Medicare Billing & Coding Update

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1

Dr Crecelius has no conflicts of interest or disclosures

2

Learning Objectives

- Identify the best code for individual patients and circumstances
- Compare advantages and disadvantages of medical decision making versus time-based billing
- Discuss the appropriateness of ancillary codes such as advance care planning and annual wellness visit exams
- Review common billing patterns seen in our field

3

Tip for Accurate Coding: Know Your Codes and Reimbursement!

Medicare Physician Fee Schedule Lookup:
https://www.cms.gov/medicare/physician-fee-schedule/search

4

4

E/M Guideline Changes

- Over several years guidelines for all cognitive E/M families of codes have been revised with the following principles:
  - Decrease administrative burden and audit needs
  - Decrease documentation burden in the medical record not needed for patient care
  - Ensure payment is resource based with no goal of redistributing payment across specialties

Select the appropriate level of E/M services based on the following:

The level of the MDM as defined for each service ◄ OR ► The total time for E/M services performed on the date of the encounter.

5

De-Emphasis of History and Physical Examination

- Must be performed and documented as clinically appropriate
- No longer an element in the selection of the level of E&M service codes
- No need to document gratuitous reviews of systems for the purpose of claims unless performed or reviewed as clinically appropriate
- Remain important activities clinically and to support medical necessity of the service

6

6

Time

- Total time on the date of the encounter, NOT "Typical time"
- The indicated total time must be met or exceeded
- Includes both face-to-face time *with the patient* and/or family/caregiver and non-face-to-face time (must include a face-to-face encounter) on a given date
- Includes time regardless of location
- Since only a single E&M service may be reported per day, total time = cumulative time of all encounters that day
- Do not count time spent on:
  - Travel
  - General teaching not limited to specific patient management
  - Other services that are reported separately

7

Medical Decision Making 2023

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal	Minimal or None	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

- Level of Medical Decision-Making is determined by the highest level in 2 of the three elements
- The details and examples of Medical Decision-Making are described entirely in the 2023 CPT Manual

8

Why learn MDM when I can use time?

HCPCS Code	Short Description	Total Time in Min.	Medical Decision-Making Level	Price (2023)
99304	1st nf care sf/low mdm	25	Straightforward or Low	$80.65
99305	1st nf care moderate mdm	35	Moderate	$133.52
99306	1st nf care high mdm	45	High	$182.31
99307	Sbsq nf care sf mdm	10	Straightforward	$39.65
99308	Sbsq nf care low mdm	15	Low	$74.55
99309	Sbsq nf care moderate mdm	30	Moderate	$106.75
99310	Sbsq nf care high mdm	45	High	$153.51

*NOTE TIME CHANGES 2024: 99306: 50 minutes; 99308 20 minutes

9

9

►Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ****Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Straightforward	**Minimal** ■ **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** ■ **2** or more self-limited or minor problems; **or** ■ **1** stable, chronic illness; **or** ■ **1** acute, uncomplicated illness or injury; **or** ■ **1** stable, acute illness; **or** ■ **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **Category 1: Tests and documents** ■ **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

Could be family member, caregiver, CNA or other staff members

10

►Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ****Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Moderate	**Moderate** ■ **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** ■ **2** or more stable, chronic illnesses; **or** ■ **1** undiagnosed new problem with uncertain prognosis; **or** ■ **1** acute illness with systemic symptoms; **or** ■ **1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** ■ **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** Examples only: ■ Prescription drug management ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social determinants of health

What is Prescription Drug Management ?

11

What is Prescription Drug Management?

A) Initiating or increasing a prescription drug that may have significant adverse effects

B) Continuing a prescription medication; documenting the decision-making involved & risk if any

C) Listing medications and writing to be continued

D) A & B

E) A,B & C

12

►Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ****Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
High	**High** ■ **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** ■ **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** ■ **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* ■ Drug therapy requiring intensive monitoring for toxicity ■ Decision regarding elective major surgery with identified patient or procedure risk factors ■ Decision regarding emergency major surgery ■ Decision regarding hospitalization or escalation of hospital-level care ■ Decision not to resuscitate or to de-escalate care because of poor prognosis ■ Parenteral controlled substances◄

13

Additional HIGH MDM for Nursing Facility 2023

"When selecting a level of medical decision making (MDM) for nursing facility services, the number and complexity of problems addressed at the encounter is considered. For this determination, a **high-level MDM type specific to initial nursing facility care** by the ***principal**** physician or other qualified health care professional is recognized. This type is:

"**Multiple morbidities requiring intensive management**: A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.

"The definitions and requirements related to the amount and/or complexity of data to be reviewed and analyzed and the risk of complications and/or morbidity or mortality of patient management are unchanged."

14

Nursing Facility Care Services 2023

Initial Nursing Facility Care

Patient: New or Established			
Code	99304	99305	99306
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making Level			
Straightforward or Low	X		
Moderate		X	
High			X
OR			
Total Time (On Date of the Encounter)			
Minutes	25	35	45

Subsequent Nursing Facility Care

Patient: New or Established				
Code	99307	99308	99309	99310
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	10	15	30	45

15

Example of New MDM and a NH Subsequent Visit #1

- CC: CHF Exacerbation
- HPI: 3 days worsening SOB, orthopnea, edema, sats low 90's w/ O2@ 3liter -f/s/c, productive cough, wheeze.
- PE: T98, BP 105/60, P 102, RR20. Bilateral bibasilar crackles, 6 cm JVD. RRR S1S2+S3 no murmur; abd: benign 2+ edema to knees
- AP: CHF acute on chronic systolic - ECHO, BMP. Daily weights, VS tid. Lasix 40. 02.

16

So what do you bill via MDM?

