Office and Other Outpatient Evaluation and Management (E/M) Visits and Prolonged Services

State(s):	LOB(s):
☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*	☒ *Commercial* ☒ *Medicare* ☒ *Medicaid*

Enterprise Policy

This information is to be used as a general reference resource regarding PacificSource Reimbursement Policies and not intended to address every aspect of a reimbursement situation. Providers are responsible for submission of accurate documentation of services performed. The code(s) reported by physicians or other health care professionals should best represent the services provided based on the American Medical Association (AMA), CMS documentation guidelines and applicable PacificSource policy. Any medical or surgical service, supply, or item, either inpatient or outpatient, reported by any code, must be clearly documented in an appropriate medical record. PacificSource will not allow reimbursement for undocumented or incorrectly reported professional, inpatient or outpatient medical and surgical services, supplies and items.

Documentation Requirements

Documentation about the duration and content of the medically necessary evaluation and management service and prolonged services reported is required in the medical record. The medical record must be appropriately and sufficiently documented to show time personally spent by the physician or other qualified non-physician healthcare professional (QHP) as well as the medical decision-making process.

The total time or start and end times should be documented in the medical record for the specific encounter. Time spent in activities such as medical record review or counseling the patient on the diagnosis must be summarized within the record in order to support the coding reported and the medical necessity of time spent. If this information is missing and/or not clearly defined as to support time documented, the documentation will be reviewed for the medical decision-making elements in order to determine the appropriate level of service.

Documentation that is determined to be “cloned” statements of time will not be accepted as these are not a reliable account of events and services rendered. Services are considered not documented when cloned documentation is found or identified, and services will be denied due to the lack of supporting documentation.

The term "cloning" refers to documentation that is worded exactly like previous entries. This may also be referred to as "cut and paste," "copy and paste" or "carried forward” and generally occurs when using a type of template although documentation can be handwritten. Documentation should be specific to the patient, and the specific encounter, as well as accurately reflect the services rendered while supporting the necessity for services.

Utilizing or carrying forward of irrelevant documentation or documentation from previous encounter notes is considered over-documentation. Over-documentation is the practice of inserting false or

irrelevant documentation to create the appearance of support for billing higher level services. Encounter notes should be unique to each visit.

Documentation is required for review of prolonged services and must show the duration and content of the evaluation and management (E/M) services and the prolonged service billed. The medical record must be appropriately and sufficiently documented to show that the provider provided direct face-to-face time. The start and end times of the visit shall be documented in the medical record.
If supporting documentation is not submitted, the claim will be denied with an EXCD code indicating that supporting documentation is required.

General Reimbursement Guidelines - Commercial

Office and Other Outpatient E/M Services

- The reported level of E/M service must be based on medical decision making (MDM) **or** time.
    - Selection based on MDM.
        - MDM is documented by the complexity of establishing the diagnosis, assessing the status of a condition, and/or selecting a management option. MDM in the office or other outpatient services category are defined by three elements:
        - The number and complexity of problem(s) that are addressed during the encounter.
        - The amount and/or complexity of data that is necessary to be reviewed, diagnostic tests, notes, reports or other information that is obtained, ordered, or analyzed for the encounter. This includes diagnostic tests that may have been considered but not selected after a shared decision-making.
        - The risk of complications and/or morbidity or mortality of patient management decisions made at the visit, and associated with the patient's problem(s), diagnostic procedure(s), or treatment(s). This includes the possible management options selected and those considered but not selected, after shared MDM with the patient and/or family.
    - Selection based on Time.
        - Time includes face-to-face and non-face-to-face time personally spent by the provider. Time is not required to be continuous and may be an accumulation total time spent by the provider on the date of encounter.
        - Does not include time in activities performed by clinical staff.
        - Time is calculated for the date of service only therefore, time spent on previous dates or any date following the encounter (e.g., after midnight) is not included in the total time.
        - Time may be used to select the appropriate level of service whether counseling and/or coordination of care dominates the service.
        - Documentation of time spent by the provider must be summarized in the medical record along with the total time spent.

