The Codes of Many Colors: Medicare Billing and Coding in PALTC: 2023 Update

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Speaker Disclosures

DR. ZOROWITZ IS AN EMPLOYEE AND STOCKHOLDER OF HUMANA, INC.

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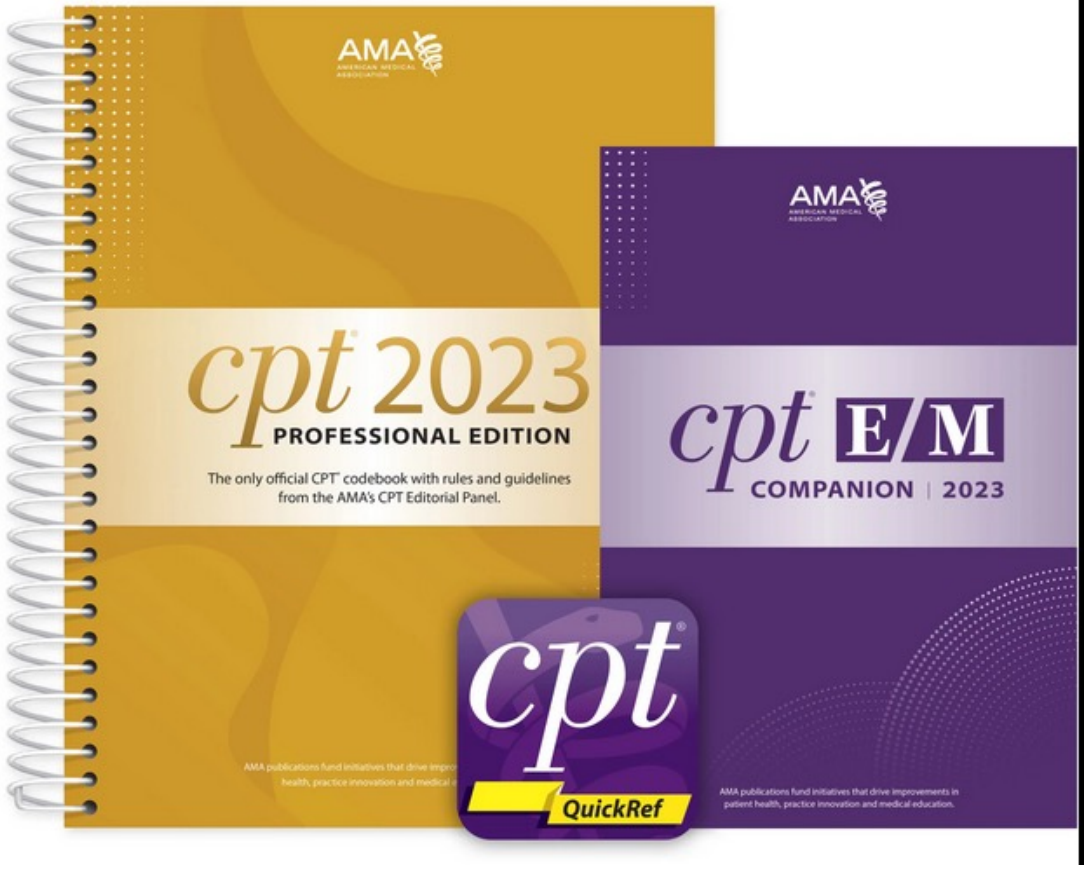
Learning Objectives

By the end of the session, participants will be able to:

- Understand the revised E&M guidelines for Nursing Facilities and Home and Residence
- Understand the revisions to Medical Decision-Making criteria
- Understand the changes in payment for telehealth services implemented since the start of the COVID-19 pandemic
- Become familiar with the various prolonged service codes
- Understand the distinction between CMS payment policy and federal statutory regulations

Tip for Accurate Coding: Know Your Codes and Reimbursement!



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

The 2023 CPT Evaluation and Management (E&M) Revisions

Nursing Facility Care 2022

Initial Nursing Facility Care

Patient: New or Established

Required Components: 3/3

Code	99304	99305	99306
REQUIRED KEY COMPONENTS			
History and Examination (#1 and #2)			
Detailed or Comprehensive	X		
Comprehensive		X	X
Medical Decision Making (Complexity) (#3)			
Straightforward or Low	X		
Moderate		X	
High			X
CONTRIBUTORY FACTORS			
Presenting Problem (Severity) (#1)			
Low	X		
Moderate		X	
High			X
Counseling and Coordination of Care (#2 and #3) Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.			
Bedside/Unit/Floor Time (#4)			
Minutes	25	35	45

Subsequent Nursing Facility Care

Patient: New or Established

Required Components: 2/3

Code	99307	99308	99309	99310
REQUIRED KEY COMPONENTS				
History and Examination (#1 and #2)				
Problem-Focused	X			
Expanded Problem-Focused		X		
Detailed			X	
Comprehensive				X
Medical Decision Making (Complexity) (#3)				
Straightforward	X			
Low		X		
Moderate			X	
High				X
CONTRIBUTORY FACTORS				
Presenting Problem (Severity) (#1)				
Stable/Recovering/Improving	X			
Responding Inadequately to Therapy/Minor Complication		X		
Significant Complication/ Significant New Problem			X	
Unstable/Significant New Problem Requiring Immediate Physician Attention				X
Counseling and Coordination of Care (#2 and #3) Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.				
Bedside/Unit/Floor Time (#4)				
Minutes	10	15	25	35

Assisted Living Facility Care 2022

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

Patient: New

Required Components: 3/3

Code	99324	99325	99326	99327	99328
REQUIRED KEY COMPONENTS					
History and Examination (#1 and #2)					
Problem-Focused	X				
Expanded Problem-Focused		X			
Detailed			X		
Comprehensive				X	X
Medical Decision Making (Complexity) (#3)					
Straightforward	X				
Low		X			
Moderate			X	X	
High					X
CONTRIBUTORY FACTORS					
Presenting Problem (Severity) (#1)					
Low	X				
Moderate		X			
Moderate to High			X		
High				X	
Unstable/Significant New Problem Requiring Immediate Physician Attention					X
Counseling (#2) See E/M Guidelines					
Coordination of Care (#3) See E/M Guidelines					
Typical Time (#4)					
Minutes	20	30	45	60	75

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

Patient: Established

Required Components: 2/3

Code	99334	99335	99336	99337
REQUIRED KEY COMPONENTS				
History and Examination (#1 and #2)				
Problem-Focused	X			
Expanded Problem-Focused		X		
Detailed			X	
Comprehensive				X
Medical Decision Making (Complexity) (#3)				
Straightforward	X			
Low		X		
Moderate			X	
Moderate to High				X
CONTRIBUTORY FACTORS				
Presenting Problem (Severity) (#1)				
Self-limited or Minor	X			
Low to Moderate		X		
Moderate to High			X	
Moderate to High/Unstable/ Significant New Problem				X
Counseling (#2) See E/M Guidelines				
Coordination of Care (#3) See E/M Guidelines				
Typical Time (#4)				
Minutes	15	25	40	60

Office/Outpatient 2022

Patient: New				
Code	**99202**	**99203**	**99204**	**99205**
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 (Range)	15-29	30-44	45-59	60-74

Patient: Established					
Code	**99211**	**99212**	**99213**	**99214**	**99215**
REQUIRED ELEMENTS					
Medically Appropriate History and/or Examination	N/A	X	X	X	X
Medical Decision Making Level					
Straightforward	N/A	X			
Low			X		
Moderate				X	
High					X
OR					
Total Time (On Date of the Encounter)					
Minutes (Range)	N/A	10-19	20-29	30-39	40-54

Guiding Principles: E/M Workgroup & CPT® Editorial Panel

The CPT/RUC Workgroup on E/M expanded the scope of their work to include the other E/M families of services to reduce the burden of having two separate sets of E/M Guidelines in the CPT code set.