A) 99307
B) 99308
C) 99309
D) 99310

17

Example of New MDM and a NH Subsequent Visit #1

- CC: CHF Exacerbation
- HPI: 3 days worsening SOB, orthopnea, edema, sats low 90's w/ O2@ 3liter -f/s/c, productive cough, wheeze.
- PE: T98, BP 105/60, P 102, RR20. Bilateral bibasilar crackles, 6 cm JVD. RRR S1S2+S3 no murmur; abd: benign 2+ edema to knees
- AP: CHF acute on chronic systolic - ECHO, BMP. Daily weights, VS tid. Lasix 40. 02.

Number and complexity of problems: MODERATE 1 or more chronic illnesses with exacerbation or side effects of treatment

Data: LOW: 2 unique tests ordered

Risk: MODERATE: Prescription drug management

18

Example of New MDM and a NH Subsequent Visit #2

- CC: CHF Exacerbation
- HPI: 3 day worsening SOB, orthopnea, edema, *declining* sats w/ O2@ 3l *(prev. RA) last 24 hours.* -f/s/c, prod cough, wheeze*. Eating more salty snacks, now more anorexic*
- PE: T98, BP 105/60, P 102, RR20, Sat 90% 3l. New bilat bibasilar crackles, 6 cm JVD. RRR S1S2+S3 no M abd: benign 2+ edema *to knees, previously trace*
- AP: CHF acute on chronic systolic - *repeat* ECHO, *last 6 month old. Check* CXR, *r/o infiltrate, effusion*. Check BMP, last Creat 1.5 *three month ago, concern for history hypokalemia with poor intake and diuretic*. Increase weights to daily *and* VS to tid *given current tenuous values -until seen in 4 days. Double Lasix to 40 pending results. Titrate 02, notify provider if needs >5 liters or RR>24. Educate family /patient on low Na diet. High risk of hospitalization if not improved next 24 hours, phone check with nurse tomorrow am.*

19

So What Do You Bill Via MDM Now?

A) 99307
B) 99308
C) 99309
D) 99310

20

Example of New MDM and a NH Subsequent Visit #2

- CC: CHF Exacerbation
- HPI: 3 day worsening SOB, orthopnea, edema, declining sats w/ O2@ 3l (prev. RA) last 24 hours. -f/s/c, prod cough, wheeze. Eating more salty snacks, now more anorexic
- PE: T98, BP 105/60, P 102, RR20, Sat 90% 3l. New bilat bibasilar crackles, 6 cm JVD. RRR S1S2+S3 no M abd: benign 2+ edema to knees, previously trace
- AP: CHF acute on chronic systolic - repeat ECHO, last 2 year old. Check CXR, r/o infiltrate. Check BMP, last Creat 1.5 three month ago, concern for history hypokalemia with poor intake and diuretic. Increase weights to daily and VS to tid given current tenuous values -until seen in 4 days. Double Lasix to 40 pending results. Titrate 02, notify provider if needs >5 liters or RR>24. Educate family /patient on low Na diet. High risk of hospitalization if not improved next 24 hours, phone check with nurse tomorrow am.

- Number and complexity of problems: HIGH 1 or more chronic illnesses with severe exacerbation or side effects of treatment
- Data: MODERATE: 3 unique tests ordered
- Risk: HIGH: Drug management requiring intensive monitoring for toxicity, impending decision to escalate care

21

Example of New MDM and Initial Visit

- CC: New admit admitted from XWZ Hospital with Acute on Chronic Syst CHF, Acute /Chronic Kidney Disease, T2 Diabetes poorly controlled, and COPD w/ exacerbation
- HPI: 86 yo admitted 7 d ago with cough, green phlegm, wheezing, fever and SOB x 2 d, found have COPD exacerbation with acute CHF, worsening renal function, hyperglycemia. Steroids, IV ATB, diuresis, SSI and now off O2, respiratory sx resolved, CHF compensated, bs back to usual low 100's, Creat back baseline. 3rd hosp admit 6 month. Feels weak, gait unsteady, still has mild DOE with any exertion
- PMHx: NKDA. Rx: Lisinopril 10 qd, Lasix 40 qd, Saxagliptin 2.5 mg qd, Trelegy qd, albuterol 2p q4 hr PMedSurgHX: Chronic CHF (EF 25%), COPD, DM T2 with Chronic Kidney Disease stage 3a
- F/S Hx: +DM, CAD. Widow, former nurse, 2 child out town, lives by self, no ETOH, 40 pk-yr but quit 3 yr ago. SDOH: finances, lack social support

22

MDM—Initial Visit Continued

- PE: T98 BP 115/70 P72 RR16 O2Sat 93 RA Skin no lesions, ENT-, Lungs mild decrease bs all fields, Cor RRR no S3, JVD, murmur, Abd benign, trace ankle edema, neuro NF
- A/P 1) Syst. CHF compensated: no change lasix/lisinopril, BMP in 2 days ordered, monitor VS esp w/ therapy, I/O

  2) COPD: compensated with Rx. Monitor sats QID, prn albuterol ordered

  3) DM T2: bs good, no change Rx, decreased bs to bid, no SSI

  4) Chronic Kidney Disease stage3a: diabetes related, last Creat @ baseline, monitor intake, ordered BMP

  5) Debility: due recent illness, PT/OT, supplements

  6) Code status: Goal of Care and Advance Directives reviewed – code status changed from full to limited

23

So What Do You Bill via MDM

A) 99304
B) 99305
C) 99306

24

MDM—Initial Visit Continued

- PE: T98 BP 115/70 P72 RR16 O2Sat 93 RA Skin no lesions, ENT-, Lungs mild decrease bs all fields, Cor RRR no S3, JVD, murmur, Abd benign, trace ankle edema, neuro NF
- A/P 1) Syst. CHF compensated: no change lasix/lisinopril, BMP in 2 days ordered, monitor VS esp w/ therapy, I/O

  2) COPD: compensated with Rx. Monitor sats QID, prn albuterol ordered

  3) DM T2: bs good, no change Rx, decreased bs to bid, no SSI

  4) Chronic Kidney Disease stage3a: diabetes related, last Create @ baseline, monitor intake, ordered BMP

