of Service: All of the following situations are examples which fail to qualify for billing Prolonged Services:

- Time spent reviewing charts
- Discussion of a member's case with the house medical staff without direct member contact.
- Waiting for test results
- Waiting for changes in the member's condition
- Waiting for end of therapy
- Waiting for the use of facilities

Prolonged Service codes can be billed only if the total duration of the physician or other qualified Non-Physician Practitioner (NPP) direct face to face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes).

If the total duration of direct face to face time does not equal the services provided by the physician or qualified NPP, the physician or qualified NPP may not bill for prolonged service.

Reporting Prolonged Services

Practitioners will select the appropriate procedure code for Office/Outpatient Evaluation and Management that includes a medically appropriate history and exam, when performed. Practitioners should perform history and exam to the extent clinically appropriate, reasonable and necessary.

When the practitioner selects a visit level using time spent, the practitioner may report prolonged office/ outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office and outpatient E/M services). Practitioners should not report prolonged office outpatient E/M visit time using CPT codes 99358 and 99359 (Prolonged service without direct patient contact). The following table provides reporting examples.

- Prolonged Office/Outpatient E/M Visit Reporting – New Patient

HCPCS Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes

- Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

HCPCS Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

HCPCS code 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 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)).

Reporting Visit Complexity

HCPCS add on code G2211 describing visit complexity inherent to office/outpatient E/M visits associated with medical services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of an ongoing care related to a patient's single, serious or complex condition and may be reported with any visit level.

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Reporting Services for an Inpatient Setting

Use hospital care codes 99221-99223, 99231-99232, nursing facility service codes 99304-99310, 99315, 99316 and 99318.

Reporting Prolonged Services without direct face-to-face patient contact service

Prolonged E/M services before and after direct member care, which do not require any direct member face-to-face contact are considered separately payable under the physician fee schedule.

Procedure codes 99358 and 99359 cannot be reported during the same service period as complex chronic care management (CCM) services or transitional care management services. 99358 and 99359 can only be used to report extended qualifying time of the billing physician or other practitioner (not including clinical staff). Prolonged services cannot be reported with a companion E/M code which also qualifies as the initiating visit for chronic care management (CCM) services if applicable providers should report the add- on code for CCM initiation.

Prolonged Services Associated with Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)

When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management 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 evaluation and management code) and should not be "rounded" to the next higher level.

In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed

REFERENCES:

- MLN Matters MM12071, Transmittal R10505CP, CR 12071. Effective 01/01/2021.

- CMS Internet Only Manual (IOM), Medicare Claims Processing Manual, Pub. 100-04, Transmittal 1875, CR 6740. Effective 01/01/2010.

POLICY UPDATE HISTORY INFORMATION:

Date	Update
1 / 2022	Implementation
3 / 2022	Updated policy header
7 / 2022	Removed 93311, 93312, 93313, 93314, 99317.
9 / 2022	Added Delaware Medicare Advantage applicable to the policy direction
1 / 2023	Removed verbiage and direction related to codes 99356 and 99357

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number: MRP- 004
Subject: Prolonged Services
Effective Date: February 7, 2022 **End Date:**
Issue Date: September 1, 2022 **Revised Date:** August 2022
Date Reviewed: August 2022
Source: Reimbursement Policy

Applicable Commercial Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY**	☐
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

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PURPOSE:

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REIMBURSEMENT GUIDELINES:

Requirements for Physician Presence

- Physicians may only count the duration of direct face to face contact between the physician and the member (whether the service was continuous or not) beyond the typical/average time of the E/M visit code billed. Reference E&M times should be used as the basis for determining whether prolonged services are appropriate to bill and determine the prolonged services codes allowable under this policy.

- Office Place of Service: In case of prolonged office services, time spent by office staff with the member, or time the member remains unaccompanied in the office cannot be billed.

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- Time spent reviewing charts
- Discussion of a member's case with the house medical staff without direct member contact.
- Waiting for test results
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- Waiting for end of therapy
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Prolonged Service codes can be billed only if the total duration of the physician or other qualified Non Physician Practitioner (NPP) direct face to face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes).