- Per AMA CPT guidelines qualifying time spent by the provider includes the following activities, when performed:

    - Preparing to see the patient (e.g., review of tests).
    - Obtaining and/or reviewing separately obtained history.
    - Performing a medically appropriate examination and/or evaluation.
    - Counseling and educating the patient/family/caregiver.
    - Ordering medications, tests, or procedures.
    - Referring and communicating with other health care professionals (when not separately reported).
    - Documenting clinical information in the electronic or other health record.
    - Independently interpreting results (when not separately reported) and communicating results to the patient/family/caregiver.
    - Care coordination (when not separately reported).

- The following work does **not** qualify for calculating total time for the encounter:

    - The performance of other services that are reported separately.
    - Travel.
    - Teaching that is general and not limited to the discussion that is required for the management of a specific patient.

- E/M office or other outpatient services CPT codes, (99202-99205, 99212-99215) do not require documentation of the extent of history or the extent of examination performed as components for determining the level of service. Practitioners will continue to obtain the patient's pertinent history, perform a relevant physical exam, and document the clinically important information from the history and exam.

- Shared or split visits.

    - A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit.

    - When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time.

    - Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

- PacificSource will allow Acupuncturists to bill an initial new patient office visit CPT 99202 or 99203 and subsequent E/M level CPT 99211 without supporting documentation; all other levels of E/M services will need supporting documentation to determine the service billed is adequately documented per the CPT guidelines and the CMS 1995 or 1997 documentation guidelines.

- Although the following list is not all inclusive and is subject to change, please be aware some specialties such as; PT/OT, SLP, LMT, LCSW, LPC, PHD, etc. are not eligible to bill for evaluation and management services.

Prolonged Services

- Prolonged services charges must be billed with an E/M code in which time is a factor in determining the level of service.
- Prolonged service charges are not reportable with non-time based procedures codes such as surgery or maternity. Other non-covered services include, but are not limited to:
    - Neuro psychological and behavioral testing
    - Intubation
    - Bronchoscopy
    - CPR
    - Infusion/chemo administration
    - Anytime spent performing and documenting separately reportable services
- The time for usual service refers to the typical/average time units associated with the companion evaluation and management (E/M) service.
- Prolonged services cannot be billed if separately reportable services were performed.
- Office visits that consist of 50% or more counseling and exceed the usual time for the E/M must first be billed to the highest level in the given E/M group (new patient, established patient) before the prolonged service can be billed. In this circumstance, time is the deciding factor in choosing the appropriate E/M code.
- Physicians may count only the duration of direct face–to-face contact between the physician and patient, whether the service was continuous or not.
- For inpatient settings, the physician cannot bill prolonged services for the time spent waiting for lab results, reviewing charts, etc.
- Services rendered during the prolonged portion of the visit must be coverable on the member's policy. For example, services for obesity, lifestyle and/or dietary counseling would not be covered unless the member's plan allows for it.
- CPT 99358 and 99359 will not be allowed if the time is spent in medical team conferences, on-line medical evaluations, care plan oversight services, anticoagulation management, or other non-face-to-face services that have more specific codes and no time limit in the CPT code set.
- CPT 99358 may not be reported in the same month as chronic care management, psychiatric collaborative care management, or behavioral health integration care management, codes 99484, 99491, 99492 and 99493.

The threshold table from the CMS website that shows the total number of usual face-to-face time and the amount of time needed before prolonged charges can be added can be found here: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/MLN-Matters-Articles-List

- CPT 99417 is used to report prolonged time personally spent by the physician or QHP.
- Can only use when the E/M has been selected based on time alone and with the highest (high risk) level of service (i.e., 99205 and 99215).
- Do **not** report 99417 for any additional time increment of less than 15 minutes.
- Reference the following tables for the correct reporting of time:

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Codes(s)
Less than 75 minutes	Not reported separately
75-89 minutes	99205 x 1 and 99417 x 1
90-104 minutes	99205 x 1 and 99417 x 2
105 or more	99205 x 1 and 99417 x 3 or more for each additional 15 minutes

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
Less than 55 minutes	Not reported separately
55-69 minutes	99215 x 1 and 99417 x 1
70- 84 minutes	99215 x 1 and 99417 x 2
85 or more	99215 x 1 and 99417 x 3 or more for each additional 15 minutes

Psychotherapy Prolonged Service:

- Codes 99354 and 99355 previously used to report psychotherapy services were deleted on January 1st, 2023. Prolonged service code 99417 may not be used with psychotherapy codes 90837 or 90838.
- Psychotherapy codes are reported as one unit/day. There no longer is a prolonged service code for use with psychotherapy.