  5) Debility: due recent illness, PT/OT, supplements

  6) Code status: Goal of Care and Advance Directives reviewed – code status changed from full to limited
- Number and complexity of problems: HIGH – multiple comorbidities requiring intensive management
- Data: MODERATE: 3 unique tests ordered
- Risk: HIGH: Drug management requiring intensive monitoring for toxicity, impending decision to descalate care, code status change

25

Nursing Home Codes and Telehealth Time

Code	Short Descriptor	Status
99304	Nursing facility care init comp	Unavailable due to Regulatory Requirement
99305	Nursing facility care init comp	Unavailable due to Regulatory Requirement
99306	Nursing facility care init comp	Unavailable due to Regulatory Requirement
99307	Nursing fac care subseq	Permanent – q 14 day limit
99308	Nursing fac care subseq	Permanent – q 14 day limit
99309	Nursing fac care subseq	Permanent – q 14 day limit
99310	Nursing fac care subseq	Permanent – q 14 day limit
99315	Nursing fac discharge day	Available up Through Dec. 31, 2024
99316	Nursing fac discharge day	Available up Through Dec. 31, 2024

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

26

26

What do I bill when I assume the care of a patient from another provider?

- Bill an Initial Nursing Facility Care code if assuming care from non-related provider (different practice)
- Clarified in the 2023 CPT manual
  - "Initial nursing facility care codes 99304, 99305, 99306 may be used once per admission, **per physician** or other qualified health care professional, regardless of length of stay".
  - "An initial service may be reported when the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice *during the stay*".
  - "An initial service may also be reported if the patient is a new patient as defined in the Evaluation and Management Guidelines".

27

What do I bill upon readmission from a hospitalization?

Somewhat unclear, BUT…

- Under §483.20(b) Comprehensive Assessments, "For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave."
- From CPT 2023: "Regulations pertaining to the care of nursing facility residents govern the nature and minimum frequency of assessments and visits. These regulations also govern who may perform the initial comprehensive visit."
- And in the CPT 2023 language to the Initial Nursing Facility Care codes:
"Initial nursing facility care codes 99304, 99305, 99306 may be used once per admission, per physician or other qualified health care professional regardless of length of stay. They may be used for the initial comprehensive visit performed by the principal physician or other qualified health care professional."
- And according to the 2023 Physician Fee Schedule Final Rule:
  - "The initial comprehensive assessment required under 42 CFR 483.30(c)(4) will be billed as an initial NF visit (CPT code 99304–99306)."

https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

28

Nursing Home Codes wRVU Revalued

- AMA RUC review of nursing home codes done in 2021
  - New values effective 1/1/23
  - Compelling evidence to review codes based off flawed methodology in 2009 and increased acuity, multiple EMRs
  - RUC accepted survey results, many thanks to those that completed the survey to derive values. Had stellar data to present
  - CMS in 2023 Final Rule accepted RUC values but felt time and values may not be accurate, request CPT & RUC to reconsider or will revalue time and wRVU themselves in 2024. Has not been done yet via Proposed Rule
  - Given Conversion Factor, practice expense etc should see about 8% increase overall

29

Revalued wRVU for 2023 (minus CF and Sequester)

	Frequency	2022 wRVU	2023 wRVU	2020 Total wRVU	2023 Total wRVU
99304	336,776	**1.64**	**1.5**	552,312	505,164
99305	1,054,727	**2.35**	**2.5**	2,478,608	2,636,818
99306	1,389,990	**3.06**	**3.5**	4,253,369	4,864,965
99307	2,372,760	**0.76**	**0.7**	1,803,297	1,660,932
99308	11,302,104	**1.16**	**1.3**	13,110,440	14,692,735
99309	10,009,767	**1.55**	**1.92**	15,515,139	19,218,763
99310	1,671,664	**2.35**	**2.8**	3,928,410	3,928,410
99315	185,707	**1.28**	**1.5**	237,705	278,560
99316	337,140	**1.9**	**2.5**	640,566	842,140
	28,660,635			42,519,846	48,628,487
				Increase wRVU	6,108,641
				% Increase	**14.37**

30

What About CPT G2211?

- 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)
- G2211 is an add-on code to office and other outpatient services, 99202–99215
- CMS plans reimbursement 2024 after a 4 year delay. Estimated to be used with 90% of PCP office visits, which may lower the CF by about 5%
- At the present time CANNOT be used with NH facility code set. There may be a possibility of using with POS-32 after future negotiations with CMS / others

31

What about coding in Assisted Living Facilities?

Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services

New Patient

►(99324, 99325, 99326, 99327, 99328 have been deleted. For domiciliary, rest home [eg, boarding home], or custodial care services, new patient, see home or residence services codes 99341, 99342, 99344, 99345)◄

Established Patient

►(99334, 99335, 99336, 99337 have been deleted. For domiciliary, rest home [eg, boarding home], or custodial care services, established patient, see home or residence services codes 99347, 99348, 99349, 99350)◄

32

Home *and* Assisted Living Facility Care 2023

(Place of service codes have not changed)

"The following codes are used to report evaluation and management services provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short-term accommodation (eg, hotel, campground, hostel, or cruise ship).

"**These codes are also used when the residence is an assisted living facility**, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility."