If the total duration of direct face to face time does not equal the services provided by the physician or qualified NPP, the physician or qualified NPP may not bill for prolonged service.

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When the practitioner selects a visit level using time spent, the practitioner may report prolonged office/ outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office and outpatient E/M services). Practitioners should not report prolonged office outpatient E/M visit time using CPT codes 99354 and 99355 (Prolonged service with direct patient contact), 99358 and 99359 (Prolonged service without direct patient contact). The following table provides reporting examples.

- Prolonged Office/Outpatient E/M Visit Reporting – New Patient

HCPCS Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes

- Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

HCPCS Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

HISTORY

HCPCS code 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)).

Reporting Visit Complexity

HCPCS add on code G2211 describing visit complexity inherent to office/outpatient E/M visits associated with medical services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of an ongoing care related to a patient's single, serious or complex condition and may be reported with any visit level.

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HISTORY

Reporting Services for an Inpatient Setting

Prolonged services codes 99356 and 99357 are not paid unless they are accompanied by the companion codes as indicated. Therefore, when reported independently, they will deny as non-covered.

- Hospital Care Codes 99221-99223, 99231-99232, Nursing Facility Service Codes 99304-99310 99315, 99316 and 99318.
- If the total direct face-to-face time equals or exceeds the threshold time for code 99356 but is less than the threshold time for code 99357, the physician should bill the visit and code 99356.
- No more than one unit of code 99356 will be accepted, additional units will deny non-covered.
- If the total direct face-to-face time equals or exceeds the threshold time for code 99356 by no more than 29 minutes, the physician bills the visit code 99356 and on unit of code 99357. One additional unit of code 99357 is billed for each additional increment of 30 minutes extended duration.

Threshold time for Prolonged Visit Codes 99356 and/or 99357 Billed with Inpatient Setting Codes

Code	Typical Time for Code	Threshold Time to Bill Code 99356	Threshold Time to Bill Codes 99356 and 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100

Add 30 minutes to the threshold time for billing codes 99356 and 99357 to get the threshold time for billing code 99356 and two units of 99357.

Reporting Prolonged Services without direct face-to-face patient contact service

Prolonged E/M services before and after direct member care, which do not require any direct member face-to-face contact are considered separately payable under the physician fee schedule.

Procedure codes 99358 and 99359 cannot be reported during the same service period as complex chronic care management (CCM) services or transitional care management services. 99358 and 99359 can only be used to report extended qualifying time of the billing physician or other practitioner (not including clinical staff). Prolonged services cannot be reported with a companion E/M code which also qualifies as the initiating visit for chronic care management (CCM) services, if applicable providers should report the add-on code for CCM initiation.

HISTORY

Prolonged Services Associated with Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)

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RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

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REFERENCES:

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POLICY UPDATE HISTORY INFORMATION:

1 / 2022	Implementation
3 / 2022	Updated policy header
7 / 2022	Removed 93311, 93312, 93313, 93314, 99317.
9 / 2022	Added Delaware Med Advantage applicable to the policy direction

HISTORY

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	MRP- 004		
Subject:	Prolonged Services		
Effective Date:	February 7, 2022	**End Date:**	
Issue Date:	July 4, 2022	**Revised Date:**	June, 2022
Date Reviewed:	June, 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY**	☐
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Prolonged Office/Outpatient E/M Visit Reporting – New Patient

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HISTORY

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Threshold time for Prolonged Visit Codes 99356 and/or 99357 Billed with Inpatient Setting Codes:

Code	Typical Time for Code	Threshold Time to Bill Code 99356	Threshold Time to Bill Codes 99356 and 99357
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https://www.cms.gov/files/document/mm12071.pdf

CMS Internet Only Manual (IOM), Medicare Claims Processing Manual, Pub. 100-04, Transmittal 1875, CR 6740. Effective 01/01/2010.
R1875CP.pdf (cms.gov)

POLICY UPDATE HISTORY INFORMATION:

January / 2022	Implementation
March / 2022	Changed Policy Header
July / 2022	Removed 93311, 93312, 93313, 93314, 99317. Updated links in reference section as they were not accessible.

