

Documentation & Coding Handbook: Palliative Care

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Based on the 2019 current procedure terminology (CPT®¹) billing codes

¹ CPT is a registered trademark of the American Medical Association

Disclaimer

This content of this handbook was developed for palliative care physician services documentation and coding. All material is current as of February 24, 2019. Be aware that the Center for Medicare/Medicaid Services (CMS) will continue to issue new guidance throughout the year; Medicare makes changes to its bundling edits each calendar quarter. Make sure someone in your organization remains current for the services your physicians and other qualified health care professionals provide.

It is also important to note that these materials were created for 2019 specifically. CMS has finalized changes to Evaluation and Management Services effective January 1, 2021. Watch out for CMS to announce any changes to the documentation requirements and/or effective dates.

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The materials were prepared as a tool to assist providers in understanding professional fee documentation and coding for palliative care. Although every effort has been made to ensure the accuracy of the information, the ultimate responsibility for the use of this information lies with the user. Acevedo Consulting, Inc. does not accept responsibility or liability with regard to errors, omissions, misuse or misinterpretation.

Third-party payer interpretations of coding and billing rules and regulations can differ greatly. This handbook is intended to provide guidance and should not be relied upon for a payment guarantee. The information provided here is general information only, and the palliative care organization should consult with their Medicare Administrative Contractor (MAC) or other payer for specific reimbursement rules prior to implementing any billing processes or decision.

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Physician Services in Palliative Care

For the most part, and definitely in a fee-for-service environment, the services that palliative care clinicians can bill and be paid for are those professional services that fall in two main categories:

1. **Physician Services:** These include the “visits” or Evaluation & Management Services (E/M) that can be reimbursed when provided by a physician, nurse practitioner, clinical nurse specialist, or physician assistant (collectively, non-physician practitioners or “NPPs”). As discussed later, physician services have evolved to include certain care management services and advance care planning, but to understand what type of clinician/who can provide and bill for “physician services,” it’s safest to recognize it includes only those clinicians who can provide and bill E/M services. Physicians and NPPs are considered qualified health care professionals for this purpose, so, doctors, nurse practitioners, clinical nurse specialists and physician assistants.
2. **Mental Health Services:** This is the Medicare benefit category that clinical social workers fall within. Social workers’ services are not paid under the physician services benefit, consequently they cannot bill E/M codes. Most, if not all, Part B Medicare Administrative Contractors (MACs) have local coverage determinations (LCDs) in place that define the circumstances under which a social worker’s services may be reimbursable, and this is typically only when s/he is providing psychotherapy services.

If your palliative care program has a chaplain, volunteer or other type of caregiver, there is little if any opportunity for their services to be reimbursable in a fee-for-service environment. As our health care reimbursement system continues its move away from fee-for-service towards payment based more on a patient-centered approach, value and outcomes, expect this to change. California’s payers are already creating or open to creating severe illness management programs that bundle services and begin to open the door for the full complement of palliative care services.

For those hospices creating a palliative care program, you are well served if you consider the “program” as a physician practice. That is how the payers classify the program: a physician practice where the doctor and NPP specialty happens to be palliative medicine. There are no Conditions of Participation as found in hospice, however, the driving factor behind whether a service is payable is twofold, (1) is it medically necessary and (2) has it been provided by a qualified individual for the benefit category. If you take nothing else away from this handbook other than how important it is to document the medical necessity of your care-at every encounter-then this effort has accomplished something meaningful.

General Documentation Guidelines

We cannot stress enough the importance of adhering to these eight logical and simple guidelines:

1. Every encounter must contain a chief complaint or medical reason for the visit or other service. To be reimbursable, each service must be clearly documented as medically necessary. See discussion below regarding medical necessity.
2. Provide specific and descriptive documentation about what is going on with the patient, and why you are seeing the patient today. Be descriptive enough that someone who had not seen the patient could read the documentation and be well informed of the patient's current condition. Beware of copying and pasting from prior entries.
3. Be careful of scripted, non-specific documentation; e.g., "to discuss goals of care."
4. Notes must be signed and legible. Please keep this in mind if your notes are not dictated or in an electronic medical record (EMR).
5. The physician or NPP who saw the patient and created the note, should sign the documentation. Medicare and most payers require authentication by the author.
6. Your documentation must indicate the date of service and that a face-to-face encounter took place (unless a code is specifically described as non-face-to-face in the CPT[®] or HCPCS² book).
7. Document to the problem, not the code. EMRs may make it easy to carry prior information forward to "today's note." However, the volume of documentation should not be the main driver of code selection. For example, where a patient is relatively stable and was seen recently, there may be no medical necessity (from a payer's perspective) for another complete review of systems, yet how many systems queried about and documented can impact code selection.
8. Document the patient's location (home, skilled nursing facility (SNF), etc.) to help ensure that the right type of E/M code is reported on the claim.

² Healthcare Common Procedural Coding System – created and maintained by CMS

Documentation Requirements for E/M Services

The use of physician services in palliative care has increased dramatically in the last decade since the specialty was acknowledged by CMS³. At the same time, billing Medicare for physician services has become more challenging, especially as the patients being seen have more complex medical conditions and the importance of ICD-10-CM coding has grown.

Given this, it comes as no surprise that many organizations are struggling to bill—and code—correctly for these services. We will now review the all-important process of documentation—namely, how to substantiate physician services⁴ through proper documentation.

The overwhelming majority of physician services must be substantiated (i.e., justified) by the level of service provided (or complexity of the patient), as well as by the amount and type of documentation the physician/NPP generates. It is also important to understand that most physicians/NPPs do not receive any formal education on how to substantiate these services from a billing perspective. A word to management: Do not fall into the trap of thinking that because the clinician was in private practice, that they know how to code. And, even if they do understand coding, the nuances and philosophy of palliative care make it critical to educate on the payers' expectations and medical necessity.

There are seven components in CPT and the CMS's documentation guidelines for E/M Services:

1. History
2. Physical examination
3. Medical decision making
4. Nature of the presenting problem
5. Counseling
6. Coordination of care
7. Time

The first of these – history, physical examination and medical decision making – are considered the “Three Key Components.”

Payers utilize either CMS's 1995 or 1997 documentation guidelines to determine whether documentation supports the “level of service” billed—but there are some nuances in how the Medicare program and most other payers look at E/M services on medical review.

³ Centers for Medicare and Medicaid Services

⁴ “Physician services” is an actual Medicare benefit and includes visits, ACP, care management, and other services, but does not include social worker services, diagnostic tests, or other services which have their own benefit category.

Medical Necessity

There has been a recent push to remind physicians that even when a “complete” note is generated, only medically necessary services for the condition of the patient *at the time* of the encounter can be considered when selecting an appropriate level of E/M service. The Medicare Claims Processing Manual, Chapter 12, §30.6 addresses this as follows:

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 (E/M) 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. (30.6.1A)

Physicians/NPPs are of course entitled to the appropriate level of reimbursement for medically necessary services that are supported by documentation. However, information that is not pertinent to the patient’s condition at the time of the encounter should not be “counted” toward code selection. The push behind this “new” perspective is electronic medical records—specifically the software that facilitates carry-overs and “repetitive fill-ins” of stored information.

For example, the entire history of present illness (HPI), dating back to when a patient was first seen, appears in “today’s” note. This may be convenient for the physician, helping him/her avoid having to flip back in the chart, *but only the new information provided by the patient that day* can “count” when selecting the E/M service code.

On the other hand, physicians should not “down code” or “code middle of the road” (such as always choosing 99232) when a higher level of service has been provided. CMS’s other contractors (such as the Comprehensive Error Rate Testing (CERT) contractor) consider down coding to be as much of an error as upcoding—and the Medicare contractors are “graded” based on the CERT contractor’s findings. Consequently, we are now seeing the MACs apply this approach, too: placing physicians on prepayment review for excessive billing of 99231 (level one hospital visit) as, on an audit, the physicians’ documentation supported a higher level of service; i.e., 99232.

Using the AMA's CPT Book for Guidance

In addition to defining the level of documentation required, the CPT® book provides guidance on *when* to use the three codes (99231-99233) for subsequent hospital visits:

- 99231—Focused Interval history (Hx) or physical exam (PE), low complexity (15 minutes): Usually used when the patient is stable, recovering or improving.
- 99232—Expanded Interval Hx or PE, moderate complexity (25 minutes): Usually used when the patient is responding inadequately to therapy or has developed a minor complication.
- 99233—Detailed Interval Hx or PE, high complexity (35 minutes): Usually used when the patient is unstable or has developed a significant complication or a significant new problem.

You can find similar descriptors for all of the E/M codes. The back of your CPT® book contains clinical examples that can further guide you to the type of patient that may be appropriate for the different E/M codes.

Many payers' medical review nurses find that subsequent hospital visits are being billed with a code that is higher than the documentation supports. The documentation may meet the required two of three components for the level billed, but not support the medical necessity for the level billed.

For example, a 99233 as billed and documented meets two of three required components, but does not reflect that the patient is unstable or has developed a significant complication or new problem, as stated in the AMA's CPT® code descriptor. These services are being recoded to meet the "type" of patient the code represents (as noted above) and the organizations are being required to repay the difference.

CMS made two changes to E/M documentation and coding effective January 1, 2019:

1. The physician/non-physician practitioner will no longer be required to document the medical necessity of a home care visit versus an office visit. Documenting the medical necessity for a visit, regardless of patient location, remains a requirement for payment.
2. For established patient office/outpatient visits, when relevant information is already contained in the medical record, the physician/NPP may choose to focus documentation on what has changed since the last visit. For pertinent items that have not changed, the provider need not re-record the defined list of required elements if the practitioner documents review of the previous information and updates it as needed. It is important to note that this change is **ONLY** for established patient office/clinic visits.
 - a. The "relevant information" includes the patient's Chief Complaint and History of Present Illness when these have been entered by ancillary staff.

New vs. Established Patient Visits (Home/Assisted Living Facility (ALF)/ Residential/Office or Clinic)

When billing for outpatient visits, it must be clear whether the patient has had a billable physician service rendered by a member of your palliative care team within three (3) years. If so, the visit must be billed using established visit codes regardless if the patient is new to the physician/NPP rendering the visit today. This “new vs. established patient” concept does not apply in the inpatient hospital or SNF/nursing facility (NF) setting.

Coding Based on Time (Counseling and Coordination of Care)

When an E/M service is dominated by counseling and/or coordination of care (i.e., more than 50 percent), *time* is the controlling factor in selecting the level of service.