Home or Residence Services

Patient: New				
Code	99341	99342	99344	99345
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	15	30	60	75

Home or Residence Services

Patient: Established				
Code	99347	99348	99349	99350
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	20	30	40	60

33

Home Care, Assisted Living, Residential Care Codes Now Combined into a Single Code Set

Code	MDM	2022 AL	2022 HC	2023	2023 Time
99341	SF new	**1.01**	**1.01**	**1**	15
99342	Low new	**1.52**	**1.52**	**1.65**	30
99344	Mod new	**2.53, 3.88**	**2.63**	**2.87**	60
99345	High new	**4.09**	**3.46, 4.09**	**3.88**	75
99347	SF est	**1**	**1**	**0.9**	20
99348	Low est	**1.56**	**1.22**	**1.5**	30
99349	Mod est	**2.33**	**2.46**	**2.44**	40
99350	High est	**3.28**	**3.58**	**3.6**	60

34

Prolonged Services

35

Prolonged Services:

- CMS rejected all CPT Prolonged Service codes in 2023 including non- face to face mainly on basis of base code service times
- Three "G" codes for prolonged services now in place
  - G0316 Prolonged Hospital or Observation Services
  - G0317 Prolonged Nursing Home Services
  - G0318 Prolonged Home or Residence Services
- Clarified the time horizon for nursing home prolonged service codes

https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

36

G0317

- ***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 99358, 99359, 99418).*
  - *(Do not report G0317 for any time unit less than 15 minutes)*

37

CMS' Logic for Prolonged Service Changes

- All code set families (e.g office, NH) include pre-, intra- and post-service times.
- Previously only intra-service time was considered for prolonged service codes.
- Nursing Facility codes include pre- (the day before), intra-service (the day of) and post-service (3 days after the date of service) times
- CMS concluded that reporting 99358-99359 on any of those days would essentially be duplicative reporting as these codes only include intra-service time
- Thus, CMS converted other CPT prolonged service codes to "I" status*:
  - 99358-99359 Prolonged E/M service before and/or after direct patient care
  - 99418 Prolonged inpatient or observation E/M service(s) time with or without direct patient contact
- In addition, taking into consideration surveyed pre-service and post-service time embedded in the reimbursement, threshold times for reporting were revised (previously only intraservice time was considered

*I="ineligible" or "no longer recognized by CMS"

38

Time Thresholds for Prolonged Services

Nursing home pre & post times=35 min initial, 25 min subsequent
Home/Residence pre & post times=50 min new, 35 min subsequent

Primary E/M Service	Prolonged Code*	Service Time (as per code descriptor)	Time Threshold to Report Prolonged	Count Physician/NPP time spent within this time period (surveyed timeframe)
Initial NF Visit (99306)	G0317	45 minutes	95 minutes	1 day before visit + date of visit + 3 days after
Subsequent NF Visit (99310)	G0317	45 minutes	85 minutes	1 day before visit + date of visit + 3 days after
NF Discharge Day Management	n/a	n/a	n/a	n/a
Home/Residence Visit New Pt (99345)	G0318	75 minutes	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	60 minutes	110 minutes	3 days before visit + date of visit + 7 days after

* Time must be used to select visit level. Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe and includes time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we do not assign a frequency limitation.

https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

39

How to Use G0317

- May only be used if reporting the following nursing facility codes, using ***time***:
  - 99306 Initial nursing facility care, per day, 45 minutes must be met or exceeded, *but threshold is 95 minutes to report G0317 X 1*
  - 99310 Subsequent nursing facility care, per day, 45 minutes must be met or exceeded, *but threshold is 85 minutes to report G0317 X 1*
- May be reported for prolonged time within the surveyed time frame:
  - One day before the E&M service
  - On the day of the E&M service
  - Up to 3 days after the E&M service
- May be reported only when the prolonged time equals or exceeds 15 minutes beyond the maximum time specified by the codes
- May be reported for each 15-minute increment beyond the maximum time specified in the codes; ***there is no frequency limitation***
- Includes both face-to-face and non-face-to-face time; may be discontinuous

40

When provider care relative to an initial nursing facility service (99306) and/or prolonged time for those services (G0317) covers a timespan of several days, what are the appropriate DOS for those services?

A) Bill 99306 using the date of patient encounter. Bill G0317 at the end of 5 day period.

B) Bill 99306 using the date of patient encounter. Bill G0317 whenever the 15 minute threshold is met

C) Bill 99306 using the date of patient encounter. Bill G0317 as appropriate using the same service date as 99306

D) Bill 99306 using the date the 95 minute threshold for prolonged services is met. Bill G0317 at the end of the 5 day period

41

Prolonged Services: RVUs

HCPCS	Descriptor	CY 2022 Work RVU	Final CY 2023 Work RVU
G3016	Prolonged hospital inpatient or observation care	NEW	0.61
G0317	Prolonged nursing facility evaluation and management service(s)	NEW	0.61
G0318	Prolonged home or residence evaluation and management service(s)	NEW	0.61

https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf
(see page 211 of the PDF document or page 69614 of the Federal Register, Vol 87, No. 222)

42

So Is It Worth the Effort to Bill Prolonged Services?

- If using prolonged service, reviewing admit materials in depth is better done the day of actual patient visit to maximize time toward a 99306 (as opposed to the day prior). Same for family communication and post time
- Prolonged service codes are used for managing the same initial problems as addressed on admission. If new problems / complications occur, a subsequent visit is more appropriate

43

Split or Shared Visits

30.6.18 - Split (or Shared) Visits
(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)
A. Definition of Split (or Shared) Visit
A split (or shared) visit is an evaluation and management (E/M) visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner (NPP) who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if furnished independently by only one of them. Payment is made to the practitioner who performs the substantive portion of the visit.
Facility setting means an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under our regulations.

--*Medicare Claims Processing Manual, Chapter 12*

44

Split Visits

E/M Visit Code Family	2022-2024 Definition of Substantive Portion	2025 Definition of Substantive Portion
SNF, Inpatient/Observation Hospital, ER, other outpatient (NOT office)	History, or exam, or MDM, or more than half the total time	More than half the total time
Office	Cannot use (office has incident to instead)	Cannot use (office has incident to instead)
Critical Care	More than half the total time	More than half the total time

45

Chronic Care Management (CCM) Available but Difficult to Use

- Two or more "significant chronic conditions" -NF only (no use in SNF)
- Non face-to-face work
  - Clinical Staff: 20 minutes (99490)
  - Physician or Other Qualified Healthcare Professional (QHP): 30 minutes (99491)
- Billed no more frequently than once per calendar month per qualified patient
- Services covered include
  - Regular development and revision of an electronic plan of care using certified EHR
  - Communication with other treating health professionals Medication management
  - 24/7 access to address a patient's acute chronic care needs
- May be billed concurrently with Transitional Care Management Services when medically necessary and reasonable

