Documentation and Coding for Rural Palliative Care

Tammy Norville, Technical Assistance Director, National Organization of State Offices of Rural Health (NOSORH)

October 20, 2020

StratisHealth

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Stratis Health

- Independent, nonprofit, Minnesota-based organization founded in 1971
  - Mission: Lead collaboration and innovation in health care quality and safety, and serve as a trusted expert in facilitating improvement for people and communities
- Working at the intersection of research, policy, and practice

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Objectives

- Summarize components of appropriate documentation and coding
- Describe Palliative Care Services in relation to overall practice services and workflow
- Describe how documentation and coding are the cornerstones of the business
- Describe how service line expansion and transition to value impact long term organizational viability

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Disclaimer

The Center for Medicare/Medicaid Services (CMS) continues to announce any changes to documentation requirements and/or effective dates periodically. The following materials were created for the current environment.

CMS will continue to issue new guidance throughout the year; Medicare makes changes to its bundling edits each calendar quarter. Changes to Evaluation and Management Services are on the horizon.

The information provided here is general information only, and the user 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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Disclaimer (continued)

Third-party payer interpretations of coding and billing rules and regulations can differ greatly. The following materials are intended to provide guidance and should not be relied on as a guarantee of payment.

The materials were prepared as a tool to assist healthcare service providers in understanding documentation and coding for palliative care and related services. 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. NOSORH does not accept responsibility or liability regarding errors, omissions, misuse or misinterpretation.

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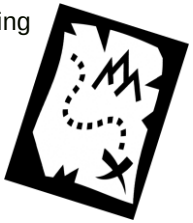
Road Map

- Getting to Know Each Other
- Introduction
- Operational Perspective
- The Reason We Do What We Do
- Documentation, Coding & (a little) Billing
- Services Related to Palliative Care
- Components & the Revenue Cycle
- Conclusion
- Resources
- Contact Info



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Getting to Know Each Other

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A Little About You!

- CEOs?
- CFOs?
- Other C-Suite folks?
- Providers?
- Clinical Managers?
- Office Managers?
- Coding/Billing folks?
- Others?

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A Little About Me!

- North Carolina native
- Graduate of UNC-Chapel Hill
- Holds CPC-I, CPC, RMM, RMC, RMB certifications
- Worked at NC ORH for almost 15 years providing TA to rural safety-net providers across the state

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Most Interesting…

Ryder

Buster

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Important Reminder

I am not clinical.

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NOSORH promotes the capacity of State Offices of Rural Health and **their stakeholders** to improve health in rural America through leadership development, advocacy, education and partnerships.

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Strategic Priorities

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State Offices of Rural Health

Core Activities:

- Information Dissemination
- Coordination – key conveners
- Technical Assistance – at least 20,000 TA clients last year

- **Noteworthy:**
- Unique federal – state partnership
- State, University and non-profits focused on state needs
- Other grantee applicants are required by FORHP to connect with the SORH

Get to know your SORH:

- What are their focus areas?
- What should they know about your work?
- Are their opportunities to disseminate information for you?

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- Rural EMS Conference
- Grant Writing Workshops
  & on demand Beyond the Basics webinars
- TruServe Web-Based Performance Measures

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Power of Rural Campaign

Nominate your stars!

Founded to bring attention to:

- Rural America is a great place to live and work and be a healthcare provider
- Quality and innovation are abundant in rural communities
- Disparities do exist and can be addressed through joint national, state and local efforts
- Growing beyond the day into a movement!

To stay informed take the Power of Rural Pledge
Visit PowerofRural.org

November 21, 2019 #powerofrural
National Rural Health Day
Celebrating the Power of Rural!
IT'S NOT JUST A DAY, IT'S A MOVEMENT.

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Important Reminder

I am not clinical.

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Introduction

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Background

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Background

What is Palliative Care?

Palliative care is **specialized care** for people living with serious illness. Care is **focused on relief** from the symptoms and stress of the illness and treatment—whatever the diagnosis. The **goal is to improve and sustain quality of life for the patient, loved ones and other care companions**. It is appropriate at **any age** and at **any stage** in a serious illness and can be provided along with active treatment. Palliative care facilitates patient autonomy, access to information, and choice. The palliative care team helps patients and families understand the nature of their illness, and make timely, informed decisions about care.

Source: https://waportal.org/partners/home/washington-rural-palliative-care-initiative

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Background

Why do we provide these services?

Rural populations are disproportionately ill, disabled, poor, and older. Rural adults are more likely than their urban counterparts to have a range of chronic conditions.

Source: http://www.stratishealth.org/documents/Stratis-Health-Rural-Palliative-Care-2014-09.pdf

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Question!?!

Are you currently providing Palliative Care services? If so, how is it funded?

**If you would like, please put answers in chat box!*

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Operational Perspective

Connection to Value

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Operational Perspective

COMPONENTS

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Value-Based Defined

"Value-based care refers to the departure from a system in which providers were paid for the number of healthcare services provided (e.g., tests, visits, procedures), to a **focus on an approach designed around patients, for improved health, quality delivery of care, and lower cost of care**."