Take, for example, a patient who has had all treatment and studies completed, and a medical decision is made to discontinue chemotherapy and be seen by palliative care. At a home visit, the physician discusses the treatment options and subsequent lifestyle effects the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service; the total time of the visit will determine the level of service billed. However, the documentation should be detailed enough to reasonably justify the amount of time the physician spent with the patient.

It is important to remember that in the outpatient setting, counseling and/or coordination of care must be provided *in the presence of the patient*. In an inpatient setting (Hospital, SNF, NF), however, the counseling and/or coordination of care can be provided at the bedside and on the patient’s floor or unit.

So, while the time spent with the family outside of the patient’s presence at home does not count towards code selection, time with the family in a meeting room on the same floor as the patient’s room can count in addition to time face-to-face with the patient for total visit time.

When time is used to substantiate the level of service, the amount of time spent in counseling or in the coordination of care, along with the total duration of the visit, must both be recorded. Document who was involved in the discussion and enough detail of the discussion to support that it was medically necessary for the patient’s care and treatment, and to support the amount of time being reported.

Coding Based on Complexity

History Elements

As a reminder, the four elements of the history component (in CMS’s documentation guidelines for E/M Services are: chief complaint; history of present illness; review of systems; and past family/social history. Their definitions have not changed, but there are new interpretations relative to the *review of systems* and when a *history is unobtainable*.

Chief Complaint

Palliative care clinicians would be well served to think of this as answering the question “what is the medical reason you are seeing the patient today?”

History of Present Illness (HPI)

HPI is the sequence of events from the time the patient was diagnosed, became symptomatic, etc. until you first saw the patient, or, on follow up, what has happened since you saw the patient last. If you consider this definition, it becomes clear that an HPI copy and pasted from a prior note into today’s note is no longer HPI; instead this would be past medical history.

Review of Systems

A review of systems (ROS) is an inventory of body systems obtained by questions to identify the signs or symptoms the patient is or has been experiencing.

Per the guidelines, a complete ROS is defined as follows: “At least 10 organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least 10 systems must be individually documented.”

In most cases, the use of “all other systems negative” with specific documentation of only a couple of systems will lead a payer’s nurse reviewer to ask, “Which other systems are negative?” And, similarly, referring to a system as being “noncontributory” calls into question whether the system was inquired about. More than likely, reviewers will question this if the patient’s presenting problem (perhaps follow up of now-controlled pain for a patient seen two days ago) does not seem to justify a complete review of systems.

A complete ROS is required for level 4 and 5 new patient home visits (commonly coded as 99344 and 99345), ALF visits (commonly coded as 99326 and 99327), and initial hospital visits (commonly coded as 99222, 99223).

When History is Unobtainable

There are times when the physician/NPP cannot obtain a history from the patient due to the patient’s condition, and there may be no one else present with knowledge of the patient’s history.

The documentation guidelines state: “If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance that precludes obtaining a history.”

The clinician should specifically document the history element s/he would have gotten and documented if they could have gotten it. Documentation along the lines of “As noted, patient is unable to provide reliable history. Chart reviewed, no family present to provide a review of systems or family history.” In this example, two history elements-ROS and family history—could be given credit for as part of the code selection process.

Physical Exam Elements

The levels of E/M services are based on four types of examination that are defined as follows:

- Problem Focused: a limited examination of the affected body area or organ system.
- Expanded Problem Focused: a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- Detailed: an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- Comprehensive: a general multi-system examination or complete examination of a single organ system. (The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.)

For purposes of examination, the following body areas are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

For purposes of examination, the following organ systems are recognized:

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

The extent of examinations performed and documented is dependent on the physician/NPP's clinical judgment and the nature of the patient's presenting problem(s). They range from limited examinations of single body areas to a general multi-system or complete single organ system examinations.

Medical Decision Making Complexity

The levels of E/M services recognize four types of medical decision making (straight-forward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the following three variables:

1. The number of possible diagnoses and/or the number of management options that must be considered;
2. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
3. The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

Since one component of medical decision making is the number and types of problems addressed during the encounter, if a problem is mentioned but not addressed, this information is considered "history" and may not be considered in determining complexity.

When the physician/NPP reviews old records, there must be documentation of what the records show. A notation of "old charts reviewed" is not sufficient.

Be sure to review the Table of Risk on page 14 when assessing the level of risk of the presenting problem or management options (for coding purposes). "High" would require:

- a. Severe exacerbation;
 - b. Injury or illness that would pose a threat to life or bodily function (sudden change in mental status, acute MI, severe respiratory distress, etc.);
 - c. Parenteral controlled substances; or
 - d. Decision to sign DNR or to de-escalate care made at today's encounter.
4. Be sure to document:
- a. Your review of lab, radiology and/or other diagnostic tests (and results).
 - b. The results of your discussion of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study.
 - c. If history is given by someone other than the patient (nurse, spouse, etc.)
 - d. The actual treatment ordered or recommended; avoid statements along the lines of "continue plan of treatment." The level of risk in the complexity determination is different for over the counter medications (low) and prescription drugs (moderate) and parenteral controlled substances (high).
 - e. Decision making is only one element in determining the level of service. A high level of decision making does not automatically equate to the highest level (code).

Most payers use a point formula to determine the type of complexity and a Table of Risk in determining the patient's overall risk for complications, morbidity and/or mortality.

To assist clinicians in determining the complexity of medical decision making, we have included the tables that most third-party payers use in determining complexity here.

TABLE OF THE RISK OF COMPLICATIONS, MORBIDITY AND MORTALITY

Level of Risk	Presenting Problems	Diagnostic Procedures Ordered	Management Options Selected
Minimal Level I - II	<ul style="list-style-type: none"> One self-limited problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> Lab tests requiring venipuncture Chest X-rays Urinalysis Ultrasound [e.g., echocardiography] KOH prep 	<ul style="list-style-type: none"> Rest Gargles Elastic Bandages Superficial Dressings
Low Level III	<ul style="list-style-type: none"> Two or more self-limited or minor problems One stable chronic illness [e.g., well-controlled hypertension or non-insulin-dependent diabetes, cataract, BPH] Acute uncomplicated illness or injury [e.g., cystitis, allergic rhinitis, simple sprain] 	<ul style="list-style-type: none"> Physiologic tests not under stress [e.g., pulmonary function tests] Non-cardiovascular imaging studies with contrast [e.g., barium enema] Superficial needle biopsies Clinical lab tests requiring arterial puncture Skin biopsies 	<ul style="list-style-type: none"> Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
Moderate Level IV	<ul style="list-style-type: none"> 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 [e.g., lump in breast] Acute illness with systemic symptoms [e.g., pyelonephritis, pneumonitis, colitis] Acute uncomplicated injury [e.g., head injury with brief loss of consciousness] 	<ul style="list-style-type: none"> Physiologic tests under stress [e.g., 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 [e.g., arteriogram, cardiac catheterization] Obtain fluid from body cavity [e.g., lumbar puncture, thoracentesis, culdocentesis] 	<ul style="list-style-type: none"> 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
High Level V	<ul style="list-style-type: none"> One or more chronic illnesses with severe exacerbation, progression or side effects of treatment Acute or chronic illnesses or injuries that may pose a threat to life or bodily function [e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure] An abrupt change in neurologic status [e.g., seizure, TIA, weakness or sensory loss] 	<ul style="list-style-type: none"> Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiologic tests Diagnostic electrophysiologic tests Diagnostic endoscopies with identified risk factors Discography 	<ul style="list-style-type: none"> Elective major surgery [open, percutaneous or endoscopic] with identified risk factors Emergency major surgery [open, percutaneous or endoscopic] Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

One criteria must be met or exceeded.

Visit Cheat Sheets

Prior to distributing these to your physicians, advanced practice RNs, or physician assistants, they should be provided with education and/or resources to help them put the information in context, keeping in mind that these tools do not address the medical necessity of a visit nor any other nuances of documentation and coding of Evaluation and Management Services.

**HOME CARE SERVICES
(1995 Guidelines)**

New Patient

(Requires all 3 Key Components be met)

Code	History	Physical Exam ³	Decision Complexity ¹	C/CC – Total Visit Time ²
99341	CC; HPI (1-3)	Limited 1 Body Area/Organ System	Straightforward	20 minutes
99342	CC; HPI (1-3); ROS (1)	Limited 2-7 Body Areas/Organ Systems	Low	30 minutes
99343	CC; HPI (4+)*; ROS (2-9); PFSH (2:3)	Extended 2-7 Body Areas/Organ Systems	Moderate	45 minutes
99344	CC; HPI (4+)*; ROS (10+); PFSH (3:3)	8 or more Organ Systems	Moderate	60 minutes
99345	CC; HPI (4+)*; ROS (10+); PFSH (3:3)	8 or more Organ Systems	High	75 minutes

HPI elements include: Location, Severity, Duration, Timing, Context, Modifying Factors, Associated Signs and Symptoms and Quality

*4 associated comorbidities or the status of 3+ chronic conditions also support an “extended” HPI

ROS includes a symptom review of the following:

Constitutional; Eyes; ENT/Mouth; CV; Resp; GI; GU; Skin/Breasts; Neuro; Psych; Endo; Hem/Lymph; Allergy/Immune; Musculoskeletal

¹Two of the following must meet or exceed the requirements for the level chosen:

Number of Diagnoses and/or Management Options; Amount and/or Complexity of Data to be Reviewed; Risk of Complications and/or Morbidity or Mortality

²Time should only be used to choose the level of service when the visit consists predominantly (>50%) of counseling and/or coordination of care

³BODY AREAS:

Head, including face	Neck	Chest, including breast/axillae	
Abdomen	Genitalia, groin, buttocks	Back, including spine	Each extremity

³ORGAN SYSTEMS:

Constitutional (e.g., vital signs, gen. app.)	Eyes	Ears, nose, mouth and throat	Cardiovascular
Respiratory	Gastrointestinal	Genitourinary	Musculoskeletal
Skin	Neurologic	Psychiatric	Hematologic/lymphatic/immunologic



**HOME CARE SERVICES
(1995 Guidelines)**

Established Patient

(Requires 2 of 3 Key Components be met)

Code	History	Physical Exam³	Decision Complexity¹	C/CC – Visit Time²
99347	CC; HPI (1-3)	Limited 1 Body Area/Organ System	Straightforward	15 minutes
99348	CC; HPI (1-3); ROS (1)	Limited 2-7 Body Areas/Organ Systems	Low	25 minutes
99349	CC; HPI (4+)*; ROS (2-9); PFSH (1:3)	Extended 2-7 Body Areas/Organ Systems	Moderate	40 minutes
99350	CC; HPI (4+)*; ROS (10+); PFSH (2:3)	8 or more Organ Systems	Moderate to High	60 minutes