46

Chronic Care Management Additional Time: Physician

99437 Each additional 30 minutes by a *physician or other qualified health care professional* per calendar month (List separately in addition to code for primary procedure)

- Applies only to 99491; cannot be applied to 99490
- Maximum 2 units per month

Total Duration of Physician Care Management Services	Chronic Care Management
Less than 30 minutes	Not reported separately
30-59 minutes	99491 X 1
60-89 minutes	99491 X1 AND 99437 X 1
90 minutes or more	99491 X 1 AND 99437 X 2 as appropriate

47

47

Chronic Care Management Additional Time: Staff

99439 Each additional 20 minutes of *clinical staff time* directed by a physician or other qualified health care professional, per calendar month

- Applies only to 99490; cannot be applied to 99491
- Maximum 2 units per month

Total Duration of Staff Care Management Services	Chronic Care Management
Less than 20 minutes	Not reported separately
20-39 minutes	99490 X 1
40-59 minutes	99490 X1 AND 99439 X 1
60 minutes or more	99490 X 1 AND 99439 X 2 (see also 99487; service of this duration may indicate Complex Chronic Care Management)

48

48

Chronic Care Management (CCM)

- Services covered include
  - Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
  - Care management for chronic conditions including systematic assessment and development of a patient centered plan of care.
  - Management of care transitions within health care.
  - Coordination with home and community based clinical service providers.
  - Enhanced opportunities for a patient to communicate with the provider through telephone and secure messaging, internet or other asynchronous non face-to-face consultation methods.

49

Chronic Care Management (CCM)

- Electronic Care Plan - components
  - establish, implement, revise, or monitor and manage an electronic care plan that addresses the physical, mental, cognitive, psychosocial, functional and environmental needs of the patient
  - maintain an inventory of resources and supports that the patient needs
  - The practice must use a certified EHR to bill CCM codes.
  - The care plan must be available to anyone providing CCM services in a timely fashion
  - A copy of the electronic care plan must be provided to the patient

50

Chronic Care Management (CCM)

- Billing
  - The practice must have the patient's consent (verbal OK)
  - Only one clinician can be paid for CCM services in a calendar month
  - Billed at the end of the month
  - CMS originally did not pay in PA/LTC, but now allows if all requirements met. Can be difficult to do as requires use of physician and not facility staff

51

Possible Example of Chronic Care Management in PA/LTC

82 year old man with moderate dementia, behavioral disturbances and heart failure who's had 2 episodes of decompensated heart failure treated in the facility in the last year. *Physician's clinical staff* coordinates visits by cardiologist and psychiatrist, providing prior history and goals of care. Care planning includes 3X week weights with parameters for extra diuretic and physician notification, regular lab test monitoring, restorative therapy, regular assessment of cardiopulmonary status and parameters for reporting changes. A care plan for behavioral symptoms is instituted as well. These elements are included in the facility care plan and shared with the authorized decision-maker. EHR is utilized for all electronic and telephonic encounters of physician and clinical staff clearly documented. Cumulative time for all encounters by clinical staff amounts to 25 minutes for that calendar month and is clearly documented

52

Possible example of complex chronic care management in PA/LTC

83-year-old male with moderate dementia with paranoid / depressive features, CHF, DM & peripheral neuropathy, recurrent falls due to combined physical and mental incapacities with minor to moderate associated injuries to date. Care planning includes frequent monitoring of multiple aspects including: medications used to treat his medical and psychiatric status; non-pharmacologic behavioral interventions; fall interventions with the interdisciplinary team; vital signs, physical and psychosocial status with pertinent call parameters for his medical diagnosis; and regular communication with a consulting psychiatrist. These elements are included in the facility care plan. EHR is utilized with all electronic and telephonic encounters of physician and the *physician's clinical staff* clearly documented and time elements summed to more than 60 minutes per month

NOTE: Complex Chronic Care Management Services 99487-99489 requires medical decision making of moderate-to-high complexity during the calendar month in which services are provided

53

More Examples of Physician Employed Staff Activities that Would Lend Themselves to CCM

- **Physician employed staff** reviews latest Oscar report for all physician patients who trigger late-loss life ADL, falls, antipsychotic use, hypnotic use, UTI, depressive behaviors and pain, collates report and identifies high risk patients who trigger 3 or more who would benefit from an intensive physician review
- **Physician employed staff** reviews all physician patient's advance directives, hospitalizations in the last year, functional status, runs prognostic scale (e.g. Porock or Flacker), reviews last facility care plans and runs report for physician to identify patients needing family discussion / education on advance directives, referral to palliative care services

54

Chronic Care Management: National Rates 2021

Code	Brief Description	wRVU	2022 NF MPFS National Rate	2022 F MPFS National Rate
99487	Cplx chrnc care 1st 60 min[2]	1.45	$83.40	$75.44
99489	Cplx chrnc care ea addl 30[2]	1.00	$60.22	$52.60
99490	Chrnc care mgmt staff 1st 20[2]	1.00	$63.33	$50.53
99491	Chrnc care mgmt phys 1st 30[1]	0.71	$48.45	$35.64
99437	Chrnc care mgmt phys ea addl 30 min[1]	0.70	$61.25	$52.26
99439	Chrnc care mgmt staff ea addl 20 min[2]	0.70	$48.45	$36.34

[1] Counts staff time
[2] Counts physician/qualified healthcare provider time
MPFS=Medicare Physician Fee Schedule; NF=Non-facility; F=Facility

55

Now that 99318 Annual Nursing Home Visit has been deleted, how can I report an annual comprehensive exam?

- May use subsequent nursing facility visit codes 99307-99310, selecting the level by either total time of the visit or medical decision-making
- Alternately, consider incorporating the Medicare Wellness Visit into your practice
- Note: Components of Wellness Exams may not be goal-concordant with frail, elderly nursing home residents; may need to customize components of wellness visits to appropriately meet the needs of nursing home residents

56

What is Included in the Initial Annual Wellness Visit ?