Source: https://nosorh.org/wp-content/uploads/2017/09/SORH-RHC-ENGAGEMENT-TOOLKIT-Final.pdf

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Value-Based Defined

"Value-based care focuses on:

- Provider **payment incentives** that reward value rather than volume
- Models of care delivery that **coordinate and integrate clinical services for both patients and communities**, with a **focus on prevention and wellness**
- Information sharing that creates **transparency on the cost and quality of care to support better decision-making** by providers and consumers"

Source: https://nosorh.org/wp-content/uploads/2017/09/SORH-RHC-ENGAGEMENT-TOOLKIT-Final.pdf

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Team??

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It Takes A Village

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Who Is On The Team?

TEAM

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The Reason We Do What We Do

Eye on the Prize

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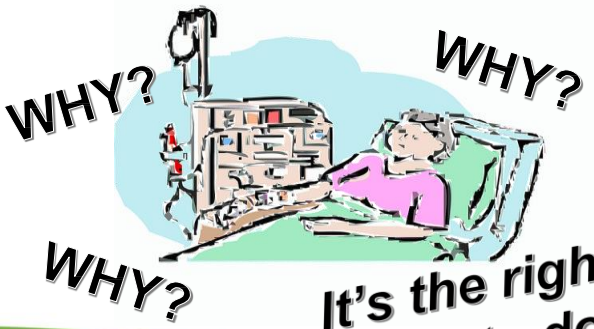
Medical Necessity



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Medical Necessity

Need to answer:

- ❑ *What service is needed?*
- ❑ *Why are we performing the service?*
- ❑ *How will the service be performed?*
- ❑ ***Where*** *will the service be performed?*

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Medical Necessity

LOCATION… Does it matter?

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Find it HERE!!

Place of Service Codes for Professional Claims

Database (updated November 2016)

Listed below are place of service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (e.g., Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. If you would like to comment on a code(s) or description(s), please send your request to posinfo@cms.hhs.gov.

NOTE: Please direct questions related to billing place of service codes to your Medicare Administrative Contractor (MAC) for assistance, and not to posinfo@cms.hhs.gov.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy**	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (Effective October 1, 2003)
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)
03	School	A facility whose primary purpose is education. (Effective January 1, 2003)
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (Effective January 1, 2003)
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (Effective January 1, 2003)

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Pl ce ,of Set'Yire Codet'!il	Pla e of Set·vtce ame	Pl ce of Se n'ire Deo;c1ipl to11
06	Indian Health Service Provider-based facility	A faciliry, orl ocation. own.edaud operaled by the Indian Health. Service. which. provides diagnostic. 1herapeu1ic (surgical 3illdnon-surgical). and reh3bilitation services rendered by, or nude.i·!he snpe.tv ision. of. physicians to American Indian:S and Alaska Nalives admitted as inpalieuls o.r·cm1},atient:S. (Effec:live January 1, 2003)
07	Ti:ibal 63S Free-slanding Facility	A fud liiy orloc..i.tiou o.,rned aud ope.rared by a federally recognized American Indian or Alaska Native tribe 01·uibal 01-ganizatiou und era 638 agreement, which provides diagnoslic, thera].)entic (sur:gical and 11Clll>$Urgicaf). and 1'ehallilitatiou Set-vices to !ribal memlle.t':!i „rho do uot 1-eqnire h.osp.it.1l!ion_ (Effeclive January 1, 2003)
08	Ti:ibal 638 Provider-based Facility	A fud lity or loc..i.tiou owned and ope.Med. bya federally recognized American Indian or A ka Native ti:ibe 01·uibal 01-ganizatiou .undera 63S agreement. wlldi1 provides diagj1os1ic, thera].)entic (sur:gical and 11Clll>$Urgicaf). and 1'ell allilitatiou Set-vices to !ribal memlle.t':!i admitted as lllll'lltient:S or oulpalieuJs, (Effeclive Jauuacy 1, 2003)
09	Pri!;Clll/Correclional Facility	A pri= .Jail . reformat01y, work farm. detention ceute.t·.orany o!her s.itn lil11'fucility main tained by eM1erFederal. State or local alllhorilies for the 1nnJ)O:le of confinement or rehabilira1io11 of adult01·juvenile crimin al of feude.t8_ (Effeclive July I. 2006}
10	Uu.as:simed	*N/A*
u	Office	Localiou, olher than a hospital. skilled mn ing facility ( ): mili!ary n·e.·ument facility. ci01rummity he..i.lth center, State or loc..i.l public he..i.lthdi:uic. or iute.tmediate c11refuc:ility (ICF)_ where 1he heahh professional rouliuely pr,ovides