The Workgroup continued their work by following their existing **guiding principles** related to the group's ongoing work product:

- To decrease administrative burden of documentation and coding, and align CPT and CMS whenever possible
- To decrease the need for audits
- To decrease unnecessary documentation in the medical record that is not needed for patient care
- To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

From 8/9/2022 Webinar, Prestesater L, Levy, B, Hollmann P. "E/M 2023: Advancing Landmark Revisions Across More Settings of Care," downloaded on 10/2/2022 from https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

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.**

- Extensive clarifications in the guidelines to define the elements of MDM
- *Total* time spent on the date of the encounter
  - Including non-face-to-face services
  - Clearer time ranges for each code
- Addition of a shorter 15-minute prolonged service add-on code (99417)
  - To be reported only when the minimum time **required when coding based on time for 99205 or 99215** has been exceeded by 15 minutes

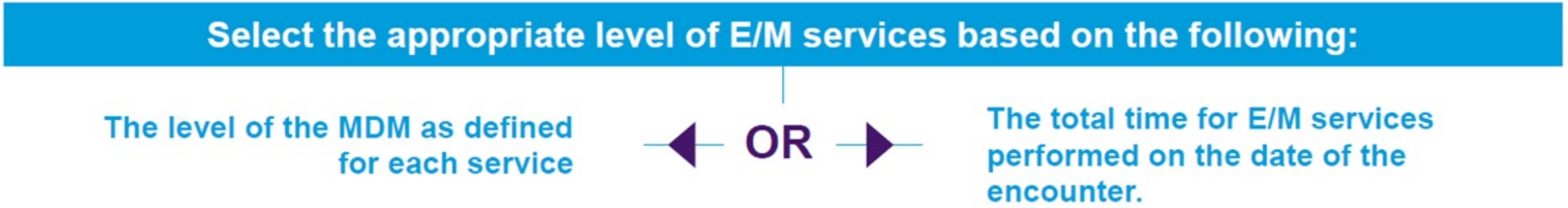
From 8/9/2022 Webinar, Prestesater L, Levy, B, Hollmann P. "E/M 2023: Advancing Landmark Revisions Across More Settings of Care," downloaded on 10/2/2022 from https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

Overview of 2023 E&M Revisions

- E&M Introductory Guidelines- Update and consolidation
- Nursing Facility Services—Deleted 99318; Revised descriptors
- Domiciliary, Rest Home or Custodial Care Services (Used for Assisted Living)—deleted and merged into Home or Residence Services
- Home or Residence Services—Revised to integrate Assisted Living and any residence
- Prolonged Services—CPT Devised new codes, but CMS has substituted ‘G’ codes
- Hospital Inpatient and Observation Services—Merged and revised descriptors

Revision of the Remaining E&M Services

- Nursing Facility Services
- Home and Residence Services
- Hospital Inpatient and Observation Services



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Tip for Accurate Coding
Know Revised Nursing Facility E&M

2022

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- **An expanded problem focused interval history;**
- **An expanded problem focused examination;**
- **Medical decision making of low complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

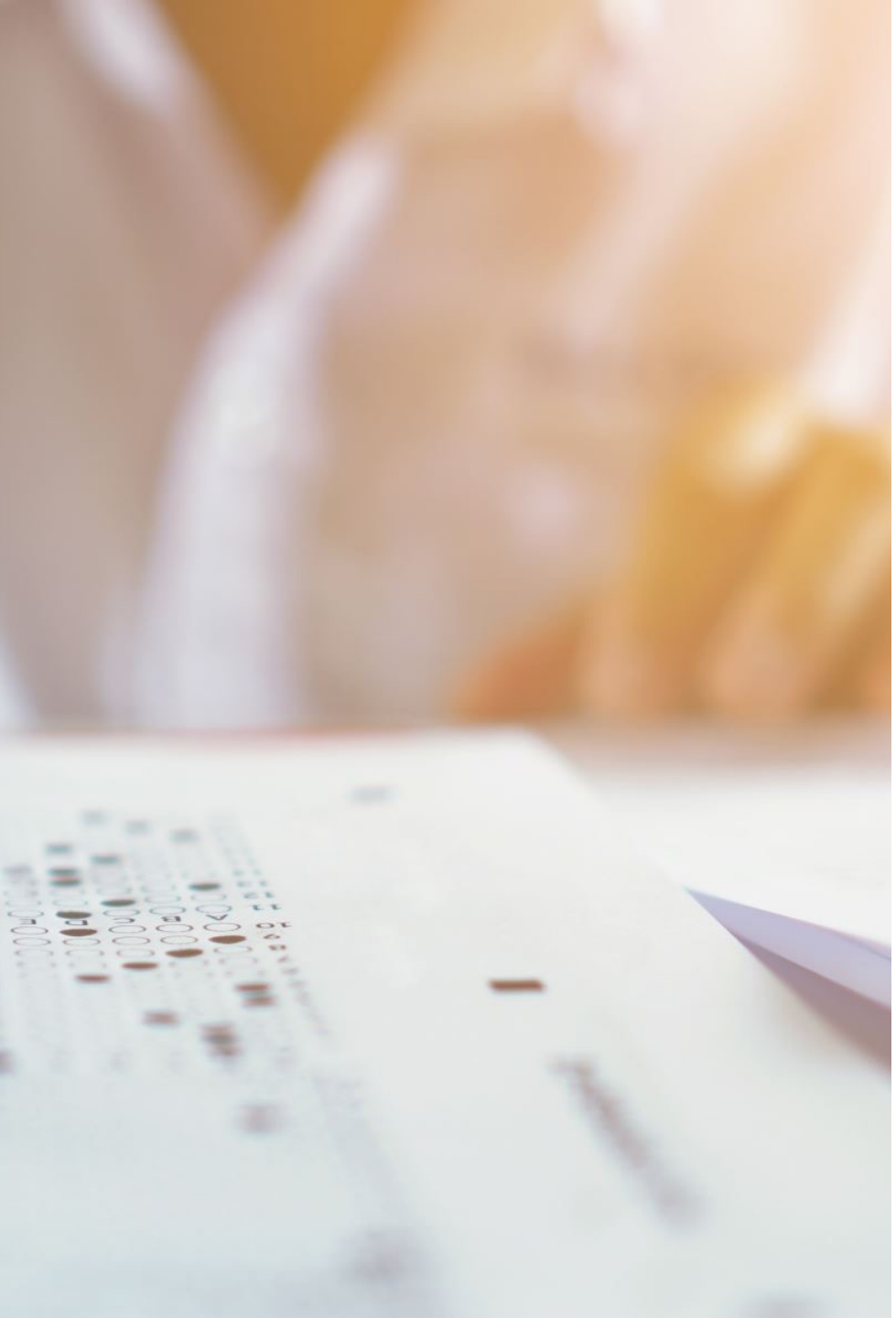
Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.