1. Perform Health Risk Assessment (HRA)
2. Establish patient's medical and family history
3. Establish list of current providers and suppliers
4. Measure/Exam
5. Detect any cognitive impairment patients may have
6. Review patient's potential depression risk factors, including current or past experiences with depression or other mood disorders
7. Review patient's functional ability and level of safety
8. Establish an appropriate written screening schedule for patients, such as a checklist for the next 5-10 years
9. Establish list of patient risk factors and conditions where primary, secondary or tertiary interventions are recommended or underway

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

57

What is Included in the Initial Annual Wellness Visit (AWV)?

10. Provide patient's personalized health advice and appropriate referrals to health education or preventive counseling services or programs
11. Review current opioid prescriptions
12. Screen for potential Substance Use Disorders (SUDs)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

58

What is included in the Subsequent Annual Wellness Visit (AWV)?

1. Review and Update ~~Perform~~ Health Risk Assessment (HRA)
2. Update ~~Establish~~ patient's medical and family history
3. Update ~~Establish~~ list of current providers and suppliers
4. Measure/Exam
5. Detect any cognitive impairment patients may have
6. ~~Review patient's potential depression risk factors, including current or past experiences with depression or other mood disorders~~
7. ~~Review patient's functional ability and level of safety~~
8. Update patient's ~~Establish an appropriate~~ written screening schedule ~~for patients, such as a checklist for the next 5-10 years~~
9. Update ~~Establish~~ list of patient risk factors and conditions where primary, secondary or tertiary interventions are recommended or underway

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

59

What is included in the Subsequent Annual Wellness Visit (AWV)?

10. As necessary, provide and update patient's Personalized Prevention Plan Services (PPPS), which includes ~~Provide patient's~~ personalized health advice and appropriate referrals to health education or preventive counseling services or programs when needed
11. Provide Advance Care Planning (ACP) services at patient's discretion
12. Review current opioid prescriptions
13. Screen for potential Substance Use Disorders (SUDs)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

60

Pearls

- Notes should concentrate on MDM and thought process. Time should not be the predominant means of billing for experienced practitioners
  - Consider using a laminated MDM cards for a few weeks to really learn MDM
  - Time elements for 99306 & 99308 will go up in 2024 to 50 & 20 minutes respectively
- Prolonged service code usage is limited, but many if not most times a subsequent code is appropriate given changing patient condition
- You should bill an initial visit code when assuming care of other provider's patients, and when patients return from a hospital stay
- Split visits between a physician and NP/PA are permitted, but not incident to
- Assisted Living is now billed via Home & Residence code set
- Chronic care management can be billed in LTC (not SNF) but requirements are difficult to meet as CCM/CCCM are designed for the office setting
- 99318 Annual Exam has been deleted. Similar work can be done through 99307-10 and the Annual Wellness Exam (which has requirements designed for outpatient use)

61

Questions?

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62

APPENDIX
Fun Facts To Know and Tell!

63

Advance Care Planning

64

Advance Care Planning Services

99497 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

+ 99498 each additional 30 minutes (List separately in addition to code for primary procedure)

- *CPT Changes: An Insider's View* 2015
- *CPT Assistant* Dec 14:11

(Use 99498 in conjunction with 99497)

65

When will CMS Cover ACP?

- "When the described service is reasonable and necessary for the diagnosis or treatment of illness or injury"
- At present, there is no controlling national coverage policy
- No specific diagnoses required

66

Are there minimum amounts of time to bill the code

- In the absence of rules otherwise, CMS defers to CPT descriptor language
- According to CPT coding convention, the threshold for minimum time is reached after the midpoint
- For 99497, "first 30 minutes" is reached at 16 minutes
- For 99498, additional 30 minutes is reached at 30 + 16 minutes=46 minutes

67

How often can ACP be billed?

- Per CPT language, there is no limit
- CMS has declined to establish frequency limits at this time
- BUT—if billed multiple times, CMS would expect to see "a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care."

68

Are there rules governing who may actually perform the service?

- Besides the CPT descriptor, there is no introductory language nor are there explanatory notes governing the performance of the service
- According to the final rule (80 Fed. Reg. 70956), "99497 and 99498 are appropriately provided by physicians or using a team-based approach provided by physicians, NPPs and other staff under the order and medical management of the beneficiary's treating physician."
- CMS expects the billing physician or NPP to "meaningfully contribute to the provision of the services in addition to providing a minimum of direct supervision."
- "Incident to" service rules apply
- All applicable state law and scope of practice requirements must be met

(NPP=Non-Physician Practitioner, usually referring to Nurse Practitioners, Physician Assistants and Clinical Nurse Specialists, subject to state laws)

69

Must the beneficiary be present?

- According to the code descriptor, the service is "face-to-face with the patient, family member(s) and/or surrogate*
- Cannot be reported if performed by phone*;
- Subject to CMS Telehealth service payment requirements (see: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf)
- According to CMS, if beneficiary is not present, must document that the beneficiary is impaired and unable to participate effectively
- Must still be face-to-face with family member(s) and/or surrogate*

*BUT MAY BE PERFORMED VIA TELEHEALTH THROUGH 2024

70

What must be documented?

- No requirements in the CPT code descriptor
- Consent is necessary, but does not require documentation
- Medicare Administrative Contractors (MACs) have so far not issued guidance
- Recommendations from CMS; document:
  - That participation is voluntary
  - An account of the discussion
  - Who was present
  - Explanation of advance directives, including any completed forms
  - Time spent in the encounter

71

Can ACP be reported in addition to other services?

- YES, May be reported in addition to E/M codes
  - But need to keep time separate
- May be reported during same service period as Transitional Care Management or Chronic Care Management
- May be reported during global surgical periods
- May use well exam diagnosis when ACP furnished as part of the Medicare Annual Wellness Visit (AWV)
  - Append modifier -33
- May not be reported on same date as certain critical care services

72

Do deductibles and copays apply?