HPI elements include: Location, Severity, Duration, Timing, Context, Modifying Factors, Associated Signs and Symptoms and Quality

*4 associated comorbidities or the status of 3+ chronic conditions also support an “extended” HPI

ROS includes a symptom review of the following:

Constitutional; Eyes; ENT/Mouth; CV; Resp; GI; GU; Skin/Breasts; Neuro; Psych; Endo; Hem/Lymph; Allergy/Immune; Musculoskeletal

¹Two of the following must meet or exceed the requirements for the level chosen:

Number of Diagnoses and/or Management Options; Amount and/or Complexity of Data to be Reviewed; Risk of Complications and/or Morbidity or Mortality

²Time should only be used to choose the level of service when the visit consists predominantly (>50%) of counseling and/or coordination of care

³BODY AREAS:

Head, including face	Neck	Chest, including breast/axillae	
Abdomen	Genitalia, groin, buttocks	Back, including spine	Each extremity

³ORGAN SYSTEMS:

Constitutional (e.g., vital signs, gen. app.)	Eyes	Ears, nose, mouth and throat	Cardiovascular
Respiratory	Gastrointestinal	Genitourinary	Musculoskeletal
Skin	Neurologic	Psychiatric	Hematologic/lymphatic/immunologic

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**NURSING FACILITY SERVICES
(1995 Guidelines)**

New or Established Patient – Subsequent Nursing Facility Care

(Requires 2 of 3 Key Components be met)

Code	History	Physical Exam ³	Decision Complexity ¹	C/CC – Total Visit Time ²
99307	CC; HPI (1:3)	Limited 1 Body Areas/Organ Systems	Straightforward	10 minutes
99308	CC; HPI (1:3); ROS (1)	Limited 2-7 Body Areas/Organ Systems	Low	15 minutes
99309	CC; HPI (4+)*; ROS (2-9) PFSH (1:3)	Extended 2-7 Body Areas/Organ Systems	Moderate	25 minutes
99310	CC;HPI (4+)*; ROS (10+) PFSH (2:3)	8 or more Organ Systems	High	35 minutes

HPI elements include: Location, Severity, Duration, Timing, Context, Modifying Factors, Associated Signs and Symptoms and Quality

*4 associated comorbidities or the status of 3+ chronic conditions also support an “extended” HPI

ROS includes a symptom review of the following:

Constitutional; Eyes; ENT/Mouth; CV; Resp; GI; GU; Skin/Breasts; Neuro; Psych; Endo; Hem/Lymph; Allergy/Immune; Musculoskeletal

¹Two of the following must meet or exceed the requirements for the level chosen:

Number of Diagnoses and/or Management Options; Amount and/or Complexity of Data to be Reviewed; Risk of Complications and/or Morbidity or Mortality

²Time should only be used to choose the level of service when the visit consists predominantly (>50%) of counseling and/or coordination of care

³BODY AREAS:

Head, including face	Neck	Chest, including breast/axillae	
Abdomen	Genitalia, groin, buttocks	Back, including spine	Each extremity

³ORGAN SYSTEMS:

Constitutional (e.g., vital signs, gen. app.)	Eyes	Ears, nose, mouth and throat	Cardiovascular
Respiratory	Gastrointestinal	Genitourinary	Musculoskeletal
Skin	Neurologic	Psychiatric	Hematologic/lymphatic/immunologic

Advanced Care Planning

Advance Care Planning⁵

Code	Description
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	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; each additional 30 minutes (list separately in addition to code for primary procedure)

Advance Care Planning (ACP) services may be billed by physicians and non-physician practitioners (NPPs) whose scope of practice and Medicare benefit category include the services described by the CPT codes above. This includes physicians, advance practice RNs, and physician assistants. This does not include clinical social workers because the benefit category for these professionals is mental health.

There are no place-of-service limitations on the ACP codes. ACP services can be appropriately furnished in both facility and non-facility settings, and are not limited to particular physician specialties.

Diagnosis

No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report the condition(s) for which you are counseling the patient.

Documentation

CPT code 99497 states that advance care planning includes 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.

CPT code 99498 is each additional 30 minutes (list separately in addition to code for primary procedure).

⁵The information in this section applies only to the Medicare Fee-For-Service program (“original Medicare”)

Guidance of appropriate documentation would include an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter.

Documentation should include⁶:

- Confirm and review the medical facts
- Create an environment conducive to dialogue
- Allow adequate time for the patient to express their concerns and include in the documentation
- Establish what the patient knows
- Introduce or reintroduce the advance planning service and what it entails (recognize that people handle information differently, depending on their educational level, ethnicity, culture, religion, socio-economic status, age and development level)
- Include who was present
- Completion of forms if performed
- Time spent face-to-face
- Plans for the next steps (additional information, tests, treatment of symptoms, referrals) should be included as needed

Note: There are no limits on the number of times ACP can be reported for a given beneficiary in a given time period, however, if repeated within a short time of a prior ACP discussion, documentation should reflect the medical necessity (precipitating factor, change in condition, etc.) of repeat ACP.

Billing

Medicare waives both the coinsurance and the Medicare Part B deductible for ACP when it is provided as part of an Annual Wellness Visit (AWV) and billed with modifier -33 (Preventive Services).

The deductible and coinsurance do apply when ACP is provided outside the covered AWV.

IMPORTANT NOTE: When billing ACP and a problem-oriented Evaluation and Management service for the patient on the same date of service, append modifier -25 (separate and significantly identifiable E/M service) to the visit code. Claims may be denied if this modifier is omitted.

⁶ PalmettoGBA, 07/13/17. https://www.palmettogba.com/palmetto/providers.nsf/Is/JM%20Part%20B~AP8Q9P8283?opendocument&utm_source=J11BL&utm_campaign=JMBl&utm_medium=email

Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services

This document answers frequently asked questions about billing advance care planning (ACP) services to the Physician Fee Schedule (PFS) under CPT codes 99497 and 99498 beginning January 1, 2016.

CPT Code 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

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

1. CPT codes 99497 and 99498 are time-based codes (a base code and an add-on code). Are there minimum amounts of time required to bill these codes?

In the calendar year (CY) 2016 PFS final rule (80 Fed. Reg. 70956), we adopted the CPT codes and CPT provisions regarding the reporting of timed services. Practitioners should consult CPT provisions regarding minimum time required to report timed services. If the required minimum time is not spent with the beneficiary, family member(s) and/or surrogate to bill CPT codes 99497 or 99498, the practitioner may consider billing a different evaluation and management (E/M) service such as an office visit, provided the requirements for billing the other E/M service are met.

2. Are there limits on how often I can bill CPT codes 99497 and 99498?

Per CPT, there are no limits on the number of times ACP can be reported for a given beneficiary in a given time period. Likewise, the Centers for Medicare & Medicaid Services has not established any frequency limits. When the service is billed multiple times for a given beneficiary, we would expect to see a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care.

3. In what settings can ACP services be provided and billed- Inpatient? Nursing home? Other?

There are no place of service limitations on the ACP codes. As we stated in the CY 2016 PFS final rule (80 Fed. Reg. 70956), ACP services may be appropriately furnished in a variety of settings depending on the needs and condition of the beneficiary. The codes are separately payable to the billing physician or practitioner in both facility and nonfacility settings and are not limited to particular physician specialties.

4. Who can perform ACP services?

As we said in the CY 2016 FPS final rule (80 Fed. Reg. 70956), the services described by CPT codes 99497 and 99498 are appropriately provided by physicians or using a team-based approach provided by physicians, nonphysician practitioners (NPPs) and other staff under the order and medical management of the beneficiary's treating physician. The CPT code descriptors describe the services as furnished by physicians or other qualified health professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and NPPs whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services. Therefore, only these practitioners may report CPT codes 99497 or 99498. The ACP services described by these codes are primarily the provenance of patients and physicians; accordingly we expect the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services in addition to providing a minimum of direct supervision. The usual PFS payment rules regarding "incident to" services apply, so that when the services are furnished incident to the billing physician or practitioner all applicable state law and scope of practice requirements must be met and there must be a minimum of direct supervision in addition to other incident to rules.

5. Can ACP services be furnished without beneficiary consent?

Since ACP services are voluntary, Medicare beneficiaries (or their legal proxies when applicable) should be given a clear opportunity to decline to receive ACP services. Beneficiaries, family members and/or surrogates may receive assistance for completing legal documents from others outside the scope of the Medicare program in addition to, or separately from, the physician or NPP.

6. What must be documented for the service?

Practitioners should consult their Medicare Administrative Contractors (MACs) regarding documentation requirements. Examples of appropriate documentation would include an account of the discussion with the beneficiary (or family members and/or surrogate) regarding the voluntary nature of the encounter; documentation indicating the explanation of advance directives (along with completion of those forms, when performed); who was present; and the time spent in the face-to-face encounter.

7. Does the beneficiary/practice have to complete an advance directive to bill the service?

No, the CPT code descriptors indicate "when performed," so completion of an advance directive is not a requirement for billing the service.

8. Can ACP be reported in addition to an E/M service (e.g., an office visit)?

CMS adopted the CPT codes and CPT provisions regarding the reporting of CPT 99497 and 99498 (see #1). This includes the CPT instructions that CPT codes 99497 and 99498 may be

billed on the same day or a different day as most other E/M services, and during the same service period as transitional care management services or chronic care management services and within global surgical periods. CMS also adopted the CPT guidance prohibiting the reporting of CPT codes 99497 and 99498 on the same date of service as certain critical care services including neonatal and pediatric critical care.

9. What diagnosis must be used?

No specific diagnosis is required for the ACP codes to be billed. It would be appropriate to report a condition for which you are counseling the beneficiary, an ICD-10-CM code to reflect an administrative examination, or a well exam diagnosis when furnished as part of the Medicare Annual Wellness Visit (AWV) (see #11, 12).

10. Do deductible/coinsurance amounts apply to this code?

The usual Part B deductible and coinsurance apply except when ACP is furnished as an optional element of the AWV (see MLN Matters article MM9271/CR9271 for more information). Since ACP services are voluntary, when a beneficiary (or family members and/or surrogate) elects to receive ACP, we encourage practitioners to notify them that Part B cost sharing will apply as it does for other physicians' services (except when ACP is furnished as an optional element of the AWV).

11. Where can I find additional information?

These FAQs draw on the final rule policies for ACP delineated in the CY 2016 PFS final rule (80 Fed. Reg. 70955 through 70959, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>). For additional information, we refer readers to that final rule and to the Medicare Learning Network Matters article MM9271/CR9271/R216BP and R3428CP (available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/2016-MLN-Matters-Articles.html>). CR9271 provides detailed billing instructions when ACP is furnished as an optional element of the AWV.