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PJ ce ,of Set'Yire Cod e<·si	Place of Set·vlce aw.e	Pl ce of Senire De!;ctiplton
		health examina1ions. diagnosis. and n·ean.uent of :illness or inimY 011illllrunlmlatot'Y basis.
12	Home	Localion, olher than a hospital or olhe.r facili!y. wh.ere 1he pai'ient 1-eceives cm:eill a pdvate. residence.
1.l	A.ss.iS!ed Living Facili!y	CongregMe re.sideuti.al fud lity with elf-0011tained li ving unils providiey asse:sSlllent of e.ad1 re.sideut's needs and on.-s.lte suppmt 24 hmuu d0y. 7 days a week. wiih. the capacity ro deliver or rn.umge fo.r services inclndiey SOllle he,1ilth ca11-ea,nd other services. (Effeclive October 1, 2003)
14	Group Home•	A residence. with shared living areas. where clients receive sup ervisi on and o!her services such as social and/or behavioral services. ctJ.:Srodialser vice. andmini.nJ.al s:eivices (e. g.• medlc.ati on administ:mtion). (Effeclive Oclober 1, 2003)
F	Mobile Unit	A facili!y/nnit that mov es from pJ.ace.,to-pla equipped to provide preven live, screening. d.iaignostk. and/or n·ean.uent services. (Effec1ive January 1, 2003)
16	Tempom1y Lodging	A sh011tterm ace,ommodation such. as a hotel. =P ground. hoolel. crui:.e _shlp or resort wh.e.re th e pa!ienr recei ves care, and. which is not identified l}y 0ny olher POSci0de. (Efficlive January l, 2-008)
17	W0lk-in. Retail Heahh Clink	A wal.k.,i11 he.althd i1llc. O!her !han an office. uri ent ca.re facili!y. l)illlllllll,'l;cy or illdepelldent d i1llc and not described by any olher Pl.are of Service cooe . !hat is located wEllil1 a relail ,operation and provides. on3ll 3illlbn.lat01y basis. µ1-eveutive 0nd prim 0ry Clif."e services .

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Pl11c e Or Set'Yi re Code{s)	Pl ·e of Set'lUc .e ame	F l:.re of Sen ire Deo;c tip li011
		(This code is available for use immediately wilh a fulilll effective dare of 'l\.fav :I 2010)
18	Place of Employment-Wo.rh ite	A localion. no described by any other l'OS ci0de. owned or opernred. by a public 01· p!.'.lvate entity whe.re lh.e 1:1atlent is employed. and where a health profe!;.'.Sional provides 011.-g or episodic. occupalional medical. therapeutic or rehabilitati ve se.rvices to the individua l. (Tili.s ci0de is avail.allle for use. effi clive January], 2013 butn.o late.t· !han Il.fay 1. 20B)
19	Off Campus.. Ou aiient Hospital	A portion.of an off-caill.i:11.is hospital provider based depml ment which provides di0gi:1oslic. therapeutic (bo1h surgical and nonsurgical), and rehaWitation servioes to sici.: or iajured per50l.1S „rho do n.ot require. hospitalizatiou or ins1irn1ionaliz.atlon. (Effective Jmma rv I. 2016)
20	Urgent Care Facilify	Locarion. disti11ct fmm a hospital eme.rgenc.y ro om. an office. or a clinic, wh e purposeis ro diagnose and ireat illness orilljmy for 1111Scheduled. ambul0£ory pa!ien!s seeking lll.lll.lediate medical al1enlion. (Effi clive January 1, 200.l)
21	hl patieJ.lt Hospit al	A fucilily. othei·ihan. psychianic. ,, rhich 1:irimmi ly 1:irovides diagnostic. 1hernpeu1ic (bo1h sur gical and. 11ousur !;ic.1.l). and rehabilitatiou services by. or u11de.t·.ihe supervisiouo f 1:ihysi to p1;11ienlsdmil1ed for vfiliefy of medical condilions .
22	On. Cetmpu s-Ouqialienl Hospilal	A portion. of a h.ospital's 1Mi11 c.1iUp us which provides diagn lic, therapeutic (bo1h surgical and nonm1-gical , a nd 1-ellabilitatiou s.e.ivices m si ck. 01· injw'ed p,e.r.sons who do not r'eq_uire h pilaliz.ati on or instlnitlonalizalion. (Desc:r-iplion change effi clive· January 1. 20:16)

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Pl ce of St1I'Yire Codt'l's l	Plate of Set'VlC·e ame	Pl:.re of Sen · ire D e-;ctipll.on
2J	Emergency RoOlll - Hospital	A poi:tioll of a hospital where emeri ency diagnosis and. tt-el.tn1ent of illness 01· injury is J)rovided,
24	Ambul aC11y Surgical Cenl er	A freer.tan<l.ing facilit:y. other 1lran a physician's office. where su rgical and dia!llloolic services are pmvided 011 an. ambu latory b.a.iis.
25	BirthiI.J.g Center	A facilit:y. other 1han.a h ospital mate mit:y facilities or o pl!ysician's office, which provides a selling for labor. delivery . and i.uuuediate post-partum care as well as immediate c:lcreof new bom in fiml"S.
26	Milireiry Tre0m1enr Facilit:y	A medical facility operated by one 01· more.of the Uni.fonned Services. Miliracy Treannent Fad li!y (MTF) als o refers. to cer!ain. fo1me.!' U.S. Public. He-illth Service (USPHS) fuciliries now designated as Unifonn ed Service I realment Fad lili es (USTF).
27-30	Unassigned	*N/A*
31	Skilled Nursing F0cilily	A fuc:ili!y whid1 primarily provides.i11p.atie.nt killed nurs.ing care and related s.e.ivices to patients who require medical. nursing. or rehahlli.ta tive ervices but does not provide the level ofc.11re or11-e.1tment availa ble. in a l!ospital.
32	Nm!:!iin g Fac.ilify	A facility which primarily provides to residenls :skilled nui:sing care and related services for the 1-ehall ilitati011 of inju.l'ed. dis.allied. 01· sick persons. or. Olla regular basis. health-related C-ill'e s.e.ivicesabove the level o:f custodial c!l'1-eto other than individuals wilfa intelleon1aal d i.s0bililies .
33	Custodial Care Facilily	A facility which provides ro Olll, board and olher pe.t'.!ion0I ass.i.smn.ce s.e.ivires. genemlly 011 a l on,g-lenn ba!ilil, and which doe rn oHnclude a medic.al component

