Commercial Reimbursement Policy

Subject: **Prolonged Services – Professional**	
Policy Number: **C-08011**	Policy Section: **Coding**
Last Approval Date: **05/19/2023**	Effective Date: **10/01/2023**

Disclaimer

These reimbursement 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 an Anthem Blue Cross and Blue Shield (Anthem) member's 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. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. 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. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan allows reimbursement for prolonged services when billed as described in this policy, unless provider, state, or federal contracts and/or mandates indicate otherwise.

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 not eligible for separate reimbursement.

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

- 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 by sufficiently detailing the content and duration of the provider's 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 the criteria listed above are not met.

Note: The initial determination of reimbursement is based on claims-data analysis.

Related Coding

Code	Description	Comments
99358	Prolonged E/M service before and/or after direct patient care; first hour	Not separately reimbursable
99359	Prolonged E/M service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)	Not separately reimbursable
99415	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an E/M service in the office or outpatient setting, direct patient contact with physician supervision; first hour	Not separately reimbursable

	(List separately in addition to code for outpatient E/M service)	
99416	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an E/M service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)	Not separately reimbursable
99417	Prolonged outpatient E/M 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 E/M service)	Eligible for separate reimbursement when billed in addition to CPT® new/established level 5 E/M 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.
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 E/M service)	Not separately reimbursable

Exemptions

Maine	Anthem Blue Cross and Blue Shield: • Allows separate reimbursement for G2212. • Uses the ICD-10 code list.

Policy History

05/19/2023	Review approved 05/19/2023 and effective:
	• 10/01/2023: removed ICD-10 code list
	  ○ Maine exemption added as TBD due to delayed implementation.
	• 05/19/2023:
	  ○ removed language requiring documentation of start and stop times
	  ○ updated Related Coding section: moved HCPCS code G2212 to Bundled Services and Supplies policy (C-08003)
	• 01/01/2023: added new CPT® code 99418 to the Related Coding section
	• 12/31/2022: removed deleted CPT® codes 99354-99357
	Maine added as TBD due to delayed implementation.

01/01/2021	Review request approved and effective: Related Coding section updated with new CPT® code 99417 and G2212; reimbursement rules for 99354 and 99355 have been updated
08/28/2020	Review approved
08/15/2020	Revised: 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	Revised: ICD-10 list added; updated to new policy template; removed description section and added definition section
09/07/2018	Review approved: minor language changes
11/01/2016	Revised: updated ICD-9 codes to ICD-10 codes
02/02/2016	Revised: added 99415-99416 as non-covered service
06/02/2015	Revised: added PTSD diagnosis
04/07/2015	Review approved: no changes
03/04/2014	Review approved: reordered paragraphs; added ICD-10 codes
03/05/2013	Review approved: no changes
12/06/2011	Review approved: CPT® definition changes
12/07/2010	Review approved: CPT® definition changes
11/03/2009	Revised: coding sections updated with embedded Excel sheet of payable diagnosis codes
04/01/2009	Policy language updated

09/18/2008	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro, 2023

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Bundled Services and Supplies – Professional
Documentation and Reporting Guidelines for E/M Services – Professional

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.