**Non-Face-to-Face
Prolonged Services**

Non-Face-to-Face Prolonged Services

These CPT codes have been in existence for many years. However, the overwhelming majority of payers “bundled” any pre- or post-visit work into the Evaluation & Management service provided and billed. In public comments in CMS’s CY 2016 PFS proposed rule, many commenters recommended that CMS should establish separate payment for non-face-to-face prolonged E/M service codes that were considered to be “bundled” under the Physician Fee Schedule (CPT codes 99358, 99359). The CPT descriptors are:

- CPT code 99358 (Prolonged evaluation and management service before and/or after direct patient care, first hour); and
- CPT code 99359 (Prolonged evaluation and management service before and/or after direct patient care, each additional 30 minutes (List separately in addition to code for prolonged service)).

Allowing separate payment for these existing CPT codes provided a means for physicians and other billing practitioners to receive payment that more appropriately accounts for time that they spend providing non-face-to-face care. CMS agreed that these codes would provide a means to recognize the additional resource costs of physicians and other billing practitioners, when they spend an extraordinary amount of time outside of an E/M visit performing work that is related to that visit and does not involve direct patient contact (such as extensive medical record review, review of diagnostic test results or other ongoing care management work). CMS also acknowledged that doing so in the context of the ongoing changes in health care practice to meet the current population’s health care needs would be beneficial for Medicare beneficiaries and consistent with their overarching goals related to patient-centered care.

These non-face-to-face prolonged service codes are only broadly described (although they include only time spent personally by the physician or other billing practitioner) and have a relatively high time threshold (the time counted must be an hour or more beyond the usual service time for the primary or “companion” E/M code that is also billed). They are not reported for time spent in care plan oversight services or other non-face-to-face services that have more specific codes and no upper time limit in the CPT code set. By mid-2017, an edit was published limiting non-face-to-face prolonged services to 2 hours on a given day for the billing provider.

CMS made specific note that these codes can only be used to report extended qualifying time of the billing physician or other practitioner (not clinical staff); and that prolonged services cannot be reported in association with a companion E/M code that also qualifies as the initiating visit for Chronic Care Management services (discussed in the next section).

There has been little guidance since on the use of 99358 and 99359. Using a conservative approach based on known guidance for face-to-face prolonged services, we recommend the following documentation at a minimum:

- Document the visit the non-face-to-face prolonged services relates to. For example, start by documenting the time you (the physician or other non-physician practitioner) began reviewing records-say, 11:05 a.m. Note which records you are reviewing; document phone calls with collaborating physicians and list their specialties/involvement with the patient; the date of the E/M service these activities relate to, and end the documentation with the time-say, 12:15 p.m.
- Document 'from and to' times rather than just total time as that is the requirement for face-to-face prolonged services.
- Document sufficiently the extent of the records reviewed, other physicians spoken to, etc. so that a reasonable person reviewing your documentation would be thinking "that sounds as if it took that amount of time (referencing the total time spent in this)."
- At the time of this writing, CPT guidelines dictate the minimum amount of time in these activities as when the midpoint has passed; so, a minimum of 31 minutes must be documented as having been spent in these activities for this to be billable time.

MLN Matters Number: MM5972

Related Change Request (CR) #: 5972

Related CR Release Date: April 11, 2008

Effective Date: July 1, 2008

Related CR Transmittal #: R1490CP

Implementation Date: July 7, 2008

Prolonged Services (Codes 99354 - 99359)

Note: This article was updated on March 7, 2017, to add a reference to MLN Matters article [MM9905](#) that alerts Medicare providers and their billing staff that beginning in Calendar Year 2017 CPT codes 99358 and 99359 (prolonged services without face to face contact) are separately payable under the Medicare Physician Fee Schedule. All other information remains unchanged.

Provider Types Affected

Physicians and other qualified non-physician practitioners (NPP) whose services are billed to Medicare Carriers or Medicare Administrative Contractors (A/B MAC).

What You Need to Know

CR 5972, from which this article is taken, updates the sections of the *Medicare Claims Processing Manual* that address prolonged services codes, in order to be consistent with changes/deletions in codes and changes in typical/average time units in the American Medical Association Current Terminology Procedural Terminology (CPT) coding system.

Make sure that your billing staffs are aware of the prolonged services CPT code changes as described in **Background**, below.

Background

Since *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Sections 30.6.15.1 Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes) and 30.6.15.2 (Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359) were first written, several code changes, code deletions, and typical/average time units have changed in the American Medical Association (AMA) Current Procedural Terminology (CPT) coding system.

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CR 5972, from which this article is taken, updates these sections that address prolonged services codes, in order to be consistent with the AMA CPT coding changes.

These manual changes:

- (In keeping with current Medicare payment policy for physician presence and supporting documentation) define Prolonged Services and explain the required evaluation and management (E&M) companion codes;
- Correct and update the tables for threshold times (reproduced below) to reflect code changes and current typical/average time units associated with the CPT levels of care in code families; and
- In a new Subsection (30.6.15.1 (H)), explain how to report physician visits for counseling and/or coordination of care when the visit is based on time and when the counseling and/or coordination service is prolonged.

A summary of these manual changes follow.

Prolonged Services Definitions

In the **office or other outpatient setting**, Medicare will pay for prolonged physician services (CPT code 99354) (with direct face-to-face patient contact that requires one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion E&M service as noted in the CPT code. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services with CPT code 99355.

In the **inpatient setting**, Medicare will pay for prolonged physician services (code 99356) (with direct face-to-face patient contact which require one hour beyond the usual service), when billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. You should report each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99357.

Note: *You should not separately report prolonged service of less than 30 minutes total duration on a given date, because the work involved is included in the total work of the evaluation & management (E&M) codes.*

You may use code 99355 or 99357 to report each additional 30 minutes beyond the first hour of prolonged services, based on the place of service. These codes may be used to report the final 15 – 30 minutes of prolonged service on a given date, if not otherwise billed. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

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Required Companion Codes

Please remember that prolonged services codes 99354 – 99357 are **not** paid unless they are accompanied by the companion codes as described here.

The companion E&M codes for 99354 are:

- Office or Other Outpatient visit codes (99201 - 99205, 99212 – 99215),
- Office or Other Outpatient Consultation codes (99241 – 99245),
- Domiciliary, Rest Home, or Custodial Care Services codes (99324 – 99328, 99334 – 99337),
- Home Services codes (99341 - 99345, 99347 – 99350);

The companion E&M codes for 99355 are 99354 and one of its required E&M codes.

The companion E&M codes for 99356 are the Initial Hospital Care and Subsequent Hospital Care codes (99221 - 99223, 99231 – 99233), the Inpatient Consultation codes (99251 – 99255); Nursing Facility Services codes (99304 -99318).

The companion codes for 99357 are 99356 and one of its required E&M codes.

Requirement for Physician Presence

You may count only the duration of direct face-to-face contact with the patient (whether the service was continuous or not) **beyond** the typical/average time of the visit code billed, to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable.

You cannot bill as prolonged services:

- In the **office setting**, time spent by office staff with the patient, or time the patient remains unaccompanied in the office; or
- In the **hospital** setting, time spent reviewing charts or discussing the patient with house medical staff and not with direct face-to-face contact with the patient or waiting for test results, for changes in the patient's condition, for end of a therapy, or for use of facilities.

Documentation

Unless you have been selected for medical review, you do not need to send the medical record documentation with the bill for prolonged services. Documentation, however, is required to be in the medical record about the duration and content of the medically necessary evaluation and management service and prolonged services that you bill.

You must appropriately and sufficiently document in the medical record that you personally furnished the direct face-to-face time with the patient specified in the CPT code definitions. Make sure that you document the start and end times of the visit, along with the date of service.

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Use of the Codes

You can only bill the prolonged services codes if the total duration of all physician or qualified NPP direct face-to-face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes).

Threshold Times for Codes 99354 and 99355 (Office or Other Outpatient Setting)

If the total direct face-to-face time equals or exceeds the threshold time for code 99354, but is less than the threshold time for code 99355, you should bill the E&M visit code and code 99354. No more than one unit of 99354 is acceptable.

If the total direct face-to-face time equals or exceeds the threshold time for code 99355 by no more than 29 minutes, you should bill the visit code 99354 and one unit of code 99355. One additional unit of code 99355 is billed for each additional increment of 30 minutes extended duration.

Table 1 displays threshold times that your carriers and A/B MACs use to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings, including outpatient consultation services and domiciliary, rest home, or custodial care services and home services codes. The AMA CPT coding-derived changes are highlighted and noted in bolded italics.

Table 1
Threshold Time for Prolonged Visit Codes 99354 and/or 99355
Billed with Office/Outpatient and Consultation Codes

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99241	15	45	90
99242	30	60	105
99243	40	70	115
99244	60	90	135
99245	80	110	155
<i>99324</i>	<i>20</i>	<i>50</i>	<i>95</i>

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Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
<i>99325</i>	<i>30</i>	<i>60</i>	<i>105</i>
<i>99326</i>	<i>45</i>	<i>75</i>	<i>120</i>
<i>99327</i>	<i>60</i>	<i>90</i>	<i>135</i>
<i>99328</i>	<i>75</i>	<i>105</i>	<i>150</i>
<i>99334</i>	<i>15</i>	<i>45</i>	<i>90</i>
<i>99335</i>	<i>25</i>	<i>55</i>	<i>100</i>
<i>99336</i>	<i>40</i>	<i>70</i>	<i>115</i>
<i>99337</i>	<i>60</i>	<i>90</i>	<i>135</i>
99341	20	50	95
99342	30	60	105
99343	45	75	120
99344	60	90	135
99345	75	105	150
99347	15	45	90
99348	25	55	100
99349	40	70	115
99350	60	90	135

To get to the threshold time for billing code 99354 and two units of code 99355, add 30 minutes to the threshold time for billing codes 99354 and 99355. For example, when billing code 99205, in order to bill code 99354 and two units of code 99355, the threshold time is 150 minutes.

Threshold Times for Codes 99356 and 99357 (Inpatient Setting)

If the total direct face-to-face time equals or exceeds the threshold time for code 99356, but is less than the threshold time for code 99357, you should bill the visit and code 99356.

Medicare contractors will not accept more than one unit of code 99356. If the total direct face-to-face time equals or exceeds the threshold time for code 99356 by no more than 29 minutes, you should bill the visit code 99356 and one unit of code 99357. One additional unit of code 99357 is billed for each additional increment of 30 minutes extended duration.