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Pl\ ce of Set'Yire Code{s)	Pla t e of SetVk'e ame	Pl:.re ofSen·ire De-;c tipll.on
34	Hospice	A faciliry,. other lb.an a palienl's Imme . in which palliative and snpp01tivec,111-e for tetm hl.ally ill])atientl and 1heir f.mJil:ies are provided,
3.5-40	U110ssiai1ed	N/A
41	Allibi.ilauce - Land	A land vehicle specifc-11illy designed. equipp ed and staffed for lifesaving and mins1,01r.ingthe sick 01·in jlUed.
42	Allibi.ilauce - Air 01·Wate1"	A11llli1'on vemervehicle :specifically designed. equipped and:staffed fol' life vi11g illl.ld 1rans1.Joi:tiui;:; 1he sick or iniured.
43-4,8	Unassigned	N/A
49	hldependent Clinic.	A location. n.o!.J)illt of 0hospit1.11 and not described by any olher Pla,ce of Service code. that is 01-ganized 0nd ope.rated to pl'ovide pi-eventi,ve di0gnos1ic, the.i·apentic. rehabilitative. or pallialive ervices ro ,outpatients only. (Effeclive October 1, 2003)
50	Federnlly Ql.l!al.ified Heal!h. CeJJ.tet·	A facility localed in a medic ally u11derserved ,111e!,!hat prnvid.es Medic1,11-e be11etici.aties preventive primary medical care ullder the :2eneral direction of a 1hvsician.
5.1	Inpatei nt Psychialtic Facility	A facility uhat provides illpalienl psychlaltic ervices for 1he diagno.sis and n·eatment of mental illness o110 24-hour basis. by om11de.i· the snoe.tv i.sion of a µhysici1.1!l.
52	Psychia!ric. Fadlity - Partial Hospiralizario n	A faciliry, for lh.ed • o s i s and n·eatment ,of mental illness that prnvides a pl.anued therapeutic program for1:mtien who do not require full lime ho.spi!alil..'ition. bi.it who need bl'oode.i· pi·og.mms th.11!lme-post ible fi'om o uti:mtient visils lo a hospital. based or ho.spilal-affiliated facility,
53	Commmury, Mental Health. CeJJ.te.t·	A fuciliiy 1h01 provides 1he following.se rvices: ,outpatient ervices. includi11g :specialized oul]:mtien.t services for children. the elderly.

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P\111ce or Set'Yire Code<s l	Pla ce of Set·v<Jc e ame	Pl:.re ofSen·ire Deo;ctipll.011
		:individuals who are chr01lical.ly ill . and 1'esidents of !he CMHC mental he.alth services area whohave been disclrarged from inpaliellt u:ea1lllent at a mental heahh facilily; 24 houra day eme.rgenc:y caire.s.e.tvices; day t:re..itment. ,other paitial hoop ilalizatioo services. or psychooocial reoobilitatioo services; screening f01•pa!ien!s. being c-011Sidered f01• 0dmiSaSion to . !ale mental heahh facililies to d m i n e the appropriateness of such admission; and 001isulra1io11 and educatio11 services..
54	Inteimediate Cace Fad lily!h1:dividual.s wi1h Inlellecmal Disabililies	A facili1y which primarily provides heahh-1-elated care and services. above the level of cmlodial care to :individuals but does not provi the level ofc are or1Tea1lllent avai lable in a hospital or SNf .
--	Res.di entillll ubs tance Abuse T1-e.atment Facility	A fuc:llity whid1 provides. t:1-e1tment fol' subs tance (alcohol and drug) abuse to live-in 1-esidenls ,,rho do nol require a-cute medical c-ille. Services il1clude il1div:idual m1dgroup tllel.'apy and coullseling. family cou llseli.J.J:!. laboratory tests. drugs al11dsupplies. psyclmlogical tesling. and room .1!!ldboard_
56	Ps.ychi01rk Residential T1-e.atmentCeni-er	A fuciliiy or di.slinct partt of a fuc.iliiy f01• psyclrian·ic care which provides a total 24-hour tlle.rape.utic.ally planned 0nd pl'Ofessiooally s10ffi d rouµliv:ine .1!!ldleamin envi:!·011111ent.
57	N011-1-esidemial . ubstance Abuse T1-e.atmentFadlily	A loc:arion. whid1 provides.!realrnem f01• subst.'!llce (lcohol and drug) buse on an ,1dnbul.at01y basis. Services i:!1dude il1divldual ,111dgroup !h.empy and. eio1111Seling,tillll:ily 0011J.lBeling laborat01y ests, drngs and :suppl ies. aud psycholog ic.al tesling. (Effic:rive October 1, 200.l)
58-59	Uoasshm.ed	N/A

