Payment Policy: Prolonged Medical Services

Reference Number: QCP.PP.013
Last Review Date: 12/1/2025

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Occasionally, a physician may need to spend extra time with a patient. In these situations, the physician may request additional compensation. QualChoice will periodically audit the use of this code. If unusual patterns of use are noted, medical records will be requested to review required documentation.

Policy/Criteria

I. Prolonged physician service with direct (face-to-face) patient contact: Prolonged services involve direct face-to-face contact between the physician and the patient that is beyond the usual service in either the inpatient or outpatient setting. These codes should be used to report the duration of face-to-face time on a given date, even though the time is not continuous. Only that time in excess of the expected time investment of other E&M services billed on the same date should be counted.

A. Prolonged Physician Services in the office or other outpatient setting
   1. For payment under 99354 to be justified, it must be clear from the clinical notes (if requested) that over 30 minutes of time were required by the clinical situation beyond that which would normally be spent on all other services billed on the same date. Preventive medicine visits (99381-99397) do not have a specified time expectation. Prolonged service codes will not be reimbursed on the same date as a preventive medicine visit
   2. Times spent by office staff with the patient and times the patient remains unaccompanied in the office are not to be counted.
   3. For payment under 99355 to be justified,
      a. 99354 must also be billed and justified, based on over 60 minutes being spent beyond that which would normally be spent on the other services on the same date.
      b. It must be clear from the clinical notes (if requested) that at least 15 additional minutes were required, beyond the time previously billed as 99354 (60 minutes) and other iterations of 99355 (at 30 minutes each).

B. Prolonged Physician Services in the inpatient setting
   1. For payment under 99356 to be justified, it must be clear from the clinical notes (if requested) that over 30 minutes of time were required beyond that which would normally be spent on all other services billed on the same date.
   2. Time spent waiting for test results, for changes in the patient's condition, for the end of a therapy, or for the use of facilities cannot be billed as prolonged services.
   3. For payment under 99357 to be justified,

a. 99356 must also be billed and justified, based on over 60 minutes being spent beyond that which would normally be spent on the other services on the same date.
b. It must be clear from the clinical notes (if requested) that at least 15 additional minutes were required, beyond the time previously billed as 99356 (60 minutes) and other iterations of 99357 (at 30 minutes each).

II. Prolonged physician service without direct (face-to-face) patient contact

1. 99358-99359: All of the activities described are included in the evaluation of levels of service for E&M coding.
2. When billed on the same date as other face-to-face E&M services, these services will be rebundled into the other E&M service.
3. When performed on a date when there was no face-to-face interaction with the patient, the nature and extent of the services must be documented in a medical record note, which will be reviewed prior to payment.
4. These claims (without other E&M services on the same date) will initially deny with a request for medical records, and will be reviewed as a clinical edits appeal.

III. Standby Services

1. 99360 - Standby services are not covered.
2. This charge may not be billed to the patient, as no service was rendered to the patient; the service rendered was to the hospital.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
99417	Prolonged outpt E/M service(s) time with or w/o direct patient contact beyond the req`d 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 outpt E/M svc) new code eff 1/1/2023
99418	Prolonged inpt or obs E/M service(s) time with or w/o direct patient contact beyond the req`d 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 inpt/obs E/M svc) new code eff 1/1/2023

CPT® Codes	Description
99354	Prolonged service(s) in the outpt setting requiring direct patient contact beyond the time of the usual service; first hr (code revised eff 01-01-2021) (code deleted & replaced by 99417 eff 1/1/2023)
99355	Prolonged service(s) in the outpt setting requiring direct pt contact beyond the time of the usual svc; each add`l 30 min (code revised eff 01-01-2021) (code deleted & replaced by 99417 eff 1/1/2023)
99356	Prolonged service in the inpt or observation setting, requiring unit/floor time beyond the usual svc; first hr (code revised eff 01-01-2021) (code deleted & replaced by 99418 eff 1/1/2023)
99357	Prolonged service inpatient (code deleted & replaced by 99418 eff 1/1/2023)
99358	Prolong service w/o contact
99359	Prolong serv w/o contact add
99360	Physician standby services

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	01/01/2005	01/01/2005
Revision	11/01/2023	11/01/2023

Addendum

1. Effective 12/01/2016: Will deny without parent codes. Will monitor use patterns and may request records to review required documentation.
2. Effective 09/01/2017: Parent codes updated to match AMA CPT coding guidelines.
3. Separated code ranges in the search box to make searchable. Updated / revised codes 99354, 99355 and 99356 (eff 01-01-2021) and updated 99201 as deleted and replaced by 99202 eff 01-01-2021.
4. Effective 01/01/2023 – Codes 99354-99357 were deleted & replaced by codes 99417 & 99418.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.