Reimbursement for the services associated with the following CPT/HCPCS is included in the reimbursement for evaluation and management services and therefore is not separately reimbursable.

- G0545 - Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious disease specialist.
- G0559 - Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable: reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation.
- G2211 - Visit complexity add-on code for certain office/outpatient evaluation and management (E/M) services.
- G2212 - Prolonged office/outpatient E/M services.

General Reimbursement Guidelines – Medicare and Medicaid

PacificSource follows CMS guidelines when billing for prolonged Evaluation and Management (E/M) services which exceeds the maximum time for the highest level (99205, 99215, 99223, etc.) E/M visit in each category by at least 15 minutes on the date of service. CMS prolonged service guidelines are different from the American Medical Association (AMA).

CPT codes 99358, 99359 or 99417 are not valid for Medicare with status indicator "I" on the physician fee schedule.

CPT/HCPCS Code(s)Descriptors:

- 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 condition, or a complex condition. (Add-on code, list separately in addition to office or outpatient E/M visit, new or established)

- 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, 99483 for office or other outpatient evaluation and management services)

    - Do not report G2212 on the same date of service as 99415, 99416

    - Do not report G2212 for any time unit less than 15 minutes

- G0316 Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using 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 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services).

    - Do not report G0316 on the same date of service as other prolonged services for evaluation and management.

    - Do not report G0316 for any time unit less than 15 minutes

- G0317 Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using 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 99306, 99310 for nursing facility evaluation and management services).

    - Do not report G0317 on the same date of service as other prolonged services for evaluation and management.

    - Do not report G0317 for any time unit less than 15 minutes

- G0318 Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using 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 99345, 99350 for home or residence evaluation and management services).

  - Do not report G0318 on the same date of service as other prolonged services for evaluation and management.
  - Do not report G0318 for any time unit less than 15 minutes

- G0513 Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)
  - Coinsurance and deductible are waived
- G0514 Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)
  - Coinsurance and deductible are waived
- G0545 - Visit complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious disease specialist.
- G0559 - Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable: reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential complications that could have arisen due to the unique circumstances of the patient's operation.

Reporting times:

When the time of the reporting practitioner is used to select the office/outpatient E/M visit level, HCPCS code G2212 could be reported when the maximum time for the highest level (level five) office/outpatient E/M visit (99205 or 99215) is exceeded by at least 15 minutes on the date of the service.

Prolonged Office/Outpatient E/M Visit Reporting:

CPT/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
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes

Other Prolonged Services:

CPT/HCPCS Code(s)	Time Threshold to Report Prolonged	Description
99223 x 1 and G0316 x 1	90 minutes	Initial inpatient or Observation visit
99233 x 1 and G0316 x 1	65 minutes	Subsequent inpatient or Observation visit
99236 x 1 and G0316 x 1	110 minutes	Inpatient or Observation same day admit and discharge
99238 and 99239	Prolonged service not applicable	Inpatient or Observation Discharge
Emergency Department Visits	Prolonged service not applicable	
99306 x 1 and G0317 x 1	95 minutes	Initial Nursing Facility Visit
99310 x 1 and G0317 x 1	85 minutes	Subsequent Nursing Facility Visit
99345 x 1 and G0318 x 1	140 minutes	Home or Residence visit, New patient
99350 x 1 and G0318 x 1	110 minutes	Home or Residence visit, Established patient
99483 x 1 and G2212 x 1	100 minutes	Cognitive Assessment and Care Planning

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

Documentation about the duration and content of medically necessary E/M service and prolonged service(s) billed is required in the medical record. The medical record must be appropriately and sufficiently documented by the physician or qualified Non-Physician Practitioner (NPP) to show that the physician or qualified NPP personally furnished the direct face-to-face time with the patient specified in the CPT code definitions.

