Reimbursement Policy:

Prolonged Services

(Commercial, Medicare and Medicaid)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20220020	EmblemHealth and ConnectiCare (Commercial & Medicare): 1/01/2021 EmblemHealth Medicaid: 4/01/2021	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

This policy identifies when EmblemHealth/ConnectiCare will separately reimburse physicians or other qualified health care professionals for Prolonged Services when reported in conjunction with companion Evaluation & Management (E/M) codes or other services.

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. EmblemHealth/ConnectiCare consider the time spent providing these services as part of the overall E/M service provided and is not eligible for separate reimbursement.

For the purpose of this policy, the Same Individual Physician or Other Qualified Health Care Professional is the same individual rendering health care services reporting the same Federal Tax Identification number.

Policy Statement:

Physicians or other qualified health care professionals should report only Prolonged Services beyond the typical duration of the service on a given date, even if the time spent by the physician or other qualified health care professional is not continuous. Providers should not include the time devoted to performing separately reportable services when determining the amount of prolonged services time.

Effective January 1, 2021, CMS finalized HCPCS code G2212 for prolonged office/outpatient E/M visits. EmblemHealth/ConnectiCare are following CMS minimum time guidelines and allowing G2212 to be used with 99205 or 99215. *Do not use 99358, 99359 or 99417* with code 99202-99215.*

Reimbursement Policy:

Prolonged Services

(Commercial, Medicare and Medicaid)

Reimbursable CPT Codes:

CPT Code	Description
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).* *Not covered by EH Medicaid Plans - use 99417, see below*
99417* **Covered for EH Medicaid plans only*	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required 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 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services).

Prolonged Office/Outpatient E/M Visit Reporting – Established Patient (99205):

CPT Code	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
99205 x 1 and G2212 x 3 each additional 15 minutes	119 minutes – 133 minutes

**Total time is the sum of all time, with and without direct patient contact and including prolonged time, spent by the reporting practitioner on the date of service of the visit.*

Criteria for Using and Submitting CPT Code G2212:

- Primary E/M service CPT Code 99205 or 99215 is selected based on time and NOT medical decision making and the service was 15 minutes or more
- Services must be Medically Necessary during the prolonged E/M service.
- The duration and the content of the evaluation and management code must be documented in the medical record.
- Only to be submitted with 99205 or 99215 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.
- Max units of 3 for G2212 will be allowed; excess units will be denied and will require that supporting medical documentation be submitted for reconsideration

Reimbursement Policy:

Prolonged Services

(Commercial, Medicare and Medicaid)

Examples of Improper Use of G2212:

- Combined physician time that is equal or less than the threshold time of the E/M service (combined time with and without direct patient contact).
- Time spent on rendering therapies or other services that are paid separately.
- Services/activities conducted during the first seventy-four (74) minutes of E/M service for a new patient (99205); or during the first fifty-four (54) minutes for an established patient.
- Discussions that apply to non-covered service or conditions.
- The time spent by office staff with the patient, or time that the patient remains unaccompanied in the office.
- Inefficient application of clinical services that result in prolonged face-to-face time in the absence of documented necessity
- Time spent waiting for test results or for changes in the patient's condition cannot be reported as prolonged services.

According to CPT, modifier 25 may be appended to prolonged service codes if there is adequate supporting documentation that describes the service provided and indicates the service is significant and separately identifiable from another service or procedure on the same date of service.

Exclusions:

- CPT Code 99417* is used to report prolonged time (i.e. combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services (i.e., 99205, 99215). **EmblemHealth/ConnectiCare will follow CMS and utilize the time and reporting requirements for G2212 and not 99417.*
    - ***G2212 is not covered by EH Medicaid plans – use 99417***
- Prolonged Services for labor and delivery are not separately reimbursable services.
- Direct Patient Contact does NOT include time spent with office Staff and/or patient time spent unaccompanied in the office. The Prolonged Services with Direct Patient Contact must be between the patient and the physician or other qualified health care professional who provided the initial service. Office staff includes anyone who is not the primary provider of the service. The time a patient remains unaccompanied by the primary provider also cannot be counted.
- CPT Code 99417 (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 15 minutes) is not covered by EmblemHealth/ConnectiCare Commercial and Medicare plans

Reimbursement Policy:

Prolonged Services

(Commercial, Medicare and Medicaid)

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.

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	2/01/2022	• Updated policy to indicate 99417 is reimbursed by *EH Medicaid plans only* **effective 4/01/2021** • Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number