Interventional Radiology Procedures *Navigator*® Supplement 2021 Edition

Prolonged Service for Outpatient & Office Visits

CMS, within the Medicare Physician Fee Schedule (MPFS) final rule for CY 2021, moved forward with a new HCPCS prolonged services code that is different from the one created by the AMA. The following is additional information about the coding differences between the AMA CPT® 99417 and CMS HCPCS G2212 for prolonged services with office/outpatient E/M visits.

There may be instances in which the time spent with the patient during office/outpatient E/M encounters will run longer than the allotted time of 74 minutes for a new patient (99205) or 54 minutes for an established patient (99215). Beginning January 1, 2021, a new prolonged services code is available for use with the revised outpatient and office visit codes. The appropriate code will depend on the payer guidelines.

The new code by the AMA and for use with payers, except Medicare, is CPT® 99417 and it replaces the previously used codes 99358 and 99359. Codes 99358 and 99359 are still valid in 2021, but they are no longer billable with the revised outpatient E/M service codes. The newly created code is billable with time-based reporting for office/outpatient visit codes that have reached the threshold for a level 5 visit (99205 and 99215).

CPT® Code	Definition
+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 (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

Due to feedback by providers, the time to meet the use for the AMA prolonged services code has also been adjusted to 15-minute increments. The visit must exceed a threshold in order to be billable, if less than 15 minutes beyond the level 5 outpatient codes are not met, the prolonged services code is not billable.

If an outpatient or office visit exceeds the threshold set for either of the level 5 visits, a prolonged services code can be billed as an add-on code to the outpatient E/M. Selecting the appropriate quantity of add-on code 99417 to report will depend on the amount of time documented. Since the use of medical decision making does not account for the time spent on date of encounter by the billing physician, the time-based method would need to be the one selected and utilized to support the prolonged service.

The following examples from *CPT® Assistant,* September 2020, review the potential billing scenarios based on time for a visit that would support billing the primary E/M service and add-on prolonged services code.

New Patient Example CPT® 99417

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

Established Patient Example CPT® 99417

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

In the CY 2021 MPFS proposed rule, CMS indicated they did not agree with the time thresholds for the level 5 office/outpatient codes to be able to bill for a prolonged services code as outlined by the AMA. For example, code 99215, level 5 established outpatient visit, the time range is 40-54 minutes. According to CMS, if the billing practitioner spent 55 minutes with the patient, they could not bill the prolonged services code in addition to the level 5 visit code. They indicated if they allowed this, the practitioner would be double dipping their time as the prolonged services code represents 15-minute increments. In the scenario presented, the practitioner would be double counting 14 minutes, the last 14 minutes to meet the top threshold for 99215 and the first 14 minutes of the prolonged service to meet the additional 15 minutes.

CMS believes when the practitioner uses the time-based method, the prolonged services code could be selected when the outpatient office visit level 5 is exceeded by at least 15 minutes on the date of service of the actual visit. For example, code 99215 as described above has a time threshold of 54 minutes, in order to bill for prolonged services CMS believes the visit must last at least 69 minutes, this is 15 more than the top threshold of 54 minutes and is completely separate time from time counted for the actual visit level.

To remedy the discrepancies in reporting for prolonged services with office/outpatient visits, CMS created the HCPCS add-on code G2212. CMS states, *"(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))."*

HCPCS Code	Definition
+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)

Utilizing tables CMS provided as part of the MPFS proposed rule which listed temporary code 99XXX, now replaced with G2212, the application of this time-based code might look something like this.

Prolonged Office/Outpatient E/M Visit Reporting - New Patient	
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
99205 x 1 and G2212 x 3 or more for each additional 15 minutes	119 or more
Prolonged Office/Outpatient E/M Visit Reporting - Established Patient	
CPT®/HCPCS Code(s)	**Total Time Required for Reporting**
99215	40 -54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

Complex Services

CMS has also created a new HCPCS code to account for complexity of services provided to new and established patients. CMS indicated they believe the updated definitions for CPT® 99202-99215 reflect the work provided in a "typical" office outpatient visit; however, for some specialties they do not adequately capture the resources associated with patient care. CMS had proposed a HCPCS add-on code, previously represented by temporary code GPC1X and finalized as G2211, is for use by any specialty for the ongoing care needs of the patient and potentially evolving illness.

HCPCS Code	Definition
+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/outpatient evaluation and management visit, new or established)

The care provided would be distinctly separate from existing services represented by preventative and care management services. Instead HCPCS add-on code G2211 "*reflects the time, intensity, and PE when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time."* CMS believes the addition of this code could bolster comprehensive and longitudinal care in the rural setting. The MPFS 2021 national rate, facility and non-facility, for code G2211 is $15.88.

CMS did indicate there would also be circumstances in which it would not be appropriate to bill HCPCS G2211, *"…there are many visits with new or established patients where HCPCS add-on code G2211 would not be appropriately reported, such as when the care furnished during the office/outpatient E/M visit is provided by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature, such as a mole removal or referral to a physician for removal of a mole; for treatment of a simple virus; for counseling related to seasonal allergies, initial onset gastroesophageal reflux disease; treatment for a fracture; and where comorbidities are either not present or not addressed, and/or and when the billing practitioner has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time."*

In addition, CMS stated G2211 would not be reported when the office/outpatient E/M visit is reported with a payment modifier, such as -25. In these instances, there are already separate and distinct services provided to the patient beyond the E/M visit, which would preclude the use of the add-on code.

Documentation to support the ongoing relationship between the practitioner and patient could be represented by the patient relationship codes, X1, X2, X3, X4, and X5 established under the Medicare Access and CHIP Reauthorization Act (MACRA). Each of the patient relationship modifiers define the relationship between the patient and practitioner at the time the item or service is furnished.