HISTORY

Highmark Reimbursement Policy Bulletin

Bulletin Number:	MRP- 004		
Subject:	Prolonged Services		
Effective Date:	February 7, 2022	**End Date:**	
Issue Date:	March 14, 2022	**Revised Date:**	March, 2022
Date Reviewed:	March, 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY**	☐
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HCPCS code 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)).

Reporting Visit Complexity:

HCPCS add on code G2211 describing visit complexity inherent to office/outpatient E/M visits associated with medical services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of an ongoing care related to a patient's single, serious or complex condition and may be reported with any visit level.

This code reflects the time, intensity, and practice expense when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. This includes furnishing patients' ongoing services that result in a comprehensive, longitudinal, and continuous relationship with the patient and involves delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

HCPCS code G2211 (Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)).

HISTORY

Reporting Services for an Inpatient Setting:

Prolonged services codes 99356 and 99357 are not paid unless they are accompanied by the companion codes as indicated. Therefore, when reported independently, they will deny as non-covered.

- Hospital Care Codes 99221-99223, 99231-99232, Nursing Facility Service Codes 99304-99318.
- If the total direct face-to-face time equals or exceeds the threshold time for code 99356 but is less than the threshold time for code 99357, the physician should bill the visit and code 99356.
- No more than one unit of code 99356 will be accepted, additional units will deny non-covered.
- If the total direct face-to-face time equals or exceeds the threshold time for code 99356 by no more than 29 minutes, the physician bills the visit code 99356 and on unit of code 99357. One additional unit of code 99357 is billed for each additional increment of 30 minutes extended duration.

Threshold time for Prolonged Visit Codes 99356 and/or 99357 Billed with Inpatient Setting Codes:

Code	Typical Time for Code	Threshold Time to Bill Code 99356	Threshold Time to Bill Codes 99356 and 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100

Add 30 minutes to the threshold time for billing codes 99356 and 99357 to get the threshold time for billing code 99356 and two units of 99357.

Reporting Prolonged Services without direct face-to-face patient contact service:

Prolonged E/M services before and after direct member care, which do not require any direct member face-to-face contact are considered separately payable under the physician fee schedule.

Procedure codes 99358 and 99359 cannot be reported during the same service period as complex chronic care management (CCM) services or transitional care management services. 99358 and 99359 can only be used to report extended qualifying time of the billing physician or other practitioner (not including clinical staff). Prolonged services cannot be reported with a companion E/M code which also qualifies as the initiating visit for chronic care management (CCM) services, if applicable providers should report the add-on code for CCM initiation.

HISTORY

Prolonged Services Associated with Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)

When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management 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 evaluation and management code) and should not be “rounded” to the next higher level.

In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-041: Services Not Separately Reimbursed

REFERENCES:

MLN Matters MM12071, Transmittal R10505CP, CR 12071. Effective 01/01/2021.
https://www.cms.gov/files/document/mm12071.pdf

CMS Internet Only Manual (IOM), Medicare Claims Processing Manual, Pub. 100-4, Chapter 12, Section 30.6.15.1. Effective 01/01/2011.
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CMS Internet Only Manual (IOM), Medicare Claims Processing Manual, Pub. 100-4, Transmittal 1490, CR 5972 Effective 07/01/2008.
www.cms.gov/Regulations-ans-Guidance/Manuals/Downloads/clm104c12.pdf

MLN Matters MM5972, Transmittal R1490CP, CR 5972. Effective 07/01/2008.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2008-Transmittals

CMS Internet Only Manual (IOM), Medicare Claims Processing Manual, Pub. 100-04, Transmittal 1875, CR 6740. Effective 01/01/2010.
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6740.pdf

HISTORY

POLICY UPDATE HISTORY INFORMATION:

January / 2022	Implementation
March / 2022	Changed Policy Header