2023

99308 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

Note that when using time for code selection, it is the total time spent, not the "typical time" indicated in prior editions, that determines code selection



History and Physical Examination

- Must be performed and documented if clinically appropriate
- No longer need to document gratuitous reviews of systems for the purpose of submission of claims unless performed or reviewed when clinically appropriate
- The extent of history and physical examination is no longer an element in the selection of the level of E&M service codes

Time

- Total time on the date of the encounter, NOT “Typical time” as in 2022 code descriptors
- To select the level based on 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
- Includes time regardless of location
- Since only a single E&M Hospital/Observation service may be reported per day, total time = cumulative time of all encounters that day
- Do not count time spent on:
  - Travel
  - Teaching that is general and not limited to discussion that is required for the management of a specific patient
  - The performance of other services that are reported separately

Medical Decision Making in 2022

Office/Outpatient Codes	All Other E&M Codes (including Hospital/Inpatient, Obs, Nursing Facility, etc.)
Number and Complexity of Problems Addressed at the Encounter	Number of Diagnoses or Management Options
Amount and/or complexity of Data to be Reviewed and Analyzed	Amount and/or Complexity of Data to be Reviewed
Risk of Complications and/or Morbidity or Mortality of Patient Management	Risk of Complications and/or Morbidity or Mortality

Medical Decision-Making Tables in 2022

For Office/Outpatient (CPT Manual)

Evaluation and Management (E/M) Services Guidelines CPT 2021

▸Table 2: Levels of Medical Decision Making (MDM)◂

▸Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: 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
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213	Low	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable, chronic illness; **or** • **1** acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 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**
99204 99214	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

For All Other E&M Services (CMS Guidelines)

Evaluation and Management Services Guide — MLN Booklet

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (for example, lump in breast) • Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (for example, head injury with brief loss of consciousness)	• Physiologic tests under stress (for example, cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors (for example, arteriogram, cardiac catheterization) • Obtain fluid from body cavity (for example, lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation

Table 5 (cont.): Table of Risk

Medical Decision-Making Tables in 2023?

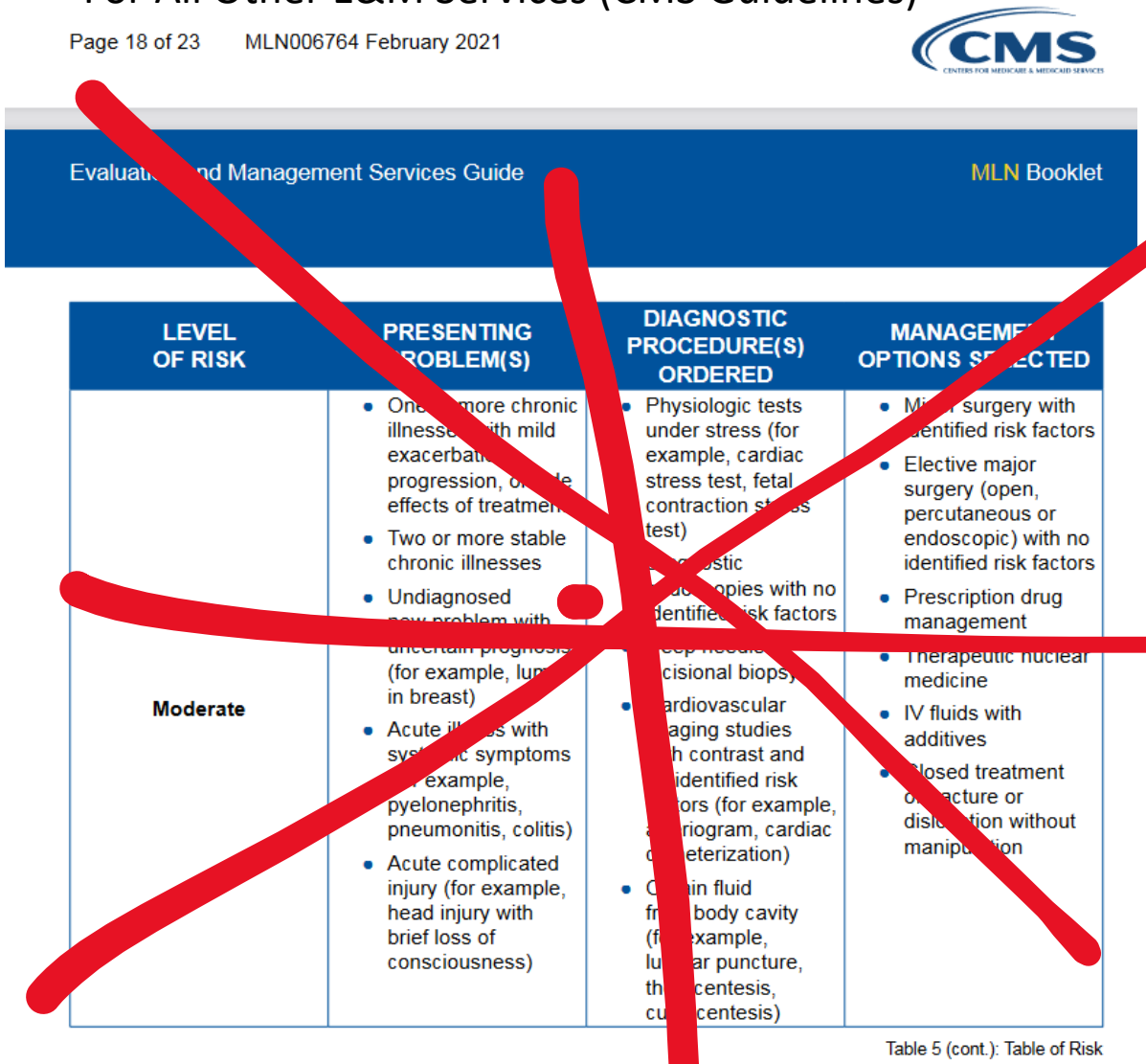
For Office/Outpatient (CPT Manual)

Evaluation and Management (E/M) Services Guidelines CPT 2021

Table 2: Levels of Medical Decision Making (MDM)

		Elements of Medical Decision Making		
▶Code	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
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213	Low	**Low** • 2 or more self-limited or minor problems; **or** • 1 stable, chronic illness; **or** • 1 acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 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**
99204 99214	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

For All Other E&M Services (CMS Guidelines)



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Evaluation and Management Services Guide — MLN Booklet

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Moderate	• One or more chronic illness with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (for example, lump in breast) • Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (for example, head injury with brief loss of consciousness)	• Physiologic tests under stress (for example, cardiac stress test, fetal contraction stress test) • Diagnostic imaging studies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors (for example, arteriogram, cardiac catheterization) • Obtain fluid from body cavity (for example, lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with no identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation

Table 5 (cont.): Table of Risk

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

Why learn MDM when I can use time?

HCPCS Code	Short Description	Total Time in Min.	Medical Decision-Making Level	Price (2022)
99304	Nursing facility care init	25	Straightforward or Low	$88.94
99305	Nursing facility care init	35	Moderate	$128.39
99306	Nursing facility care init	45	High	$164.73
99307	Nursing fac care subseq	10	Straightforward	$43.60
99308	Nursing fac care subseq	15	Low	$68.87
99309	Nursing fac care subseq	30	Moderate	$90.67
99310	Nursing fac care subseq	45	High	$133.58

▶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**

▶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

▶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◀

Additional 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."

Nursing Facility Care 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

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

NOTE: As of 2023, 99318 Annual Nursing Facility Assessment is deleted.