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Place of Service Code(s)	Place of Service Name	Place of Service Description
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A

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Pl ce , of Set 'Yire Cod('{sl	P l e ofSet·kv .e ame	P b r e of Set'l'ire De,;ct'ipli,011
8,j	Indepen,dent Labornto,y	A laboratory oeirilled to pecfoan d • o s t k llllI<IIo·i clinkal rests independent of lll1l inslimlion or avbvsician.'s office.
31-98	Un0ssig11ed	N/A
99	Oilier Plare of Service	Olher place of service not identified above.

• Rew ed, effective April I. 2004.

.. Revised. effi ctive Oelober 1. 2005.

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Connecting Medical Necessity & Value

In our value definition it says "…focus on an approach designed around patients, for improved health, quality delivery of care, and lower cost of care."

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Switching Gears…

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Documentation, Coding & (a little) Billing

Quick Course

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Qualifier!

I am not clinical.

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What is Coding?

"Medical coding is the **transformation of healthcare diagnosis, procedures, medical services, and equipment into universal medical alphanumeric codes.**"

Source: https://www.aapc.com/medical-coding/medical-coding.aspx

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Why Do We Code?

- "Accurate" **reimbursement**
- Exchange health **data** with other organizations and government agencies
- Provide **evidence** for healthcare policy advocacy work
- **Evaluate** utilization of resources
- **Track** potential public health threats (such as Lyme Disease, Flu, Ebola, etc.)
- **Measure quality of care (aka, VALUE!)**

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Documentation

The ***cornerstone*** of the business.

(aka, If it's not documented, it didn't happen and therefore cannot be coded nor billed for reimbursement.)

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Some Palliative Care Considerations…

- Think like payers and "classify" the program/services - a physician practice where provider specialty happens to be palliative medicine
- Remember that (generally) for a service to be payable it must
  1. be medically necessary (complexity/intensity)
  2. was provided by a qualified individual for the benefit category

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Documentation Components

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 (complexity/intensity)
4. Nature of the presenting problem
5. Counseling
6. Coordination of care
7. Time (complexity/intensity)

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Documentation Components

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

CMS's 1995 or 1997 documentation guidelines are used 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/documentation review.

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Remember…

The Medicare Claims Processing Manual, Chapter 12, §30.6 addresses Medical Necessity 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)

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Documentation Components

Chief Complaint – describes the symptom, problem, condition, diagnosis or other factor that is the reason for the encounter, usually stated in the patient's words.

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History

- History of Present Illness
- Review of Systems
- Past, Family, Social History

HPI (History of Present Illness), ROS (Review of Systems), and PFSH (Past, Family, Social History) combine to make the history component of the E/M level determination

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4 Types of History

- Problem focused – chief complaint, brief history of present illness or problem (1)
- Expanded problem focused – chief complaint, brief history of present illness, problem pertinent system review (2-7)

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4 Types of History *(Continued)*

- Detailed – chief complaint, extended history of present illness, problem pertinent system review extended to include a limited number of systems, **pertinent** past, family and/or social history **directly related to the patient's problems** (5-7)
- Comprehensive – chief complaint, extended history of present illness, review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems, **complete** past, family, and social history (8 or more)

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Nature of Presenting Problem

A disease, condition, illness, injury, symptom, sign, finding, compliant, or other reason for encounter, with or without a diagnosis being established at the time of the encounter.

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5 Types of Presenting Problems

- Minimal – may not require the presence of the physician, but service is provided under they physician's supervision
- Self-limited or minor – runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance
- Low severity – the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected

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5 Types of Presenting Problems *(continued)*

- Moderate severity – the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment
- High severity – risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment

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Examination

The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four (4) types of examinations.

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4 Exam Types

- Problem focused – limited exam of the affected body area or organ system (1 body area or organ system)
- Expanded problem focused – limited exam of the affected body area or organ system and other symptomatic or related organ system(s) (2 – 7)
- Detailed – extended exam of the affected body area(s) and other symptomatic or related organ system(s) (2-7 w/ 1 detailed/expanded upon)
- Comprehensive – general multi-system exam or a complete exam of a single organ system (8 or more)

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CPT Recognized Body Areas

- Head, including face
- Neck
- Chest, including breasts & axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

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CPT Recognized Organ Systems

- Eyes
- Ears, Nose, Mouth, & Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/ Lymphatic/ Immunologic

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1995 CMS Recognized Exam Elements

Body Areas

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

Organ Systems

Cardiovascular
Constitutional symptoms (e.g., vital signs, general appearance)
Ears, nose, throat, mouth
Eyes
Gastrointestinal
Genitourinary
Hematologic/lymphatic/

Immunologic
Musculoskeletal
Neurologic
Psychiatric
Respiratory
Skin

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How do you code an encounter?