Table 2 displays the following threshold times that your Medicare contractors uses to determine if the prolonged services codes 99356 and/or 99357 can be billed with the inpatient setting codes. The AMA CPT coding-derived changes are highlighted and noted in bolded italics.

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Table 2
Threshold Time for Prolonged Visit Codes 99356 and/or 99357
Billed with Inpatient Setting Codes

Code	Typical Time for Code	Threshold Time to Bill Code 99356	Threshold Time to Bill Codes 99356 and 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100
99233	35	65	110
99251	20	50	95
99252	40	70	115
99253	55	85	130
99254	80	110	155
99255	110	140	185
99304	25	55	100
99305	35	65	110
99306	45	75	120
99307	10	40	85
99308	15	45	90
99309	25	55	100
99310	35	65	110
99318	30	60	105

Prolonged Services Associated With E&M Services Based Counseling and/or Coordination of Care (Time-Based)

When an E&M service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or the qualified NPP and the patient in the office/clinic or the floor time in the scenario of an inpatient service, the E&M code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the E&M code) and should not be “rounded” to the next higher level. **Further, in E&M services in which the code level is selected based on time, you may only report prolonged services with the highest code level in that family of codes as the companion code.**

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Billing Examples

Examples of billable and non-billable prolonged services follow.

- **Billable Prolonged Services**

EXAMPLE 1

A physician performed a visit that met the definition of an office visit CPT code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills CPT code 99213 and *one* unit of code 99354.

EXAMPLE 2

A physician performed a visit that met the definition of a domiciliary, rest home care visit CPT code 99327 and the total duration of the direct face-to-face contact (including the visit) was 140 minutes. The physician bills CPT codes 99327, 99354, and one unit of code 99355.

EXAMPLE 3

A physician performed an office visit to an established patient that was predominantly counseling, spending 75 minutes (direct face-to-face) with the patient. The physician bills CPT code 99215 and one unit of code 99354.

- **Non-billable Prolonged Services**

EXAMPLE 1

A physician performed a visit that met the definition of visit code 99212 and the total duration of the direct face-to-face contact (including the visit) was 35 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

EXAMPLE 2

A physician performed a visit that met the definition of code 99213 and, while the patient was in the office receiving treatment for 4 hours, the total duration of the direct face-to-face service of the physician was 40 minutes. The physician cannot bill prolonged services because the total duration of direct face-to-face service did not meet the threshold time for billing prolonged services.

EXAMPLE 3

A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354. The physician must bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.

Finally, you should remember that Medicare contractors will not pay (nor can you bill the patient) for prolonged services codes 99358 and 99359, which do not require any

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direct patient face-to-face contact (e.g., telephone calls). These are Medicare covered services and payment is included in the payment for other billable services.

Additional Information

You can find more information about billing with prolonged services codes 99354 – 99359 by going to CR 5972, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1490CP.pdf>.

You will find the updated *Medicare Claims Processing Manual* Chapter 12 (Physicians/Nonphysician Practitioners), Sections 30.6.15.1 Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes) and 30.6.15.2 (Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359) as an attachment to that CR.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html>.

Document History

Date of Change	Description
March 7, 2017	This article was changed to add a reference to MLN Matters article MM9905 , that alerts Medicare providers and their billing staff that beginning in Calendar Year 2017, CPT codes 99358 and 99359 (prolonged services without face to face contact) are separately payable under the Medicare Physician Fee Schedule.
July 12, 2013	The article was updated, to reflect current Web addresses.
April 29, 2008	Article released

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Chronic Care Management

Chronic Care Management

As the fee-for-service health care reimbursement system, nudged by CMS, continues its move towards one based on value and outcomes, there have been an increasing number of services in a new code category: Care Management Services. What is so interesting about this is how many of these services have a non-face-to-face component, or are by their nature non-face-to-face. It was only a few years ago that documenting that the patient was physically present was a requirement of a service if one expected to get paid for it.

Chronic care management services (CCM)-other than the initiating visit if provided-are provided via telephone, EMR secure portal, secure email, etc., with no requirement for patient or caregiver presence. The service has evolved since it was first covered in 2015. Gone is the requirement for a patient's written consent. The physician/NPP should still document that the patient agrees to CCM, knows they can only receive CCM from one provider, acknowledges that Medicare's deductible and co-insurance apply, and that they can discontinue CCM at any time (although if sufficient CCM had been provided in that month to be billable, CCM would be discontinued at the next month).

This year (2019) Medicare began paying for CCM provided personally by the physician/NPP with CPT code 99491, and two years ago, the CMS created a HCPCS code (G0506) to reimburse for the development of the required plan of care if that happened during a face-to-face encounter. Both of these developments, and the elimination of a written consent, are to encourage physicians/NPPs to provide CCM and are a direct result of input from physicians when queried why there were not providing CCM. These changes decrease physician burden and will hopefully have the desired impact of increasing the number of beneficiaries receiving CCM and the frequency with which the service is provided.

CMS's *Connected Care* initiative provides resources and tools that can help health care professionals learn how to implement chronic care management (CCM) and receive payment for providing these services. Chronic care management is care coordination services done outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. These services are typically non-face-to-face and allows eligible practitioners to bill for at least 20 minutes or more of care coordination services per month

Physicians and the following health care professionals can bill for CCM services: Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Nurse Midwives. Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals can also bill for CCM services. Only one practitioner per patient may be paid for CCM services for a given calendar month

Eligible Beneficiaries

Patients must have 2 or more chronic conditions that are expected to last 12 or more months, with significant risk of death, functional decline, exacerbation or decompensation. E.g., hypertension, heart disease, diabetes, high cholesterol, osteoarthritis, COPD, etc.

- CMS expected to cover 2/3 of all Medicare beneficiaries that have 2 or more chronic conditions

Staff Supervision

CMS provided an exception under Medicare's "incident to" rules that permits clinical staff to provide the CCM service incident to the services of the billing physician (or other appropriate practitioner) under the general supervision (rather than direct supervision) of a physician (or other appropriate practitioner).

- General supervision means when the service is not personally performed by the billing practitioner, it is performed under his or her overall direction and control although his or her physical presence is not required.

Patient Consent

Explain cost-sharing to the patient and obtain their consent prior to providing the service. Consent may be verbal or written but must be documented in the medical record, and includes informing them about:

- The availability of CCM services and applicable cost-sharing
- That only one practitioner can furnish and be paid for CCM services during a calendar month
- The right to stop CCM services at any time (effective at the end of the calendar month)

Informed patient consent need only be obtained once prior to furnishing CCM, or if the patient chooses to change the practitioner who will furnish and bill CCM.

Although patient cost-sharing applies to the CCM service, most patients have supplemental insurance to help cover CCM cost sharing. Also CCM may help avoid the need for more costly services in the future by proactively managing patient health, rather than only treating severe or acute disease and illness.

CCM Must Have a Care Plan

What is it: A person-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with particular focus on the chronic conditions being managed) You must provide the patient and/or caregiver with a copy of the care plan.

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals

- Symptom management
- Planned interventions and the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies/specialists unconnected with the practice will be directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan

Things to consider including in the Care plan:

Top concerns and barriers

- The main things I would like to fix or improve about my health are:
- The main things preventing me from improving my health are:

Symptom management

- The main symptoms I wish to reduce or eliminate are:
- *To treat these, your provider will help you complete the “Summary of things I need to do,” next page, at your appointment.*

Health care providers

- List any other providers you see regularly for health care (for example, ophthalmologist, cardiologist, therapist): (list)

Resources and supports

- Besides your health care team, who could you turn to for help for health-related problems (for example, family members, friends, a spiritual leader)?
- *Complete the remaining sections with your provider at your appointment:*

My medications*

(list)

I agree to do the following:

- Discuss concerns I have about taking any of my medications with my primary care provider (PCP) and/or pharmacist,
- Advise my PCP if I choose to stop my medication(s), including my reasons for stopping, and discuss potential alternatives,
- Advise my PCP of bothersome side effects from my medication(s),

Treatment goals/targets

These are mutually agreed upon, measurable goals to help the patient improve or control their medical conditions or manage their symptoms

- For example:
 - LDL cholesterol <100;
 - BP <150/90;
 - weight of 150 pounds;
 - 7 hours of uninterrupted sleep;
 - average pain level of 5;
 - ability to walk to my mailbox daily

Access to Care

The provider of CCM should ensure continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments

- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care by telephone and also through secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods (for example, email or secure electronic patient portal)

The Codes to Report

The initiating visit

+G0506: Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service).

- *"We believe G0506 might be particularly appropriate to bill when the initiating visit is a less complex visit (such as a level 2 or 3 E/M visit) although G0506 could be billed along with higher level visits if the billing practitioner's effort and time exceeded the usual effort described by the initiating visit code. It could also be appropriate...when the initiating visit addresses problems unrelated to CCM, and the billing practitioner does not consider the CCM-related work he or she performs in determining what level of initiating visit to bill."* CMS in the final 2017 MPFS rule

An Initiating visit is required only for new patients or patients not seen within one year of initiating CCM instead of for all beneficiaries receiving CCM services. To report G0506, the encounter must be face-to-face. This HCPCS code is meant to be reported in addition to the problem-oriented E/M service performed on the same day. Only report once per physician/NPP per patient. The Care Plan must be developed at this encounter for G0506 to be billed.

Once the care plan has been initiated, one of the following 4 CPT codes may be reported each month that CCM has been provided and the noted time threshold has been met (and documented):

CPT® 99490 is billed when at least 20 minutes of clinical staff time directed by a physician or other health care professional, is spent in care management activities in a calendar month.

CPT® 99491 is billed when at least 30 minutes of physician or other qualified healthcare professional time is spent in care management activities in a calendar month

CPT® 99487: Complex chronic care management services, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient that place the patient at significant risk of death, acute exacerbation, decompensation, or functional decline
- Establishment or substantial revision of a comprehensive care plan
- Moderate or high complexity medical decision making by the billing physician/NPP must be documented
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

CPT® +99489: Each additional 30 minutes of clinical staff time for CCCM directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure/99487)

Palliative care programs must be using an ONC (Office of the National Coordinator) certified Electronic Medical Record as required for Merit-based Incentive Payment System (MIPS)⁷. Anecdotally, this is the main impediment for palliative care programs in deciding whether to provide chronic care management. The specialty is well versed in looking at a patient holistically and in helping to determine goals, so developing a patient-centric care plan is more instinctive to palliative care than many other specialties.