What about 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)◄

Home *and* Assisted Living Facility Care 2023

"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

Prolonged Services

Prolonged Services CPT Changes for 2023

99354-99357 Prolonged Service with Direct Patient Contact deleted

99417 Remains for Outpatient/Office Services (but not recognized by CMS, which requires G2212)

- May be used with Home or Residence Services
- May be used with Cognitive Assessment and Care Plan Services
- May be used with Office Consultation Services

99418 Prolonged Service with or without Direct Patient Contact in Inpatient Setting—NEW!

99358-99359 Non-face-to-face Prolonged Service revised to be consistent with CMS payment rules

However, hot off the press: The CY 2023 Physician Fee Schedule Final Rule

- Finalized the proposal to create 3 “G” codes for prolonged services
  - G0316 Prolonged Hospital or Observation Services
  - G0317 Prolonged Nursing Home Services
  - G0318 Prolonged Home or Residence Services
- Finalized the proposal to convert Non-face-to-face prolonged service codes 99358-99359 to status “I,” i.e. “Not valid for Medicare purposes” or “Ineligible.”
- Clarified the time horizon for nursing home codes
- Established the use of G0317 for Prolonged Nursing Home Services

https://www.cms.gov/files/document/cy2023-physician-fee-schedule-final-rule-cms-1770f.pdf

OK—Follow me on this…

- When the nursing facility visit codes were resurveyed by the RUC, the survey time included the day before, the day of, and up to and including 3 days post the date of service
- Therefore, CMS concluded that reporting 99358-99359 on any of those days would essentially be duplicative reporting
- Thus, they finalized the proposal to convert to "I" status*:
  - 99358-99359 Prolonged evaluation and management service before and/or after direct patient care
  - 99418 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact
- Ultimately finalizing G0317

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

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)*

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
  - 99310 Subsequent nursing facility care, per day, 45 minutes must be met or exceeded
- 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

G0318

- 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 99358, 99359, 99417).*
  - *(Do not report G0318 for any time unit less than 15 minutes).*

How to Use G0318

- Would be reportable when the total time for the **home or residence** visit (specified in the time file) is exceeded by 15 or more minutes
- Reportable as add on code to:
  - 99345 Home or residence visit for the evaluation of a new patient, 75 minutes must be met or exceeded
  - 99350 Home or residence visit for the evaluation of an established patient, 60 minutes must be met or exceeded
- May be reported for prolonged service(s) spent during:
  - The pre-service 3-days before the E&M visit
  - During the intraservice time on the day of the visit
  - The post-service time up to 7 days after the day of the visit

99418 Prolonged inpatient or observation services

(replaces deleted codes 99354-99357 in 2023)

99418 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required 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 inpatient and observation **Evaluation and Management** service)

CPT Changes: An Insider's View 2023

►(Use 99418 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310)◄

►(Do not report 99418 on the same date of service as 90833, 90836, 90838, 99358, 99359)◄

►(Do not report 99418 for any time unit less than 15 minutes)◄

Note: To be used for both Hospital and Nursing Facility Services

99418 Prolonged inpatient or observation services

(replaces deleted codes 99354-99357 in 2023)

99418 Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required 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 inpatient and observation **Evaluation and Management** service)

CPT Changes: An Insider's View 2023

►(Use 99418 in conjunction with 99223, 99233, 99236, 99255, 99316, 99310)◄

►(Do not report 99418 on the same date of service as 90833, 90836, 90838, 99358, 99359)◄

►(Do not report 99418 for any time unit less than 15 minutes)◄

Note: To be used for both Hospital and Nursing Facility Services

G0316

- 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 99358, 99359, 993X0).*
- *(Do not report G0316 for any time unit less than 15 minutes)*

Time Thresholds to Report Prolonged E&M Services

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.

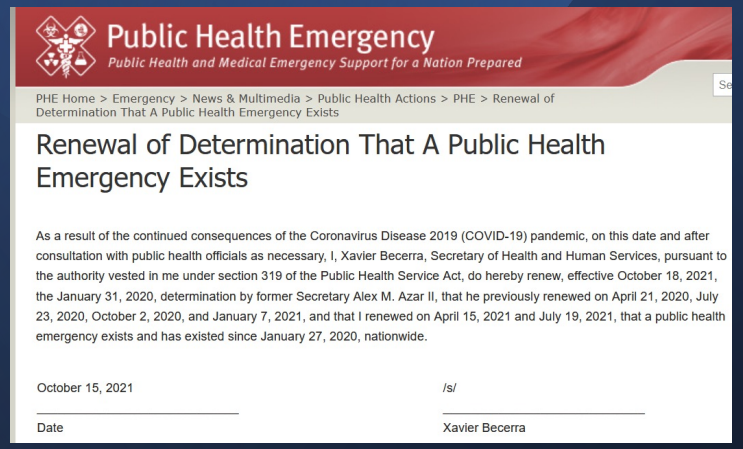
https://www.cms.gov/files/document/cy2023-physician-fee-schedule-final-rule-cms-1770f.pdf

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

Public Health Emergency Waivers

Public Health Emergency Waivers


Public Health Emergency
Public Health and Medical Emergency Support for a Nation Prepared

PHE Home > Emergency > News & Multimedia > Public Health Actions > PHE > Renewal of Determination That A Public Health Emergency Exists

Renewal of Determination That A Public Health Emergency Exists

As a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic, on this date and after consultation with public health officials as necessary, I, Xavier Becerra, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective October 18, 2021, the January 31, 2020, determination by former Secretary Alex M. Azar II, that he previously renewed on April 21, 2020, July 23, 2020, October 2, 2020, and January 7, 2021, and that I renewed on April 15, 2021 and July 19, 2021, that a public health emergency exists and has existed since January 27, 2020, nationwide.

October 15, 2021 — Date

/s/ — Xavier Becerra

- HHS Secretary Xavier Berrera renewed the Public Health Emergency (PHE) declaration on October 13, 2022
- 60-day notice to be given if the PHE is ended
- In July, the House passed Advancing Telehealth Beyond COVID-19 Act of 2022 (HR 4040)
  - Extends telehealth waivers through the end of 2024
  - Has not yet passed the Senate

https://www.congress.gov/bill/117th-congress/house-bill/4040
https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVDI-15Oct21.aspx

A Timeline of Major Medicare Coverage Expansions of Telehealth

March 2020	March 2020	December 2020	November 2021	March 2022
Coronavirus Preparedness and Response Supplemental Appropriations Act provides waiver authority that significantly expands Medicare coverage of telehealth during public health emergency	Coronavirus Aid, Relief, and Economic Security (CARES) Act includes provisions that amend additional telehealth flexibilities in the Medicare program, such as allowing FQHCs and rural health centers to provide telehealth services to beneficiaries	Consolidated Appropriations Act of 2021 permanently expands Medicare coverage of telehealth for mental health services, allows audio-only mental health telehealth services, allows beneficiary to use telehealth services in their home, and requires in-person exam	2022 Physician Fee Schedule Final Rule extends payment for a subset of expanded telehealth services through December 2023 (or the year the public health emergency ends) to give CMS and stakeholders time to evaluate whether services should be included permanently	Consolidated Appropriations Act of 2022, extends telehealth flexibilities that were tied to the public health emergency for an additional 5 months (151 days) after the end of the public health emergency

KFF

https://www.kff.org/medicare/issue-brief/faqs-on-medicare-coverage-of-telehealth/

Eligible Telehealth Services

- Nursing facility visits, New and Established, and nursing facility discharge day management (CPT codes 99304-99310; CPT codes 99315-99316)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99324- 99328; CPT codes 99334-99337)—Will be deleted in 2023
- Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350)—Includes Assisted Living Facilities as of 1/1/2023
- Transitional Care Management Services (99495-99496)—For the F2F visit
- Annual Wellness Visit (PPPS) (G0438-G0439)- May be done by audio-only
- New and Established Office/Outpatient Services (99201-99215)
- Advance Care Planning (99497-99498)-May be done by audio-only
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)