- YES, except when reported as element of the AWV; use modifier -33
- YES, when reported in addition to Introductory Preventive Physical Examination ("Welcome to Medicare Exam")
- Recommend that practitioners let beneficiaries know

73

Advance Care Planning: National Rates 2022

Code	Short Description/ CMS Posted Typical Time(s)	2021 NF MPFS National Rate	2021 F MPFS National Rate
99497	Advance care plan 30 min	$85.48	$77.86
99498	Advance care plan addl 30 min	$74.06	$73.36

MPFS=Medicare Physician Fee Schedule; F=Facility; NF=Non-facility

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

74

What is medically necessity?

- E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B[1]
- Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor[2]
- The overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported

[1]Medicare Claims Processing Manual, Chapter 12, Physicians/Non-physician Practitioners
[2]www.cms.gov/apps/glossary/search.asp?Term=medically+necessary&Language=English&SubmitTermSrch=Search

75

Summarizing:

The visit must be medically necessary AND

The level of service reported must be medically necessary (supported by H&P, MDM etc.)

THEREFORE: **Documentation must support both the medical necessity of the visit itself AND the level of service being reported**

76

Mandated regulatory physician visits: Frequency

F712
(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)
§483.30(c) Frequency of physician visits

- **§483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.**
- **§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.**
- **§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.**
- **§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.**

77

Mandated regulatory physician visits: Content

DEFINITIONS §483.30(c) Must be seen, for purposes of the visits required by §483.30(c)(1), means that the physician or NPP must make actual face-to-face contact with the resident, and at the same physical location, not via a telehealth arrangement. There is no requirement for this type of contact at the time of admission, since the decision to admit an individual to a nursing facility (whether from a hospital or from the individual's own residence) generally involves physician contact during the period immediately preceding the admission. (SOM/Appendix PP, p 445)

IMPLICATIONS

- Though payment policy allows nursing home visits to be performed via Telehealth (payment policy), this does not apply to regulatory visits (federal regulations)
- Regulatory visits must be face-to-face
- Other visits may be performed via Telehealth, subject to the q14 day limitation

78

Mandated regulatory physician visits: Content

F711
(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.30(b) Physician Visits
The physician must—

- **§483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;**
- **§483.30(b)(2) Write, sign, and date progress notes at each visit; and**
- **§483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.**

79

Authority for Non-Physician Practitioners to Perform Visits, Sign Orders and Sign Medicare Part A Certifications/Recertifications When Permitted by the State

	Initial Comprehensive Visit /Orders	Other Required Visits^	Other Medically Necessary Visits & Orders+	Certification/ Recertification ±
SNFs				
PA, NP & CNS employed by the facility	May not perform/ May not sign	May perform alternate visits	May perform and sign	May not sign
PA, NP & CNS not a facility employee	May not perform/ May not sign	May perform alternate visits	May perform and sign	May sign subject to State Requirements
NFs				
PA, NP, & CNS employed by the facility	May not perform/ May not sign	May not perform	May perform and sign	Not applicable
PA, NP, & CNS not a facility employee	May perform/ May sign*	May perform	May perform and sign	Not applicable

*At the option of the state, NPP may perform admission H&P. Physician must leave order to admit

^ 30/60 regulatory visits

+Medically necessary visits are independent of required visits and may be performed prior to the initial comprehensive visit.

80

Physician/NP Visits Relative to Admission

Medicare Claims Processing Manual, Chapter 12, Sect. 30.6.13:

- "Beginning January 1, 2006, the new CPT codes, Initial Nursing Facility Care, per day, (99304 - 99306) shall be used to report the initial federally mandated visit. Only a physician may report these codes for an initial federally mandated visit performed in a SNF or NF (with the exception of the qualified NPP in the NF setting who is not employed by the facility and when State law permits, as explained above)." (*with AI modifier)

2023 AMA CPT Manual:

- "The principal physician or other qualified health care professional may work with others (who may not always be in the same group) but are overseeing the overall medical care of the patient, in order to provide timely care to the patient. Medically necessary assessments conducted by these professionals prior to the initial comprehensive visit are reported using subsequent care codes (99307, 99308, 99309, 99310)."

81

Are Counseling and Coordination of Care visits without a patient exam still allowed in the in-patient and Nursing Home and Assisted Living settings? If so, I assume it must be a time-based service and how should the service be documented?

Counseling and Coordination of Care remain important clinical services

They are no longer separate components for the purposes of selecting a level of service

Counseling and Coordination of Care may be included in the total time of the encounter, if using time to select the level of care, or medical-decision making

82

BILLING PATTERNS

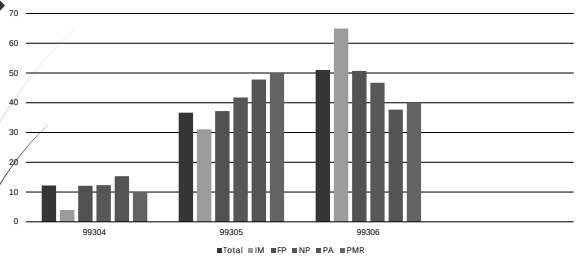
83

General Patterns

- Total visits decreased in 2020 but are close to baseline 2021
  - 26,443,733 encounters in 2021
- Percent SNF vs. NF increased in 2021
  - Historically 60-40 split SNF-NF
  - 2021: 67.3% SNF
  - ?Effect COVID
- NP/PA continue to increase presence in 2021
  Percent of all visits made:
  - NP: 41.4% PA: 6.3% NP/PA: 47.7%
  - IM: 21.7% FP: 12.1% PMR: 5%