As palliative care programs grow and mature, MIPS reporting also becomes a reality and management does not want to have a payment penalty imposed under this Medicare Part B payment initiative. Not being a successful reporter under MIPS in 2019 can have up to a 7% payment penalty in payment year 2021. Since one of MIPS' requirements is use of a certified EMR, the lack of a certified EMR quickly becomes a nonissue.

Looking at nontraditional services that a palliative care program can and should provide typically provides enhanced quality of care and one more step towards financial sustainability. Each program should make a conscious effort to know what new and different services are about to become payable in an upcoming year. With the growth of Medicare and commercial payers' Accountable Care Organizations (ACOs) and quality payment programs, it may well be the innovative palliative care programs that find themselves in demand by their local hospitals, insurance companies and managed care organizations, and the growing number of ACOs and bundled payment initiatives looking for outside-the-box partners.

As a final note, the information contained in this Handbook was current when it was developed in early 2019. Keep your eye out for changes that may need to be made to your program in the coming months.

⁷ Merit-Based Incentive Payment System



CONNECTED CARE

THE CHRONIC CARE MANAGEMENT RESOURCE

HEALTH CARE PROFESSIONAL TOOLKIT

Overview of CCM

Chronic care management (CCM) is a critical component of primary care that contributes to better outcomes and higher satisfaction for patients. The Centers for Medicare & Medicaid Services (CMS) recognizes CCM takes time and effort. CMS established separate payment under billing codes for the additional time and resources you spend to provide the between-appointment help many of your Medicare and dual eligible (Medicare and Medicaid) patients need to stay on track with their treatments and plan for better health.

CCM payments can be made for services furnished to patients with two or more chronic conditions who are at significant risk of death, acute exacerbation/decompensation, or functional decline. CMS [data](#) show that two thirds of people on Medicare have two or more chronic conditions, which means many of your patients may benefit from a CCM program, including the help provided between visits. CCM can help deliver the coordinated care your patients need and deserve.

This toolkit includes information for health care professionals, including tips for getting started, fact sheets on the requirements for implementing a CCM program, and educational materials to share with patients.

Information about CCM

Below is an overview of the codes for practitioners billing under the Physician Fee Schedule:



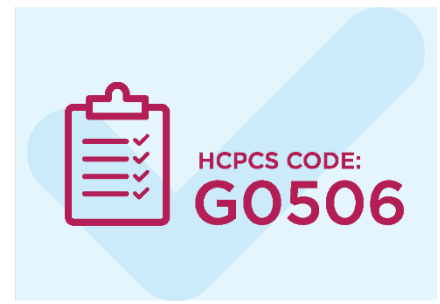
CMS adopted a separately payable Medicare Part B billing code for CCM services in 2015 (CPT code 99490). This code allows eligible practitioners to bill for at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month, spent on activities to manage and coordinate care for Medicare and dual eligible beneficiaries with two or more chronic conditions that are expected to last at least 12 months or until death. To recognize the costs of providing these services to Medicare and dual eligible patients managing multiple chronic conditions, CMS adopted three additional codes that recognize additional costs, including those related to more complex medical management beginning January 1, 2017.



CPT code 99489 is an add-on code to complex CCM (CPT 99487) for each additional 30 minutes of clinical staff time.



CPT code 99487 is for complex CCM that requires establishment or substantial revision of a care plan, moderate or high complexity medical decision making, and 60 minutes of clinical staff time.



HCPCS code G0506 is an add-on code to the CCM initiating visit that describes the work of the billing practitioner in a comprehensive assessment and care planning to patients outside of the usual effort described by the initiating visit code.

Making Coordinated Care Happen: Benefits to Your Patients and Practice



Thank you for working to implement a successful CCM program at your practice. CCM is a critical component of primary care that contributes to better health and care for individuals.

CMS [data](#) shows that two thirds of people on Medicare have two or more chronic conditions, which means many of your patients may benefit from a CCM program. CCM will help you deliver the coordinated care your patients need and deserve.

Why Is CCM Important?

Patients Benefit from CCM

- **Your patients will gain a team of dedicated health care professionals who can help them plan for better health and stay on track.** Services such as monthly check-ins and ready access to their care team improves their care coordination, including improved communication and management of care transitions, referrals, and follow-ups.
- **Patients will receive a comprehensive care plan.** The plan will help support their disease control and health management goals, including physical, mental, cognitive, psychosocial, functional, and environmental factors. Patients may also receive a list of suggested resources and, if available, community services, and may be encouraged to keep track of referrals, community support, and educational information.
- **Encouraging patients to use CCM will give them the support they need between visits.** Having a regular touch point may help patients think about their health more and engage in their treatment plan, for example, becoming more conscious of taking their medications and other self-management tasks. Getting this help may also help patients stay on track and improve adherence to their treatment plan.

CCM Supports Your Practice

- **Improve care coordination.** Chronic care management can help improve care coordination and health outcomes, and now you will receive payment specifically in support of your provision of care using this approach. Encouraging patients to use CCM services will give them the support they need between visits to your office.
- **Support patient compliance and help patients feel more connected:** Some health care professionals say CCM services may help improve their efficiency, improve patient satisfaction and compliance, and decrease hospitalization and emergency department visits.
- **Sustain and grow your practice.** Ongoing care management work has not always been separately recognized, making it difficult for practices to sustain. Appropriate billing for CCM services may help sustain your ongoing work. Offering CCM may provide you with additional resources to help your practice care for more patients in need.

Read on to find out how your practice can begin to provide and seek separate payment for CCM services.

CMS has developed fact sheets and FAQs with information about CCM services and payment: [CCM Services Fact Sheet](#), the [Chronic Care Management Services Changes for 2017](#), the [Frequently Asked Questions about Physician Billing for Chronic Care Management](#), and the [Chronic Care Management \(CCM\) Services in Rural Health Clinics \(RHCs\) and Federally Qualified Health Centers \(FOHCs\) FAQs](#)

Getting Your Practice Started with CCM



CCM will help you deliver the coordinated care your patients need and deserve. Offering CCM may enable you to sustain and grow your practice. The full details for implementing CCM in your practice, including eligibility, included services, billing requirements, how to spend time, and payment amounts can be found on the [Connected Care Hub](#).

Additional resources can be found on:

- [CMS Care Management Site](#)
- [CCM Services Fact Sheet](#)
- [Care Management Physician Fee Schedule](#)
- [CCM Services Changes for 2017](#)
- [CCM Services FAQs](#)
- [RHC & FQHC CCM FAQs](#)

Eligibility

Patients eligible for separately payable CCM services are Medicare and dual eligible (Medicare and Medicaid) beneficiaries with two or more chronic conditions expected to last at least twelve months or until the death of the patient, when those conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. These are the only diagnostic criteria.

Examples of chronic conditions include, but are not limited to, the following: Alzheimer's disease and related dementia, Arthritis (osteoarthritis and rheumatoid), Asthma, Atrial fibrillation, Autism spectrum disorders, Cancer, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Depression, Diabetes, Hypertension and Infectious diseases such as HIV/AIDS.

CCM services may be billed by*:

- Physicians and certain Non-Physician Practitioners (Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Nurse Midwives)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Hospitals, including Critical Access Hospitals (CAHs)

**Only one physician, NPP, RHC or FQHC, and one hospital, can bill for CCM for a patient during a calendar month.*

Many activities can count toward the minimum monthly service time to bill for CCM. These include:

- Provide comprehensive care management for patients outside of in-person visits, such as by phone or through secure email. CCM includes, in large part, activities that are not typically or ordinarily furnished face-to-face with the patient and others, such as telephone communication, review of medical records and test results, self-management education and support, and coordination and exchange of health information with other practitioners and health care professionals. It may also include some face-to-face interaction with the patient or other providers.
- Share patient's health information, including their electronic health plan, with the patient's other health care professionals and providers.
- Manage care transitions, including providing referrals and facilitating follow-ups for patients after they are discharged.
- Coordinate with home- and community-based clinical service providers and document this activity in the patient's medical record.

For more information and tools to implement CCM, please visit: go.cms.gov/CCM.

Billing Codes and Payment for CCM

Getting up to speed may take some effort, but offering chronic care management services can help support quality care, may improve health outcomes and patient satisfaction, and may enable you to grow your practice.

The billing codes and Medicare physician fee schedule payments for CCM services are:

- CCM initiating visit (these include most standard face-to-face Evaluation and Management E/M visit codes as well as the Annual Wellness Visit (AWV), Initial Preventive Physical Exam (IPPE), or Transitional Care Management (TCM)): \$44-\$209. CCM initiating visits are only required for new patients or those not seen within a year prior to commencing CCM. The CCM initiating visit (where applicable) is billable separate from the monthly CCM services.
 - HCPCS G0506*: \$64, add-on to the CCM initiating visit for the billing practitioner's time and effort personally providing extensive comprehensive assessment and CCM care planning to patients outside of the usual effort described by the initiating visit code.
- CPT 99490: \$43 for 20 minutes or more of clinical staff time spent on non-complex CCM per calendar month that requires establishment, implementation, revision, or monitoring of a care plan.
- CPT 99487*: \$94 for 60 minutes of clinical staff time for complex CCM that requires establishment or substantial revision of a care plan, and moderate or high complexity medical decision making per calendar month.
 - CPT 99489*: \$47, add-on to use with CPT 99487 for each additional 30 minutes of clinical staff time for complex CCM per calendar month.

**These codes are for "complex CCM," which requires moderately to highly complex medical decision-making by the billing practitioner and substantial establishment or revision of the patient's care plan. They cannot be combined with CPT code 99490, since a patient's care management is either complex or not complex.*

Please note that RHCs and FQHCs can receive payment for CCM when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. RHCs and FQHCs are not currently authorized to bill codes 99487, 99489, or G0506.

The usual cost-sharing rules apply to these services, so many patients are responsible for the usual Medicare Part B cost sharing (deductible and copayment/coinsurance) if they do not have supplemental ("wrap-around") insurance. Please note that the majority of dual eligible beneficiaries (patients with Medicare-Medicaid) are exempt from cost sharing. Medigap plans must provide wrap-around coverage of cost sharing for CCM, and most beneficiaries have Medigap or other supplemental insurance.

The following is a sample of actions that are required to bill for CCM:

- Obtain verbal or written agreement to receive CCM services from patients, including: awareness of applicable cost sharing, information that they can stop participating at any time, and acknowledge that only one practitioner (and/or hospital) can provide CCM in a calendar month.
- Create and update an electronic “Comprehensive Care Plan” for the patient that tracks their health issues, and share it with the patient or their caregiver, when appropriate. Periodically review the plan with the patient, and share it with their other providers as appropriate.
- Provide continuity of care for patients through a designated care team member with whom the patient can schedule appointments, and who is regularly in touch with the patient to help them manage their chronic conditions.
- Record certain data through certified Electronic Health Records (EHR), including: patient’s demographics, medical problems, medications, and medication allergies.
- Provide patients with a way to reach your practice at any time to address urgent needs.