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

List of Medicare Telehealth Services Updated November 1, 2022

Code	Short Descriptor	Status
99304	Nursing facility care init*	Temporary Addition for the PHE; Expires with PHE plus 151 days
99305	Nursing facility care init*	Temporary Addition for the PHE; Expires with PHE plus 151 days
99306	Nursing facility care init*	Temporary Addition for the PHE; Expires with PHE plus 151 days
99307	Nursing fac care subseq*	
99308	Nursing fac care subseq*	
99309	Nursing fac care subseq*	
99310	Nursing fac care subseq*	
99315	Nursing fac discharge day*	Available Through December 31, 2023
99316	Nursing fac discharge day*	Available Through December 31, 2023

*Since January 1, 2021, the limit for nursing facility services is one telehealth visit every 14 days

NOTE: subsequent nursing facility care services reported for a Federally-mandated periodic visit under 42 CFR 483.40(c) may not be furnished through telehealth

List of Medicare Telehealth Services Updated November 1, 2022

Code	Short Descriptor	Status
99341	Home visit new patient	Temporary Addition for the PHE; Expires with PHE plus 151 days
99342	Home visit new patient	Temporary Addition for the PHE; Expires with PHE plus 151 days
99344	Home visit new patient	Temporary Addition for the PHE; Expires with PHE plus 151 days
99345	Home visit new patient	Temporary Addition for the PHE; Expires with PHE plus 151 days
99347	Home visit est patient	
99348	Home visit est patient	
99349	Home visit est patient	Available Through December 31, 2023
99350	Home visit est patient	Available Through December 31, 2023

NOTE: 99343 Home visit new patient has been deleted for 2023

Services Finalized for Permanent Addition to the Medicare Telehealth Services List on a Category 1 Basis, effective January 1, 2023

HCPCS Code	Short Descriptor
G0316	Prolonged inpatient or observation services by physician or other qualified health professional (QHP)
G0317	Prolonged nursing facility service by physician or other QHP
G0318	Prolonged home or residence services by physician or other QHP
G3002	Chronic pain treatment monthly bundle, first 30 minutes per calendar month
G3003	Additional 15 minutes pain management

Place of Service (POS) Code - Telehealth

- Telehealth services *usually* submitted under POS 02
- Under the interim guidance telehealth services that would have been previously provided in person should be submitted under the same POS as if they were in person, therefore 31 SNF or 32 NF
- Practitioners should submit the E/M code that best describes the nature of the service they are providing
- Medicare in April 6, 2020 rule: Use Modifier -95 to identify as telehealth services

Telehealth Originating Site Facility Fee

- Nursing facilities can submit a claim for the Originating Site Facility Fee
- Reported under HCPCS code Q3014
- Bill their A/B/MAC (A) for the originating site facility fee using TOB 22X or 23X
- For Part A SNF patients, submit on 22X TOB
- All SNFs use revenue code 078X and must submit on a separate line from all other services
- Fee ~ $20@

Telephone Services (2022 Prices)

HCPCS Code	Short Description	Non-Facility Price	Facility Price	Work RVU
99441	Phone e/m phys/qhp 5-10 min	$56.75	$35.99	0.70
99442	Phone e/m phys/qhp 11-20 min	$91.71	$67.14	1.30
99443	Phone e/m phys/qhp 21-30 min	$129.77	$98.97	1.92
99213	Office O/P est low 20-29 min	$92.05	$67.48	2.30
99308	Nursing fac care subseq	$68.87	$68.87	1.16

CY=Calendar year; F=Facility; NF=Non-facility

Note: During the Public Health Emergency, CMS has equated the Telephone E/M services to the analogous **Office/Outpatient Services**

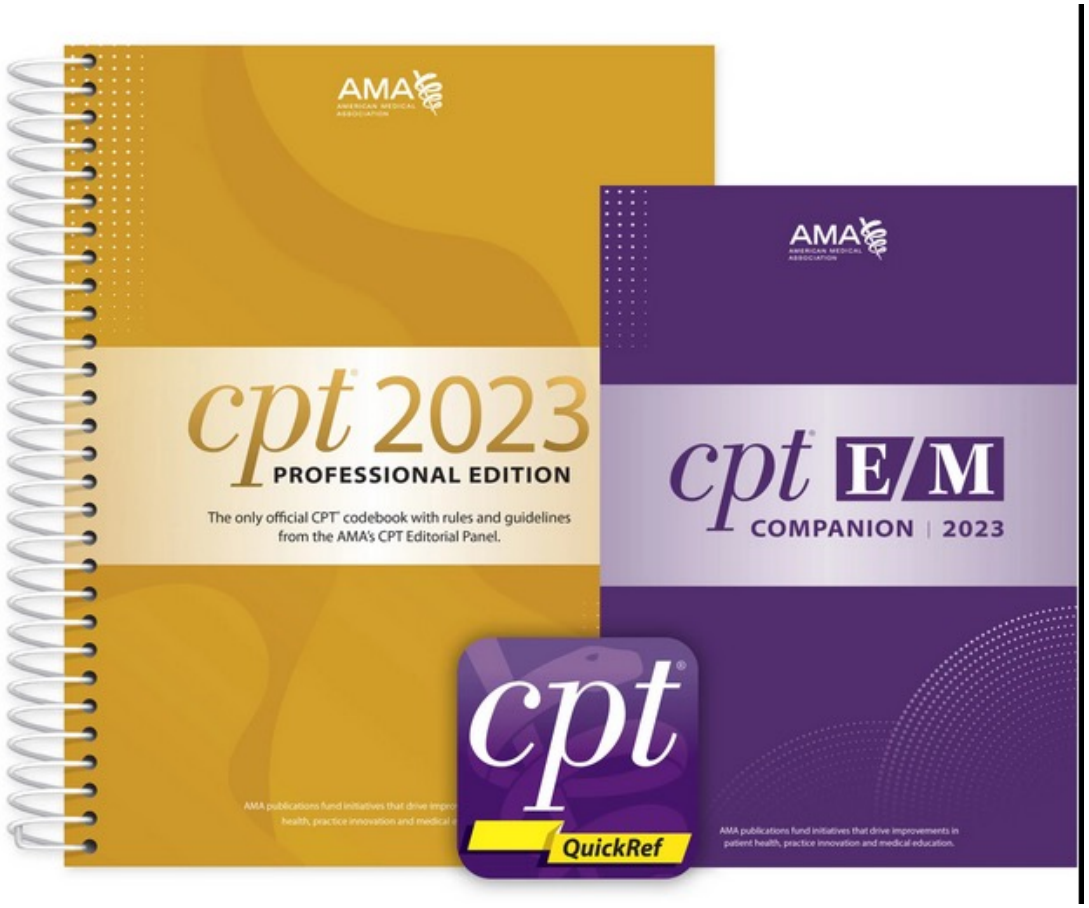
Services to be Removed from the Medicare Telehealth Services List After 151 Days Following End of the PHE