- Determine the extent of history completed
  Problem Focused, Expanded Problem Focused, Detailed, Comprehensive
- Determine the extent of exam performed
  Problem focused, Expanded Problem Focused, Detailed, Comprehensive

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How do you code an encounter?

- Determine the complexity ***(aka, intensity!)*** of medical decision making
- Select appropriate level of E/M services based on key component requirements as stipulated in the CPT manual – some stipulate all key components, some stipulate two of three

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Documentation

The ***cornerstone*** of the business.

(aka, If it's not documented, it didn't happen and therefore cannot be coded nor billed for reimbursement.)

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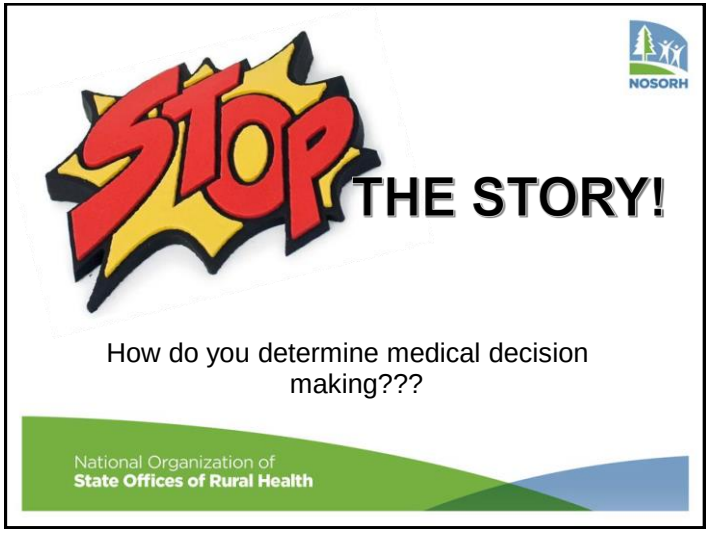

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AMA Proposal

Code set revisions take effective ***January 1, 2021***.

The proposal scope is completely focused on revisions to the E/M office or other outpatient visits (CPT codes 99201-99215).

Source: https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

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Primary Objectives

- To decrease administrative burden of documentation and coding
- To decrease the need for audits, through the addition and expansion of key definitions and guidelines
- To decrease unnecessary documentation in the medical record that is not needed for patient care
- To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

Source: https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

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TABLE OF CONTENTS

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Medical Decision Making

Refers to the **complexity** of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and
- 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.

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4 Types of Medical Decision Making

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

To qualify for a given type of decision making, two of the three elements in the Table of Risk must be met or exceeded.

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Find it HERE!

Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering these factors:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- 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

This table depicts the elements for each level of medical decision making. Note that to qualify for a given type of medical decision making, two of the three elements must either be met or exceeded.

Elements for Each Level of Medical Decision Making

TYPE OF DECISION MAKING	NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS	AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED	RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Number of Diagnoses or Management Options

The number of possible diagnoses and/or the number of management options to consider is based on:

- The number and types of problems addressed during the encounter
- The complexity of establishing a diagnosis
- The management decisions made by the physician

In general, decision making for a diagnosed problem is easier than decision making for an identified but undiagnosed problem. The number and type of diagnosed tests performed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those problems that are worsening or failing to change as expected. Another indicator of the complexity of diagnostic or management problems is the need to seek advice from other health care professionals.

MEDICAL DECISION MAKING

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MEDICAL DECISION MAKING

Here are some important points to keep in mind when documenting the number of diagnoses or management options. You should document:

- An assessment, clinical impression, or diagnosis for each encounter, which may be explicitly stated or implied in documented decisions for management plans and/or further evaluation:
  - For a presenting problem with an established diagnosis, the record should reflect whether the problem is:

Improved, well controlled, resolving, or resolved

Inadequately controlled, worsening, or failing to change as expected

- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a "possible," "probable," or "rule out" diagnosis

- The initiation of, or changes in, treatment, which includes a wide range of management options such as patient instructions, nursing instructions, therapies, and medications
- If referrals are made, consultations requested, or advice sought, to whom or where the referral or consultation is made or from whom advice is requested

Amount and/or Complexity of Data to Be Reviewed

The amount and/or complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. Indications of the amount and/or complexity of data being reviewed include:

- A decision to obtain and review old medical records and/or obtain history from sources other than the patient (increases the amount and complexity of data to be reviewed)
- Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test (indicates the complexity of data to be reviewed)
- The physician who ordered a test personally reviews the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation (indicates the complexity of data to be reviewed)

Here are some important points to keep in mind when documenting amount and/or complexity of data to be reviewed. You should document:

- The type of service, if a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter.
- The review of laboratory, radiology, and/or other diagnostic tests. A simple notation such as "WBC elevated" or "Chest x-ray unremarkable" is acceptable. Alternatively, document the review by initialing and dating the report that contains the test results.
- A decision to obtain old records or additional history from the family, caretaker, or other source to supplement information obtained from the patient.