For more information about billing and to review the details above, visit the [Connected Care Hub](#) or the: [CCM Services Fact Sheet](#), [Chronic Care Management Services Changes for 2017](#), [CCM Services FAQs and RHC & FOHC CCM FAQs](#).

For more information and tools to implement CCM, please visit: go.cms.gov/CCM.

Speaking with Staff about Chronic Care Management



The information below is designed to help health care decision-makers talk to staff about what chronic care management services are, what payment for patient support (typically provided on a non-face-to-face basis) is under the billing codes, and what are the benefits to the practice and to the patients if such a program is implemented. This information does not replace the official guidance on implementing and seeking payment for CCM.

1. What Is CCM?

Chronic Care Management or CCM is the provision of coordinated care services to patients with multiple chronic conditions.

Examples of chronic conditions include, but are not limited to:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS

2. What Do We Need to Do to Furnish and Bill for CCM?

Please note that the following is not a complete list. A comprehensive list of actions associated with a CCM program can be found on the [CCM Fact Sheet](#).

- Our office performs a number of the tasks that will be required for a CCM program already, however we must meet specific requirements to be eligible to bill for them. While it may take some time and effort to fully get up to speed, I expect these changes and services will help us to continually improve the care we provide.
- We will provide comprehensive care management focused on management of the patient’s chronic conditions and preventive care. We will ensure the patient receives all recommended preventive services.
- We will complete a comprehensive assessment and develop and maintain a comprehensive care plan for all health issues, including medical and psychosocial issues, with special focus on the patient’s chronic conditions.
 - We will engage and educate the patient by developing and sharing the care plan with him or her (and any applicable caregiver).
 - The care plan will be reviewed periodically and revised as needed.
 - We will provide care that is tailored to the individual (also known as “person-centered” care).
 - We will work with home- and community-based clinical service providers as needed by the patient.
- We will educate the patient and give them the tools they need to monitor and manage their chronic conditions and any medications. We will ensure their safety and provide continuous care by reconciling our medication list with medications prescribed by other providers (e.g., by a specialist or during a hospital stay).
- We will manage any care transitions (referrals or discharges from facilities) by sharing information timely within our practice and with other providers who are involved in the patient’s care. We will follow up with our patients on a timely basis after facility stays or referrals.
- We will use some standardized electronic technology to assist us in sharing information on a timely basis with other providers. We will record “core” patient health information (demographics, problems, medications, and allergies) in the medical record using our certified Electronic Health Record.

- We will provide the patient with continuous care, such as:
 - 24-hour-a-day, 7 day-a-week access to a qualified health care professional who has access to necessary health information to address any urgent needs after hours.
 - We will offer enhanced methods of patient communication. Patients will be able to contact us at any time by methods other than just telephone (e.g., secure email portal).
- We will keep track of the time we spend providing these services by [insert recommended workflow based on practice needs].
- Though not required, please consider documenting the name of the billing physician overseeing the patient and who will be reviewing the care plan monthly. For example: [Insert billing physician's name] will be overseeing the care for [insert patient's name].

3. What Is Required of Patients?

Patients must give advance consent to ensure they are involved with their treatment plan and aware of any applicable cost sharing. They must understand that only one health care practitioner and/or one hospital can provide these services, so they can't receive it from each doctor they see and should not provide consent to receive these services from anyone else. They should also know that they can request to stop CCM at any time. Please note that beginning January 1, 2017, the informed consent can be given verbally, though you may choose to do it electronically or via a paper form.

4. How Will Our Practice Be Paid for Providing CCM Services?

- There are several Medicare billing codes to pay for chronic care management services (payment rates noted below are under the Medicare physician fee schedule):
 - CCM initiating visit (AWV, IPPE, TCM or other qualifying face-to-face E/M): \$44-\$209. CCM initiating visits are only required for new patients or those not seen within a year prior to commencing CCM. The CCM initiating visit (where applicable) is billable separate from the monthly CCM services.
 - HCPCS G0506*: \$64, add-on to the CCM initiating visit for the billing practitioner's time and effort personally providing extensive comprehensive assessment and CCM care planning to patients outside of the usual effort described by the initiating visit code.

- CPT 99490: \$43 for 20 minutes or more of clinical staff time spent on non-complex CCM that requires establishment, implementation, revision, or monitoring of a care plan.

- CPT 99487*: \$94 for 60 minutes of clinical staff time for complex CCM that requires establishment or substantial revision of a care plan, and moderate or high complexity medical decision-making.

- CPT 99489*: \$47, add-on to use with CPT 99487 for each additional 30 minutes of clinical staff time for complex CCM.

**These codes are for “complex CCM,” which requires moderately to highly complex medical decision-making by the billing practitioner and establishment or substantial revision of the patient’s care plan. They cannot be combined with CPT code 99490, since a patient’s care management is either complex or not complex.*

Please note that payments for RHC and FQHC services are not adjusted for length or complexity of the visit. RHCs and FQHCs are not authorized to bill 99487, 99489, and G0506 codes. RHCs and FQHCs can receive payment for CCM when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim.

Benefits

The Benefits of Implementing a CCM Program to Our Practice:

- Improved care for patients.
- Increased payment to practice for the coordinated CCM services we provide outside of face-to-face visits.

The Benefits of Providing a CCM Program to Our Patients:

- By implementing a CCM program and billing for it under Medicare, we can provide our eligible patients with help from a member of our team who is dedicated to overseeing their care. That team member can help them plan for better health and stay on track with treatments, medication, referrals, and appointments through regular check-ins and reminders.
 - For regular or “non-complex” care, patients will receive at least 20 minutes a month of time dedicated to care coordination services.
 - For complex chronic care management, patients will receive additional time and services.
- Encouraging patients to use CCM services may offer them the support they need between visits.

Explaining CCM to Patients



The information below is designed to help practice or health system decision-makers talk to patients and caregivers about what CCM services are, their benefits to the patients and their caregivers, and their role in the process of coordinating these services.

What Is CCM?

- If you have Medicare or Medicare and Medicaid, and have two or more chronic conditions, Medicare is offering chronic care management (CCM) services to help you manage your health and spend more time doing the things you love.
- If you have a chronic condition like Alzheimer's disease and related dementia, arthritis (osteoarthritis and rheumatoid), asthma, atrial fibrillation, Autism spectrum disorders, cancer, cardiovascular disease, chronic obstructive pulmonary disease, depression, diabetes, hypertension, and infectious diseases such as HIV/AIDS, chronic care management could be an important piece of the care your provider can offer.

What Are the Benefits of CCM?

- Regular chronic care management, or connected care, means you can better manage your care and spend more time focusing on your health. CCM can help you work towards your health and quality of life goals.
- Coordinated care means you'll get personal attention and help.
 - You can feel secure knowing you'll gain a comprehensive care plan, and at least 20 minutes a month of chronic care help when you need it, and regular check-ins.
- Someone I work with (or I) will help you keep track of your health care needs, so your loved ones can spend more quality time with you.
- You don't always have to come into the office to get help; you can also make a call.
- Reaching me or the designated person will help you make the best choices for your health, all from the comfort of your own home.
- Having a regular touch-base between doctor's visits will help keep you on track and stay focused on your health.

Informed Consent Notification

Patients must give consent to receive CCM services. Effective January 2017, a change was made to allow a verbal consent that is documented in the medical record, though written consent can still be obtained. It must be documented in the medical record that consent included informing patients they can stop at any time and that only one health care professional or hospital can provide CCM in a calendar month. Information about applicable cost sharing should be included as well. The language below is intended to be a guide for conversations seeking verbal consent. Please consider the key points below.

- Your dedicated care team will review your records and may contact you if needed. They may also connect with you about how they are working for you and your health.
 - o Do you have any questions about these services?
 - o Do you agree to receive these services?
 - o How do you prefer to be contacted?
 - o Tip: Refer to [Agency for Healthcare Research and Quality \(AHRQ\) Use the Teach-Back Method](#)

- This also means the care team will share information about your health with me to make sure we can talk about everything when we meet again.
 - o Do you have any questions about these services?
 - o Do you agree to receive these services?
 - o How do you prefer to be contacted?
 - o Tip: Refer to [Agency for Healthcare Research and Quality \(AHRQ\) Use the Teach-Back Method](#)

- (If applicable): We want to work with [specialist/service agency 1], [specialist/service agency 2], and [specialist/service agency 3] to coordinate care and services for you with the goal of improving your health. This is called chronic care management. You can ask us to stop doing this at any time.
 - o Do you have any questions about these services?
 - o Do you agree to receive these services?
 - o How do you prefer to be contacted?
 - o Tip: Refer to [Agency for Healthcare Research and Quality \(AHRQ\) Use the Teach-Back Method](#)

Contact information for CCM

For more information and updates on chronic care management, visit the CMS OMH [Connected Care Hub](#), the [Medicare Physician Fee Schedule Look-up Tool](#), and the [CMS Care Management site](#). For general questions, please send an email to CCM@cms.hhs.gov.

For more information and tools to implement CCM, please visit: go.cms.gov/CCM. Printed copies of the *Connected Care* postcards and posters can be ordered at no cost to your organization. Visit the *Connected Care* [Product Ordering page](#) to learn how to place an order.



CCM Tools & Resources

Learn more about what CCM is, why it is important, and how to get resources for a successful program.

Information about CCM

- [Chronic Care Management Fact Sheet](#)
Read a primer on CCM services separately paid by CMS, requirements, and how to bill for CCM.
- [Chronic Care Management Services Changes for 2017](#)
Read about changes to CCM services separately paid by CMS in 2017.
- [Chronic Care Management \(CCM\) Services in Rural Health Clinics \(RHCs\) and Federally Qualified Health Centers \(FQHCs\) Frequently Asked Questions](#)
Learn how to use the CCM payment codes at Federally Qualified Health Centers and Rural Health Clinics.
- [Frequently Asked Questions about Physician Billing for Chronic Care Management Services](#)
Answers to common questions about CCM, what is separately paid by CMS, and requirements for billing.
- [Final Rule: Payment Policies under the Physician Fee Schedule CY 2017](#)
Find out more about the fee schedule changes, including the addition of new separate payments in the Final Rule published in the *Federal Register*.
- [Care Management Resources](#)
Additional CMS resources for CCM and other care management services.

