Prolonged Services Reimbursement Policy – Commercial and Medicare					
Policy Number	2020RP501A	**Annual Approval Date**	3/31/2020	**Approved By**	Optum Behavioral Reimbursement Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the procedure code or codes that correctly describe the health care services provided to individuals whose behavioral health benefits are administered by Optum, including but not limited to UnitedHealthcare members. This reimbursement policy is also applicable to behavioral health benefit plans administered by OptumHealth Behavioral Solutions of California.

Our behavioral health reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other procedure coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding our reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to behavioral health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for behavioral health care services provided to members. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: member's benefit coverage, provider contracts and/or legislative mandates. Finally, this policy may not be implemented exactly the same way on the different electronic claim processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this website. However, the information presented in this policy is accurate and current as of the date of publication.

**CPT® is a registered trademark of the American Medical Association*

Applicability

This reimbursement policy applies to all health care services billed on CMS 1500 forms and to services billed on the UB-04 claim form and to electronic claim submissions (i.e., 837p and 837i) and for claims submitted online through provider portals. This policy applies to Commercial and Medicare products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

This policy identifies when Optum 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.

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

For specific guidance related to Spravato Services please refer to the Spravato Reimbursement Policy Spravato Reimbursement Policy.

Reimbursement Guidelines

Optum reimburses Prolonged Services when reported with E/M codes in which time is a factor in determining level of service in accordance with CPT and or HCPCS guidelines. 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.

In accordance with The Centers for Medicare and Medicaid Services (CMS) and American Medical Association (AMA), Optum will reimburse for prolonged office or other outpatient evaluation and management service(s) cpt code 99417 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. 99417 must be listed separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services.

Optum follows CMS guidelines in regard to HCPCS code G2212 which must be listed separately in addition to codes 99205 or 99215 for office or other outpatient Evaluation and Management Services for Medicare only.

Optum requires providers to list the appropriate start and stop time for prolonged services code in the medical records in order to determine the appropriate type of prolonged services.

Code Definitions	
99417 (Commercial 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)
G2212 (Medicare Only	(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 for any time unit less than 15 minutes)

Codes

Primary E/M Codes	E/M Codes Time Range	**CPT Code 99417** (Commercial Only Prolonged Services Add-On Code) CPT®: times to add on 99417	**HCPC Code G2212 (**Medicare Only Prolonged Services Add-On Code) CMS: times to add on G2212
99205	60-74 min.	**75**-89 min.	**89**-103 min.
99215	40-54 min.	**55**-69 min.	**69**-83 min.

Questions and Answers

1	**Q:** Will Optum reimburse prolonged service code G2212 for commercial billed with the appropriate E/M code 99205 or 99215? **A:** No. Optum will not reimburse G2212 for commercial. You must bill the appropriate prolonged services code for commercial cpt code 99417 and only bill the appropriate prolonged HCPC codes G2212 for Medicare with the appropriate E/M codes 99205 or 99215.
2	**Q:** Is time spent waiting for test results or for potential changes in a patient's condition reported as prolonged services? **A:** Per CMS, time spent waiting for test results or for changes in the patient's condition cannot be reported as prolonged services.

Resources

- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

History / Updates

April, 2022	New Reimbursement Policy