Start and end times, or total time, of the visit should be documented in the medical record along with the date of service.

Psychotherapy Prolonged Service:

Codes 99354 and 99355 previously used to report psychotherapy services were deleted on January 1st, 2023. To report extended services now, report two units of code 90834 (individual psychotherapy for 45 minutes), for a total of 90 minutes. If the visit/session needs to be extended due to crisis, code 90839 and 90840 may be billed. When providing prolonged services beyond 50 minutes for 90847 (family therapy with the patient present), provider should report two units as well.

References

American Medical Association. "Evaluation and Management (E/M) Code and Guideline Changes" effective January 1, 2023 https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf.

American Medical Association. "Evaluation and Management Services." Current Procedural Terminology (CPT), Current Professional Edition. Chicago: AMA Press.

Medicare Learning Network® (MLN) Matters®. "Summary of Policies in the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment

Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List." MLN Article MM 12071. < https://www.cms.gov/files/document/mm12071.pdf >.

Noridian. "Prolonged Service Code."https://med.noridianmedicare.com/web/jeb/specialties/em/prolonged-service-code

Appendix

Policy Number: [Policy Number]

Effective: 1/1/2021 **Next review:** 11/1/2025

Policy type: Enterprise

Author(s): Marie Dearing

Depts: Claims

Applicable regulation(s): [Applicable Regulation(s)]

External entities affected: [External Entities Affected]

Approved by:

Modification History

<table>
<tr><th>Date</th><th>Modified By</th><th>Reviewed By</th><th>Modifications</th></tr>
<tr><td>6/10/2025</td><td>Marie Dearing</td><td>Claims Team Leaders</td><td>Added G0545 and G0559 to Commercial and Government sections.</td></tr>
<tr><td>10/29/2024</td><td>Marie Dearing</td><td>Claims Team Leaders</td><td>Updated policy to include information from Prolonged Services policy (now retired) and Guidelines for Submitting Evaluation and Management Codes for Payment (now retired). Removed deleted CPT's. Added new CPT's. Removed Coding Information.</td></tr>
<tr><td>8/20/2024</td><td>Marie Dearing</td><td>Claims Team Leaders</td><td>Removed references to deleted CPT codes 99354, 99355, 99356, and 99357. Updated G2212: (Do not report G2212 on the same date of service as 99358, 99359, 99415, or 99416). Updated references: American Medical Association. "Evaluation and Management (E/M) Code and Guideline Changes" effective January 1, 2023 https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf and American Medical Association. "Evaluation and Management Services." Current Procedural Terminology (CPT), Current Professional Edition. Chicago: AMA Press.</td></tr>
<tr><td>11/13/2023</td><td>Marie Dearing</td><td>Claims Team Leaders</td><td>Annual review, updated several codes to 2024 guidelines.
OFFICE/OUTPATIENT E/M CODING GUIDANCE ON TIME, 2023 AND 2024
<table><tr><th>E/M code</th><th>Total time spent on date of the encounter (2023 guidelines)</th><th>Total time on the date of the encounter that must meet or exceed (2024 guidelines)</th></tr><tr><td>99202</td><td>15-29</td><td>15</td></tr><tr><td>99203</td><td>30-44</td><td>30</td></tr><tr><td>99204</td><td>45-59</td><td>45</td></tr><tr><td>99205</td><td>60-74</td><td>60</td></tr><tr><td>99212</td><td>10-19</td><td>10</td></tr><tr><td>99213</td><td>20-29</td><td>20</td></tr><tr><td>99214</td><td>30-39</td><td>30</td></tr><tr><td>99215</td><td>40-54</td><td>40</td></tr></table></td></tr>
<tr><td>11/22/22</td><td>Marie Dearing</td><td>Claims Team Leaders</td><td>Annual review, minor grammatical changes.</td></tr>
<tr><td>11/17/21</td><td>Marie Dearing</td><td>Claims Team Leaders</td><td>Annual review, no changes.</td></tr>
<tr><td>8/27/21</td><td>Marie Dearing</td><td>Claims Team Leaders</td><td>New policy</td></tr>
</table>