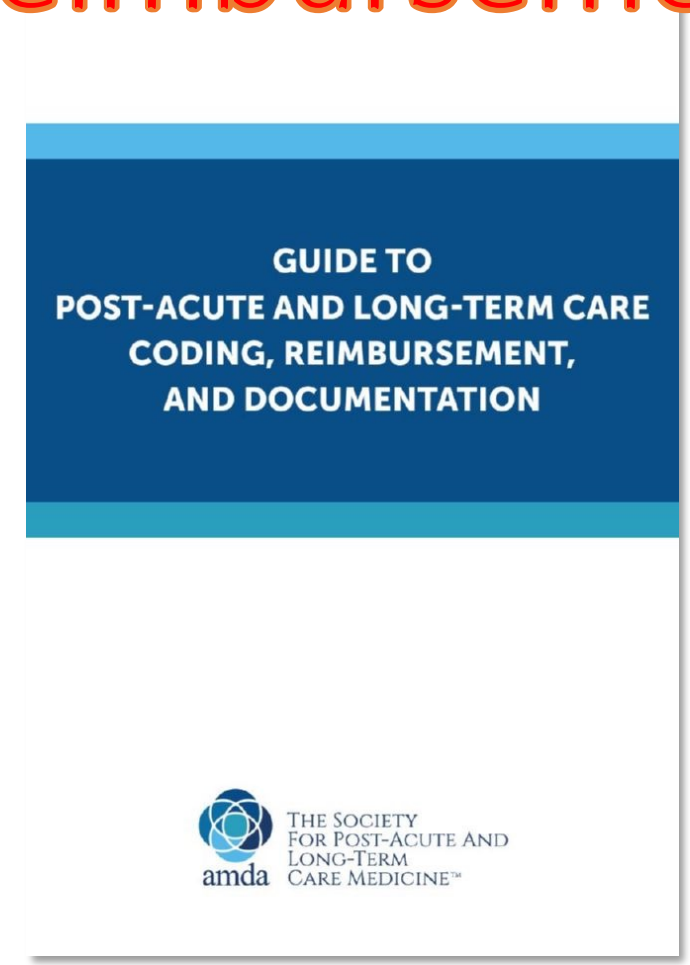
HCPCS/CPT	Short descriptor
99218	Initial observation care
99219	Initial observation care
99220	Initial observation care
99221	Initial hospital care
99222	Initial hospital care
99223	Initial hospital care
99234	Observ/hosp same date
99235	Observ/hosp same date
99236	Observ/hosp same date
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init

HCPCS/CPT	Short descriptor
99324	Domicil/r-home visit new pat (deleted from the PFS for CY 2023)
99325	Domicil/r-home visit new pat (deleted from the PFS for CY 2023)
99326	Domicil/r-home visit new pat (deleted from the PFS for CY 2023)
99327	Domicil/r-home visit new pat (deleted from the PFS for CY 2023)
99328	Domicil/r-home visit new pat (deleted from the PFS for CY 2023)
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient (deleted from the PFS for CY 2023)
99344	Home visit new patient
99345	Home visit new patient
99441	Phone e/m phys/qhp 5-10 min
99442	Phone e/m phys/qhp 11-20 min
99443	Phone e/m phys/qhp 21-30 min

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

#1 Tip for Accurate Coding
Know your codes and reimbursement!





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

Payment: Fun Facts to Know and Tell

What Visits Does CMS Reimburse in SNF/NF?

- Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial federally mandated visit by the physician or qualified NPP where permitted, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.
- Subsequent Nursing Facility Care, per day, (99307 - 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.
- E/M visits, prior to and after the initial federally mandated physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.
- Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes.

–Medicare Claims Processing Manual, Chapter 12, Section 30.6.13B

What is a medically necessary visit?

- “Medically necessary 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.”
- “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.”—CMS at https://www.cms.gov/apps/glossary/search.asp?Term=medically+necessary&Language=English&SubmitTermSrch=Search
- “Medical necessity of a service is 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.”

Medicare Claims Processing Manual, Chapter 12, Physicians/Non-physician Practitioners

In other words

The visit must be medically necessary AND

The level of service reported must be medically necessary

THEREFORE:

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

“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.**

"Regulatory" Physician Visits: Contents

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.

--State Operations Manual; Appendix PP—Guidance to Surveyors, page 445. Downloaded on 10/11/2022 from: https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf

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

“Regulatory” Physician Visits: Contents

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.**

The Initial Nursing Facility Visit

- The federally mandated visits in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4) and (f)).
- The principal physician of record must append the modifier "-AI", (Principal Physician of Record), to the initial nursing facility care code. This modifier will identify the physician who oversees the patient's care from other physicians who may be furnishing specialty care.
- All other physicians **or qualified NPPs** who perform an initial evaluation in the NF or SNF may bill the initial nursing facility care code.
- The initial federally mandated visit is defined in S&C-04-08 (see: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter04-08.pdf) as the initial comprehensive visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the nursing facility resident.
- A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.
- For Survey and Certification requirements, a visit must occur no later than 30 days after admission.

Medicare Claims Processing Manual, Chapter 12, Physicians/Non-physician Practitioners

Authority for Non-physician Practitioners to Perform Visits, Sign Orders and Sign Medicare Part A Certifications/Re-certifications 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

*A NPP may provide admission orders if a physician personally approved in writing a recommendation for admission to the facility prior to admission. For additional requirements on physician recommendation for admission and admission orders, see §483.30(a), F710.

^Other required visits are the physician visits required by §483.30(c)(1) other than the initial comprehensive visit.

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

±Though not part of a compliance determination for this section, this requirement is provided for clarification and relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.

Discharge from SNF/NF

- Medicare Part B payment policy requires a face-to-face visit with the patient provided by the physician or the qualified NPP to meet the SNF/NF discharge day management service as defined by the CPT code.
- The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date.
- The Discharge Day Management Service may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.

Medicare Claims Policy Manual, Chapter 12, Section 30.6.13

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 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

Split Visits

Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	***2022 Definition of Substantive Portion***	***2023 Definition of Substantive Portion***
*Other Outpatient**	*History, or exam, or MDM, or more than half of total time*	*More than half of total time*
Inpatient/Observation/ Hospital/SNF	*History, or exam, or MDM, or more than half of total time*	*More than half of total time*
Emergency Department	*History, or exam, or MDM, or more than half of total time*	*More than half of total time*
Critical Care	*More than half of total time*	*More than half of total time*

Acronyms: E/M (Evaluation and Management), MDM (medical decision-making), SNF (Skilled Nursing Facility)

**Office visits are not billable as split (or shared) services.*

- ***30.6.18 - Split (or Shared) Visits***

NOTE: In the Final Rule, released on 11/1/2022, CMS finalized its proposal to postpone revision of the change to split visits for 1 year

Medicare Claims Policy Manual, Chapter 12,

Split Visits

Reporting Prolonged Services for Split (or Shared) Visits

E/M Visit Code Family	*2022*		*2023*
	If Substantive Portion is a Key Component…	***If Substantive Portion is Time…***	***Substantive Portion Must Be Time***
*Other Outpatient**	*Combined time of both practitioners must meet the threshold for reporting HCPCS G2212*	*Combined time of both practitioners must meet the threshold for reporting HCPCS G2212*	*Combined time of both practitioners must meet the threshold for reporting HCPCS G2212*
Inpatient/Observation/Hospital/SNF	*Combined time of both practitioners must meet the threshold for reporting CPT 99354-9 (60+ minutes > typical)*	*Combined time of both practitioners must meet the threshold for reporting CPT 99354-9 (60+ minutes > typical)*	*Combined time of both practitioners must meet the threshold for reporting prolonged services*
Emergency Department	*N/A*	*N/A*	*N/A*
Critical Care	*N/A*	*N/A*	*N/A*

Acronyms: E/M (Evaluation and Management); SNF (Skilled Nursing Facility)
**Office visits are not billable as split (or shared) services.*

Medicare Claims Policy Manual, Chapter 12,

- ***30.6.18 - Split (or Shared) Visits***

NOTE: In the Final Rule, released on 11/1/2022, CMS finalized its proposal to postpone revision of the change to split visits for 1 year

Physicians in Group Practice

- Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.
- If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems.
- Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.
- Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group.