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MEDICAL DECISION MAKING

- Relevant findings from the review of old records and/or the receipt of additional history from the family, caretaker, or other source to supplement information obtained from the patient. You should document that there is no relevant information beyond that already obtained, as appropriate. A notation of "Old records reviewed" or "Additional history obtained from family" without elaboration is not sufficient.
- Discussion about results of laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study.
- The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician.

Risk of Significant Complications, Morbidity, and/or Mortality

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with these categories:

- Presenting problem(s)
- Diagnostic procedure(s)
- Possible management options

The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next encounter.

The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category determines the overall risk.

The level of risk of significant complications, morbidity, and/or mortality can be:

- Minimal
- Low
- Moderate
- High

Here are some important points to keep in mind when documenting level of risk. You should document:

- Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality.
- The type of procedure, if a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter.
- The specific procedure, if a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter.
- The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis. This point may be implied.

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MEDICAL DECISION MAKING

This table can help determine whether the level of risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk.

Table of Risk

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
Minimal	• One self-limited or minor problem (for example, cold, insect bite, tinea corporis)	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound (for example, echocardiography) • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness (for example, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH) • Acute uncomplicated illness or injury (for example, cystitis, allergic rhinitis, simple sprain)	• Physiologic tests not under stress (for example, pulmonary function tests) • Non-cardiovascular imaging studies with contrast (for example, barium enema) • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (for example, lump in breast) • Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (for example, head injury with brief loss of consciousness)	• Physiologic tests under stress (for example, cardiac stress test, fetal contraction stress test) • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors (for example, arteriogram, cardiac catheterization) • Obtain fluid from body cavity (for example, lumbar puncture, thoracentesis, culdocentesis)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation

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MEDICAL DECISION MAKING

Table of Risk (cont.)

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function (for example, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) • An abrupt change in neurologic status (for example, seizure, TIA, weakness, sensory loss)	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography	• 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

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What's The Big Deal?

Improper coding results in the practice

- Loss of revenue
- Refunds
- Fines
- Accusations of Fraud
- Medicare – OIG – "Men in Black"

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Who Cares, Anyway?

Other than the insurance companies that are paying claims – including Medicare and Medicaid

Baltimore Statistical Office

EVERY claim goes through this office without common knowledge. All ICD-10 codes are tracked – including trended to physician – and extracted. This information is disseminated to appropriate agencies (ex, CDC).

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CMS Guidelines for Use of ICD-10 Codes

"The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.

The appropriate code or codes from A00.0 through T88.9, Z00-Z99.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

Source: https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf

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Chapters of the ICD-10-CM

AOO-B99 Certain Infections & Parasitic Diseases	LOO-L99 Diseases of the Skin & Subcutaneous Tissue
COO-D49 Neoplasms	MOO-M99 Diseases of the Musculoskeletal System
D50-D89 Diseases of the Blood & Blood-forming Organs & Certain Disorders involving Organs & Certain Disorders involving the Immune Mechanism	NOO-N99 Diseases of the Genitourinary System
EOO-E89 Endocrine, Nutritional & Metabolic Diseases	O00-O9a Pregnancy childbirth & the Puerperium
F01-F99 Mental & Behavioral Disorders	POO- P96 Certain Conditions Originating in the Perinatal Period
GOO-G99 Diseases of the Nervous System	QOO-Q99 Congenital Malformations, Deformations & Chromosomal Abnormalities
HOO-H59 Diseases of the Eye & Adnexa	ROO-R99 Symptoms, Signs & Abnormal Clinical & Laboratory Findings, Not elsewhere Classified
H60-H95 Diseases of the Ear and Mastoid Process	SOO-T88 Injury, Poisoning & Certain Other Consequences of External Causes
IOO-I99 Diseases of the Circulatory System	VOO- Y99 External Causes of Morbidity
JOO-J99 Diseases of the Respiratory System	ZOO-Z99 Factors Influencing Health Status & Contact With Health Services
KOO-K94 Diseases of the Digestive System	

The Medical Management Institute

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Like Dominoes

Incomplete documentation, leads to incomplete coding, leads to incomplete billing, leads to incomplete reimbursement.

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Services Related to Palliative Care

Transitional Care Management
Chronic Care Management
Advanced Care Planning
Prolonged Services

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Coding

- Palliative Care Codes (PCC)
- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
- Advanced Care Planning (ACP)
- Prolonged Services Codes
- Evaluation & Management (E/M)

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Learn about Transitional Care Management (TCM) services:

- TCM services
- Health care professionals who may furnish TCM services
- Supervision
- TCM services settings TCM components Billing TCM
- services
- Billing TCM Services Frequently Asked Questions (FAQs)
- Resources

TCM SERVICES

The requirements for TCM services include:

- Services during the beneficiary's transition to the community setting following particular kinds of discharges
- Health care professionals accepting care of the beneficiary post-discharge from the facility setting without a gap
- Health care professionals taking responsibility for the beneficiary's care
- Moderate or high complexity medical decision making for beneficiaries who have medical and/or psychosocial problems

The 30-day TCM period begins on the beneficiary's inpatient discharge date and continues for the next 29 days.