84

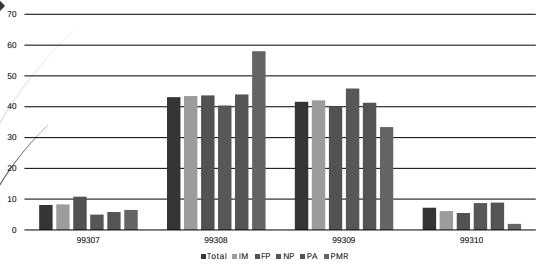
Initial Nursing Home Code Distribution



Caveat: Your distribution may be different based off medical necessity

85

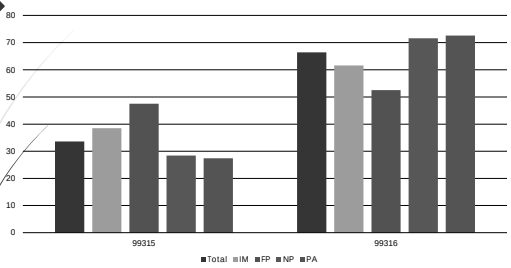
Subsequent Nursing Home Code Distribution



Caveat: Your distribution may be different based off medical necessity

86

Discharge Nursing Home Code Distribution



Caveat: Your distribution may be different based off medical necessity

87

Time Thresholds for Prolonged E&M Services: 2023

Primary E/M Service	Prolonged Code*	Service Time (as per code descriptor)	Time Threshold to Report Prolonged	Count Physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	75 minutes	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	50 minutes	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	85 minutes	125 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	n/a	n/a	n/a	
Initial NF Visit (99306)	G0317	45 minutes	95 minutes	1 day before visit + date of visit + 3 days after
Subsequent NF Visit (99310)	G0317	45 minutes	85 minutes	1 day before visit + date of visit + 3 days after
NF Discharge Day Management	n/a	n/a	n/a	n/a
Home/Residence Visit New Pt (99345)	G0318	75 minutes	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	60 minutes	110 minutes	3 days before visit + date of visit + 7 days after
Consults	n/a	n/a	n/a	
Cognitive Assessment and Care Planning (99483)	G2212	60 minutes (typical)	100 minutes	3 days before visit + date of visit + 7 days after

* Time must be used to select visit level. Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe and includes time with or without direct patient contact by the physician or NPP. As with CPT's approach, we do not assign a frequency limitation.

https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

88

Name of Service	
AMA Link to 2023 Evaluation and Management CPT Code Revisions	https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjTy7DP3NP6AhW4IIkEHSZ-CTsQFnoECBAQAQ&url=https%3A%2F%2Fwww.ama-assn.org%2Fsystem%2Ffiles%2F2023-e-m-descriptors-guidelines.pdf&usg=AOvVaw3602CDkjKKTlCu7RZECisq
CMS Website on COVID-19 Waivers	https://www.cms.gov/coronavirus-waivers
Appendix PP: State Operations Manual—Guidance to Surveyors (All the F-tags and federal regs for nursing facilities)	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
Medicare Claims Processing Manual, Chapter 12 (Physician/Non-physician Practitioners)	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
CMS List of Covered Telehealth Services during the COVID-19 Pandemic	https://www.cms.gov/Medicare/Medicare-General-information/Telehealth/Telehealth-Codes
Health and Human Services Telehealth Info	https://www.telehealth.hhs.gov/
CMS COVID-19 Waivers	https://www.cms.gov/coronavirus-waivers

89

Name of Service	Where to find the information
Chronic Care Management Services	https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
Cognitive Assessment and Care Services	https://www.alz.org/careplanning/downloads/cms-consensus.pdf
Advance Care Planning Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf
2023 Medicare Physician Fee Schedule Final Rule (Source for CMS Prolonged Service 'G' Codes)	https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf
Care Management Services in Rural Areas	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

90

Name of Service	Where to find the information
The Initial Preventive Physical Exam ("Welcome to Medicare Visit")	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
Annual Wellness Exam (AWV)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html
Incorporating the AWV into the Nursing Facility (This is one example of how to incorporate part of the AWV into nursing home practice)	Little MO, Sanford AM, Malmstrom TK, Traber C, Morley JE. Incorporation of Medicare Annual Wellness Visits into the Routine Clinical Care of Nursing Home Residents. J Am Geriatr Soc. 2020 Dec 18. doi: 10.1111/jgs.16984. Epub ahead of print. PMID: 33339071. https://agsjournals.onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.16984
Transitional Care Management Services	https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/transitional-care-management/faq.html (May require membership, password or fee) https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/transitional-care-management.html (May require membership, password or fee)
Behavioral Health Integration Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf
Medicare Physician Fee Schedule Lookup	https://www.cms.gov/medicare/physician-fee-schedule/search

91

Other resources for Telehealth Services during the COVID-19 Pandemic

92

- Special coding advice during COVID-19 public health emergency

https://www.ama-assn.org/system/files/2020-03/covid-19-coding-advice.pdf

- AMA quick guide to telemedicine in practice

https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice

- Medicare Telemedicine Provider Fact Sheet

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

NOTE: Because of rapidly changing rules and directives during the COVID-19 Public Health Emergency, please check the dates on internet resources to be assured the information is accurate and current

92

Other resources for Telehealth Services during the COVID-19 Pandemic

93

- Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit (note: dates from 2020, so much of the information is dated)

https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf

- AMA quick guide to telemedicine in practice

https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice

- Rural Crosswalk: CMS Flexibilities to Fight COVID-19

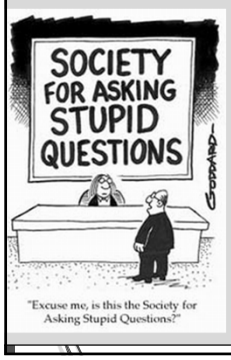
https://www.cms.gov/files/document/omh-rural-crosswalk-5-21-21.pdf

- Telehealth Services (Medicare Learning Network)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

NOTE: Because of rapidly changing rules and directives during the COVID-19 Public Health Emergency, please check the dates on internet resources to be assured the information is accurate and current

93



"Excuse me, is this the Society for Asking Stupid Questions?"

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94