Medicare Claims Policy Manual, Chapter 12, Section 30.6.5

Advance Care Planning (ACP)

Tip for Accurate Coding: Advance Care Planning

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)

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
- May be used for POLST-paradigm, though technically not ACP
- Bad news: recent article casts doubt on ACP
  - Morrison RS, Meier DE, Arnold RM. What's Wrong With Advance Care Planning? JAMA. 2021 Oct 8. doi: 10.1001/jama.2021.16430. Epub ahead of print. PMID: 34623373

National Rates 2022

Code	Short Description/ CMS Posted Typical Time(s)	2022 NF MPFS National Rate	2022 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

During COVID-19 pandemic, reimbursement will be the same if performed via telehealth or audio-only

Medicare Wellness Visits

Tip for Accurate coding:
Incorporate the Annual Wellness Visit into your Practice!

Medicare Physical Exams Coverage

Initial Preventive Physical Exam (IPPE)

Review of medical and social health history and preventive services education

✓ **Covered** only once within 12 months of first Part B enrollment

✓ Patient pays nothing (if provider accepts assignment)

"Welcome to Medicare Visit"

Annual Wellness Visit (AWV)

Visit to develop or update a Personalized Prevention Plan (PPP) and perform a Health Risk Assessment (HRA)

✓ **Covered** once every 12 months

✓ Patient pays nothing (if provider accepts assignment)

Note: See components of AWV in the appendix

Routine Physical Exam

Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury

✗ **Not covered** by Medicare; prohibited by statute, however, the IPPE, AWV, or other Medicare benefits cover some elements of a routine physical

✗ Patient pays 100% out-of-pocket

Note: Components of Wellness Exams may not be goal-concordant with frail, elderly nursing home residents

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

How do the AWV and Annual NH Assessment Differ?

COMPONENT	Annual Wellness Exam (G0438-G0439)	Annual NH Assessment (99318)
Health Risk Assessment[1]	Required	Not explicitly required[4]
Age and Gender Appropriate History	Required[2]	Required: Detailed
Physical Examination	Not required	Required: Comprehensive
Medical Decision Making	Not required	Required: Low to Mod
List of Current Providers and Suppliers	Required	Not required
Cognitive Assessment	Required	Not explicitly required[4]
Functional/Safety Assessment	Required	Not explicitly required[4]
Written Screening Schedule	Required	Not required
List of Risk Factors/Interventions	Required	Not explicitly required[4]
Advance Care Planning	At beneficiary's	At beneficiary's discretion
Measurements (Height, Weight, Body Mass Index [BMI], BP, etc.)	Required	See physical examination
Ordering of Lab/Diagnostic Procedures	Not required[3]	Not required

99318 Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components:

- **A detailed interval history;**
- **A comprehensive examination; and**
- **Medical decision making that is of low to moderate complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.

CPT Changes: An Insider's View 2006, 2008, 2010, 2013

CPT Assistant Jan 11:3, Jan 12:3, Jan 13:9, Jun 13:3, Nov 14:14

(Do not report 99318 on the same date of service as nursing facility services codes 99304-99316)

99318 Annual Nursing Facility Assessment to be deleted in 2023!

[1]Includes demographic data, self-assessment of health status, psychosocial risks, behavioral risks, Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)

[2]Includes family history, past medical and surgical history, medications and opioid use

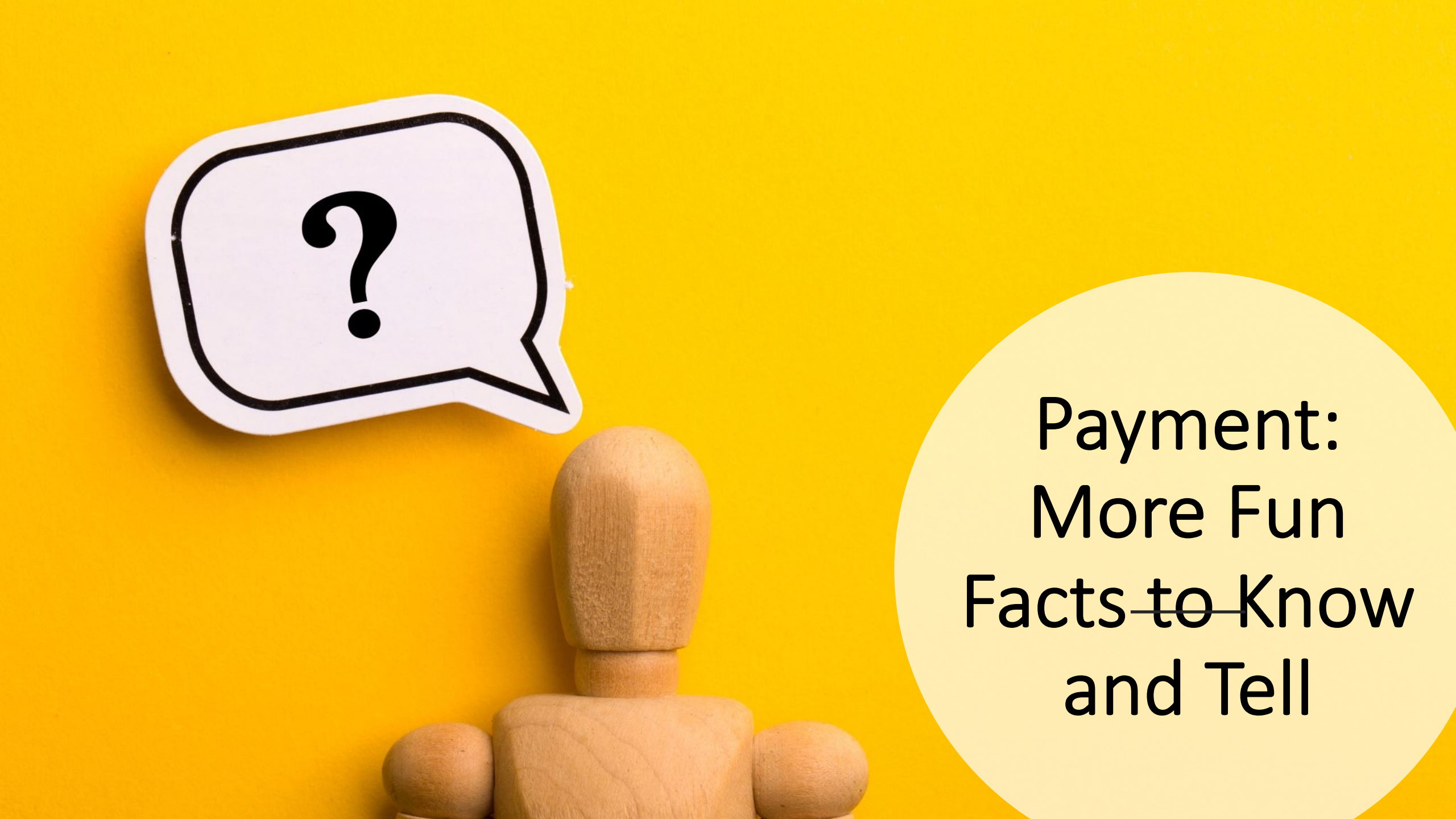
[3]Additional Part B preventive services may be added as indicated

[4]May be recommended by evidence-based guidelines, eg. United States Preventive Services Task Force (USPTF) Recommendations