Tools for Educating Patients, Caregivers, Advocates, and Community Members

- ***Connected Care* “Connecting the Dots” Animated Video for Patients in [English](#) and [Spanish](#)**
Use this video to help explain the benefits of CCM services to patients.
- ***Connected Care* Postcard for Patients in [English](#) and [Spanish](#)**
Share this postcard with patients, caregivers, advocates, and other community members to explain what CCM is, who it is for, why it is beneficial, and how patients can ask for it.
- ***Connected Care* Poster for Patients in [English](#) and [Spanish](#)**
Download and hang this poster in your practice for patients and caregivers to see.
- **[Sample Language for Newsletter Articles, Blog Posts and Emails for Patient, Advocate, and Community Constituents](#)**
Use this sample language to communicate with patients, community advocates, and leaders about the benefits of CCM and the *Connected Care* initiative.
- **[Shareable Connected Care Posts and Graphics for Social Media](#)**
Share social media posts through your Facebook and Twitter accounts.
- **[HHS Education and Training Curriculum on Multiple Chronic Conditions](#)**
Developed by the Office of the Assistant Secretary for Health, in collaboration with the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, the HHS Education and Training Resources on Multiple Chronic Conditions (MCC) provides health professionals with education to care for people living with multiple chronic conditions.
- **[Agency for Healthcare Research and Quality \(AHRQ\): Use the Teach-Back Method](#)**
The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that you have explained things in a manner your patients understand.
- **[National Institute on Aging: Talking With Your Older Patient](#)**
This toolkit provides an array of resources to help improve communication with older people in different situations, such as understanding a patient’s health history or sharing bad news.

Tools for Health Care Professionals

- **[Connected Care Physician Testimonial Video about Chronic Care Management](#)**
Watch and share this video, in which one doctor shares how offering CCM is benefiting her Medicare patients and her practice in rural North Carolina.
- **[Connected Care Postcard for Health Care Professionals](#)**
Designed for health care professionals, this postcard explains what CCM is and its benefits.
- **[Sample Language for Newsletter Articles, Blog Posts, and Emails for Health Care Professionals](#)**
Use or adapt this language for communicating with your constituents.

- [Shareable *Connected Care* Posts and Graphics for Social Media](#)
Share social media posts through your Facebook and Twitter accounts.
- [Connected Care Presentation](#)
Share this presentation with health care professionals to help them learn about the *Connected Care* public education campaign and start a successful program in their practice.
- [Connected Care Web Badges](#)
Post this graphic on your website to link directly to the CMS CCM page.
- [Certified Electronic Health Record Technology \(CEHRT\)](#)
For information on EHRs and additional links for guidance on standards and incentive payments.

Additional Resources on CCM

- [Noridian Healthcare Solutions Chronic Care Management Page](#)
Noridian is a private health insurer awarded a Medicare Administrative Contract (MAC) responsible for administering both Medicare Part A and Medicare Part B claims. Their website offers information on billing, eligibility, documentation, and pricing.
- [PowerPoint: Chronic Care Management \(CCM\) Services Presented by Noridian Part B Medicare](#)
This presentation offers an overview of CCM, eligibility, scope of services, billing, and additional resources.
- [TMF QIN CCM Network](#)
TMF is one of CMS's Quality Innovation Network (QIN) Quality Improvement Organizations tasked with improving the quality of health care for all Medicare beneficiaries through data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, improve clinical quality, and spread best practices. The TMF QIN offers a CCM network including fact sheets, infographics, a business case, calculators, sample care plan, sample tracking log, checklist, and step-by-step guides.
- [Agency for Healthcare Research and Quality](#)
AHRQ offers a Shared Care Plan to help health care professionals develop a patient-centered health record designed to facilitate communication among members of the care team, including the patient and providers.

Where to Go for Help

For more information and updates on chronic care management, visit the CMS OMH [Connected Care Hub](#), the [Medicare Physician Fee Schedule Look-up Tool](#), and the [CMS Care Management site](#). For general questions, please send an email to CCM@cms.hhs.gov.

Printed copies of the *Connected Care* postcards and posters can be ordered at no cost to your organization. Visit the *Connected Care* [Product Ordering page](#) to learn how to place an order.



[GO.CMS.GOV/CCM](https://www.cms.gov/ccm)

Avoiding Risk

Avoiding Risk

In light of recent Office of the Inspector General (OIG) Work Plans, CERT results and ongoing Medicare Part B education and auditing initiatives under the Targeted Probe and Educate initiative, it is crucial that your physicians/NPPs understand and clearly define their role in delivering care to your patients.

As your organization continues to expand the number of physician services it offers, ensuring that these services are not viewed by payers as duplicative care will be imperative to your program's success. The Medicare Policy Manual clearly warns Medicare contractors to "assure that the services of one physician do not duplicate those provided by another." Thorough, concise documentation is your best ally in substantiating the services you are rendering as medically necessary and non-duplicative in nature. It also helps to coordinate the care with your physician colleagues, so that they have a clear understanding of your physician's/NPP's role.

Medicare specifically addresses concurrent care, stating that "reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services"; this requires each physician rendering concurrent care to play an active role in the patient's treatment.

CMS has instructed its contractors to apply the following criteria in determining the worthiness of concurrent care:

Does the patient's condition "warrant the services of more than one physician on an attending (rather than consultative) basis?"

Are the services provided by each physician "reasonable and necessary?"

It is important, therefore, that your clinicians' documentation support their services as a necessary, concurrent, but not duplicative component of the patient's care.

Once you have established the general necessity for services, the focus turns to substantiating the necessity for "today's" visit. This is another area that takes coordination and communication between the treating physicians, since contractors have been instructed to "assure that the services of one physician do not duplicate those provided by another."

For palliative care patients seen in the hospital, nursing facility, or as an outpatient, you must be sure to paint a clear picture of the services you are providing from a medical perspective. Remember, these patients are more than likely still receiving care from one or more physicians of other specialties. Your notes must support what it is that you bring to the table that the other clinicians are not addressing -once again document the medical necessity of the initial consultation and all follow up encounters.

One must also remember that the majority of third-party insurers, whether Medicare, Medicaid, managed care or commercial payers, are only providing reimbursement for a “physician” service delivered to the patient. Consequently, the doctor’s, nurse practitioner’s or physician assistant’s documentation must support that only someone with their level of clinical ability could have provided the service.

Avoid nonspecific statements that don’t easily support the medical necessity of a visit. The documentation of each encounter should make it clear what medical care and treatment the palliative care physician/NPP was addressing. Statements that do not support medical necessity may include:

- Routine visit
- “Will continue to follow along with you,” or “Will continue to follow monthly” without documentation of a deteriorating clinical condition needing a monthly physician visit.
- Plan: “Supportive care.” Medicare, Medicaid, other payers expect that medical care and treatment requiring a physician level of expertise is being provided for a medical condition.
- “Chief Complaint: Pain and symptom management” in a patient with no pain, not today nor by history.
- “Plan: will continue to assess for hospice eligibility” leaves the reader with the impression that the patient is only being seen to evaluate for when they meet hospice eligibility.

As with any service line, you must also be sure to incorporate physician billing into your compliance program to help ensure you avoid under/overpayments—and someone should truly own the responsibility for this. You need to be able to turn to an individual and ask the following questions and receive reassuring responses:

Are we assessing physician documentation?

Are we assessing medical necessity?

Since WE are billing for these services, are they being documented appropriately?

Are we up to date on annual code changes and changes to coding and documentation rules?

Are we in compliance today?

You should identify any internal experts you may have as well as try and identify physician champions of compliance as they can be your best allies when addressing concerns with the physician/NPP team. Education is the key! Not just for the providers though; you should include the appropriate billing staff and leadership as they need to know what the risks are. As always, thorough and concise documentation is paramount, and, if possible, you should provide your clinicians with cheat sheets as the documentation requirements are not always easy to digest (even for your best clinical team members). It is important to incorporate quality reviews and, possibly, mock payer reviews/audits.

About Acevedo Consulting Incorporated

When a patient is receiving palliative care services, billing for physician patient care services can be very complex. Acevedo Consulting Incorporated (ACI) appreciates that optimizing physician billing requires an understanding of the complex regulatory requirements effecting this unique industry. CPT® codes and modifiers vary based on the location of the service, and can at time be effected a provider's role with respect to the patient and a hospice/palliative care organization. And, as the use of nurse practitioners expands, consideration must be given as to how best to incorporate these practitioners into the program and still be compliant with the regulations.

Our consultants are respected as the premier compliance experts in Hospice and Palliative Care physician services. We are honored to be the only consultants with this expertise to include both the National Hospice and Palliative Care Organization (NHPCO) and the American Academy of Hospice and Palliative Medicine (AAHPM), as well as several state and local hospice and palliative care organizations as clients of our firm. Additionally, the firm's compliance and coding expertise has been sought out by the Office of Inspector General (OIG), The Department of Justice (DOJ) and numerous legal firms to serve as expert witness, render opinions on suspected fraudulent billing, and assist with overpayment appeals. Acevedo Consulting also provides compliance guidance and serves as an Independent Review Organization (IRO) for several organizations while under Corporate Integrity Agreements (CIA).

ACI prides itself on staying ahead of the curve and the ability to educate organizations on the reimbursement challenges and opportunities available in health care today and into the future, including Medicare's Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Whether in private practice, hospital-based or part of a large entity, you can rely on our seasoned team to guide you and your organization through the labyrinth of coding, reimbursement and regulatory compliance issues of the ever changing and complex health care industry.

Clients who have implemented ACI's recommendations find that third-party payers are less successful in retrospective recoupment. And, they are paid appropriately for services provided by optimizing revenue potential, especially for physician services.

What Our Hospice & Palliative Care Clients Find Most Valuable...

Annual Support & Education

Our Annual Support program offers unlimited support for industry-related questions and access to selected ACI-offered educational webinars throughout the year.

Our education options allow for one-on-one focused training or lectures for large groups. Education can be provided remotely via webinar or on-site; whichever suits your current need.

Consulting

ACI's knowledgeable consultant are available remotely or for on-site consultations at your request on areas such as compliance program effectiveness, process review and the billing of contracted services for the Hospice program and Part B billing for Palliative services.

Reviews

ACI offers a variety of chart review services developed specifically for the Hospice and Palliative Care industries. Our team will review the necessary documentation and compare it to current regulations and/or standards for accuracy and compliance.

Palliative Care Reviews Include:

- Evaluation & Management Coding and Documentation
 - Shared/Split Visits
 - Advance Care Planning Coding and Documentation
 - Clinical Social Worker Services
 - Quality Assurance
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