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

Options for Annual Nursing Home Resident Assessment

CPT/HCPCS Code	Service	wRVU	Non-Facility Price, National (2022)	Comments
G0402	Welcome to Medicare Visit	2.6	$169.57	Officially: “Initial Preventive Physical Examination” (IPPE)
G0438	Annual Wellness Visit, Initial	2.6	$169.57	Officially: “Personalized Prevention Plan of Service,” Initial visit
G0439	Annual Wellness Visit, Subsequent	1.92	$132.54	Officially: “Personalized Prevention Plan of Service”, Subsequent visit
99318	Annual Nursing Facility Assessment	1.71	$95.17	Requires detailed history, comprehensive exam, low-mod MDM (Deleted for 2023)
99385-99387	Preventive Medicine Services: age 18+, New	N/A	N/A	Not reimbursed by CMS (but may be reimbursed by other payers)
99395-99397	Preventive Medicine Services: age 18+, Est.	N/A	N/A	Not Reimbursed by CMS (but may be reimbursed by other payers)



Payment: More Fun Facts ~~to~~ Know and Tell

Consultation Services

- Consultation codes are not recognized by CMS For Part B Medicare payment
- In the inpatient hospital setting and the nursing facility setting, physicians (and qualified nonphysician practitioners where permitted) may bill the most appropriate initial hospital care code (99221-99223), subsequent hospital care code (99231 and 99232), initial nursing facility care code (99304-99306), or subsequent nursing facility care code (99307-99310) that reflects the services the physician or practitioner furnished.
- The principal physician of record shall append modifier “-AI” (Principal Physician of Record), in addition to the E/M code.

Emergency Department or Office/Outpatient Visits on Same Day As Nursing Facility Admission

Emergency department visit provided on the same day as a comprehensive nursing facility assessment are not paid. Payment for evaluation and management services on the same date provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date as the nursing facility admission.

Medicare Claims Policy Manual, Chapter 12, section 30.6.11

What if you are asked to see a patient in the ED?

- If the patient is admitted to the hospital by the patient's personal physician, then the patient's regular physician should bill only the appropriate level of the initial hospital care (codes 99221 - 99223)
- If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service.
- The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department.

Medicare Claims Policy Manual, Chapter 12, section 30.6.11

Observation Services

- Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient's observation services began.
- All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.
- For example, if an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial and subsequent observation care codes. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate.
- When a patient receives observation care for less than 8 hours on the same calendar date, the Initial Observation Care, from CPT code range 99218 - 99220, shall be reported by the physician. The Observation Care Discharge Service, CPT code 99217, shall not be reported for this scenario.

Medicare Claims Policy Manual, Chapter 12, Section 30.6.8

100.1 - Payment for Physician Services in Teaching Settings Under the MPFS

Pursuant to 42 CFR 415.170, services furnished in teaching settings are paid under the physician fee schedule if the services are:

- Personally furnished by a physician who is not a resident;
- Furnished by a resident where a teaching physician was physically present during the critical or key portions of the service; or
- Certain E/M services furnished by a resident under the conditions contained in §100.01.C.

Medicare Claims Policy Manual, Chapter 12,

100.1 - Payment for Physician Services in Teaching Settings Under the MPFS

For purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

- That the teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and

- The participation of the teaching physician in the management of the patient.

- The presence of the teaching physician during E/M services may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

Medicare Claims Policy Manual, Chapter 12,

Questions?

Appendix

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Nursing Home Codes and Telehealth Time

Code	Short Descriptor	Status
99304	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic
99305	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic
99306	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic
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 through Dec. 31, 2023
99316	Nursing fac discharge day	Available through Dec. 31, 2023

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

Domiciliary / Rest Home and Telehealth

Code	Short Descriptor	Status
99324	Domicil/r-home visit new pat	Temporary Addition for COVID-19 PHE-Deleted eff. 1/1/2023
99325	Domicil/r-home visit new pat	Temporary Addition for COVID-19 PHE-Deleted eff. 1/1/2023
99326	Domicil/r-home visit new pat	Temporary Addition for COVID-19 PHE-Deleted eff. 1/1/2023
99327	Domicil/r-home visit new pat	Temporary Addition for COVID-19 PHE-Deleted eff. 1/1/2023
99328	Domicil/r-home visit new pat	Temporary Addition for COVID-19 PHE-Deleted eff. 1/1/2023
99334	Domicil/r-home visit est pat	Permanent –Deleted eff. 1/1/2023
99335	Domicil/r-home visit est pat	Permanent—Deleted eff. 1/1/2023
99336	Domicil/r-home visit est pat	Temporary Addition for COVID-19 PHE-Deleted eff. 1/1/2023
99337	Domicil/r-home visit est pat	Temporary Addition for COVID-19 PHE-Deleted eff. 1/1/2023

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

Home Care Codes and Telehealth Time

Code	Short Descriptor	Status
99341	Home visit new patient	Temporary Addition COVID-19 Pandemic PHE
99342	Home visit new patient	Temporary Addition for COVID-19 PHE
99343	Home visit new patient	Temporary Addition for COVID-19 PHE
99344	Home visit new patient	Temporary Addition for COVID-19 PHE
99345	Home visit new patient	Temporary Addition for COVID-19 PHE
99347	Home visit est patient	Permanent
99348	Home visit est patient	Permanent
99349	Home visit est patient	Available through December 31, 2023
99350	Home visit est patient	Available through December 31, 2023

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

St. Louis University Annual Medicare Wellness Visit for Nursing Home Residents

SLU Annual Medicare Wellness Visit

Nursing Home _____

Name_____ DOB___/___/_____ Date___/___/_____

Vital Signs: Ht____Wt_____ B/P_____/____ Pulse_____ RR_____

Vaccinations:		Date
Influenza	Y / N	___/___/_____
Pneumococcus	Y / N	___/___/_____
Prevnar	Y / N	___/___/_____
Tetanus	Y / N	___/___/_____

		Date
Hepatitis B	Y / N	___/___/_____
Herpes Zoster	Y / N	___/___/_____
PPD	Y / N	___/___/_____

Active Diseases:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Medications:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

PHQ 9 _____ Hearing Impaired Y/ N
FRAIL _____ Cerumen impacted Y / N
FRAIL NH___ Vision Impaired Y / N
Pain Score____ Falls Y / N
SARC-F_____ Smoking Y/N
SNAQ _____ Weight Loss Y/N
RCS _____ Advance Directive Y / N

A Scale to Identify Frailty in the Nursing Home - FRAIL NH Scale

	0	1	2
Fatigue	No	Yes	PHQ-9 ≥10
Resistance (Transfer)	Independent Transfer	Set Up	Physical Help
Ambulation	Independent	Assistive Device	Not Able
Incontinence	None	Bladder	Bowel
Loss of Weight	None	≥5% in 3 mo.	≥10% in 6 mo.
Nutritional Approach	Regular Diet	Mechanically Altered	Feeding Tube
Help with Dressing	Independent	Set Up	Physical Help
Total			0-14

Assessment: Patient had annual wellness visit. Agree with findings. Pt is cognitively intact / impaired, not frail, not falling, not disabled. Pt and/or family counseled.
Recommendations:_____

Signature_____ G0439

Morley JE, Abele P. The Medicare Annual Wellness Visit in Nursing Homes. J Am Med Dir Assoc. 2016 Jul 1;17(7):567-9. doi: 10.1016/j.jamda.2016.05.008. PMID: 27346648.

Note: This recommended data may not completely meet the requirements for the AWV

REFERENCE MATERIALS

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=2ahUKEwjTy7DP3NP6AhW4lIkEHSZ-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

Name of Service	Where to find the information
Chronic Care Management Services	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3678CP.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
Non-Face-to-Face Prolonged Services (note: descriptor will be revised effective 1/1/2023)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9905.pdf
Care Management Services in Rural Areas	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

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	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 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

Other resources for Telehealth Services during the COVID-19 pandemic

- 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

Other resources for Telehealth and other Services during the COVID-19 Pandemic

- 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

Thank you!

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