HEALTH CARE PROFESSIONALS WHO MAY FURNISH TCM SERVICES

These health care professionals may furnish TCM services:

- Physicians (any specialty)
- Non-physician practitioners (NPPs) legally authorized and qualified to provide the services in the State where they furnish them:
  - Certified nurse-midwives (CNMs) Clinical nurse specialists (CNSs) Nurse practitioners (NPs)
  - Physician assistants (PAs)

CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services "incident to" the services of a physician and other CNMs, CNSs, NPs, and PAs. When we use "you" in this fact sheet, we are referring to these health care professionals.

SUPERVISION

You must furnish the required face-to-face visit under minimum direct supervision, subject to applicable State law, scope of practice, and the Medicare Physician Fee Schedule (PFS) incident to rules and regulations. You may provide the non-face-to-face services under general supervision. These services are also subject to applicable State law, scope of practice, and the PFS incident to rules and regulations. The practitioner must order services, maintain contact with auxiliary personnel, and retain professional responsibility for the services.

TCM SERVICES SETTINGS

You may provide TCM services, beginning the day of the beneficiary's discharge from one of these inpatient hospital settings:

- Inpatient Acute Care Hospital Inpatient Psychiatric Hospital
- Long-Term Care Hospital Skilled Nursing Facility Inpatient
- Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

After inpatient discharge, the beneficiary must return to their community setting:

- Home Domiciliary
- Rest home
- Assisted living facility

TCM COMPONENTS

When a beneficiary discharges from an approved inpatient setting, you may furnish the following three TCM components beginning the day of discharge up to 30 days:

1) An Interactive Contact

Within 2 business days following the beneficiary's discharge, you must make an interactive contact with them and/or their caregiver via telephone, email, or face-to-face. You or clinical staff can address patient status and needs beyond scheduling follow-up care. For more information about interactive contacts, refer to the CPT Codebook available from the American Medical Association at the American Medical Association Store.

Report the service if you make two or more unsuccessful separate attempts in a timely manner. Document your attempts in the medical record if you meet all other TCM criteria. Continue your attempts to communicate with the beneficiary until they are successful. If the face-to-face visit is not within the required timeframe, you cannot bill TCM services (for more information, see the Face-to-Face Visit section).

Additional resources are available to help you understand and identify disparities that may affect TCM:

- Building an Organizational Response to Health Disparities – Resource and concepts for improving equity and responding to disparities. Concepts include: data collection, data analysis, culture of equity, quality improvement, and interventions
- Guide to Reducing Disparities in Readmissions – An overview and case studies of key issues and strategies related to care coordination and readmissions for racially and ethnically diverse Medicare beneficiaries

2) Certain Non-Face-to-Face Services

You must furnish non-face-to-face services to the beneficiary, unless you determine they are not medically indicated or needed. Clinical staff under your direction may provide certain non-face-to-face services.

Services Furnished by Physicians or NPPs

Physicians or NPPs may furnish these non-face-to-face services:

- Obtain and review discharge information (for example, discharge summary or continuity-of-care documents)
- Review need for, or follow-up on, pending diagnostic tests and treatments
- Interact with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems
- Provide education to the beneficiary, family, guardian, and/or caregiver Establish or re-
- establish referrals and arrange for needed community resources Assist in scheduling
- required follow-up with community providers and services

Services Provided by Clinical Staff Under the Direction of a Physician or NPP

Clinical staff under your direction may provide these services, subject to the State's supervision law, and other rules already discussed:

- Communicate with agencies and community services the beneficiary uses
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management,
- independent living, and activities of daily living
- Assess and support treatment adherence and medication management Identify available
- community and health resources
- Assist the beneficiary and family in accessing needed care and services

3) Face-to-Face Visit

You must furnish one face-to-face visit within certain timeframes described by the following two Current Procedural Terminology (CPT) codes:

- CPT Code 99495 – Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of at least moderate complexity during the service period; Face-to-face visit, within 14 calendar days of discharge
- CPT Code 99496 – Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of high complexity during the service period; Face-to-face visit, within 7 calendar days of discharge

You should not report the TCM face-to-face visit separately.

Telehealth Services

You may furnish CPT codes 99495 and 99496 via telehealth. Medicare pays for a limited number of Part B services a physician or practitioner furnishes to an eligible beneficiary via a telecommunications system. Using eligible telehealth services substitutes for an in-person encounter.

Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option by considering these factors:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- 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

Table 1 shows the elements for each level of medical decision making. Note that to qualify for a given type of medical decision making, two of the three elements must be either met or exceeded.

Table 1. Elements for Each Level of Medical Decision Making

Type of Decision Making	Number of Possible Diagnoses and/or Management Options	Amount and/or Complexity of Data to Be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

For more information about medical decision making, refer to the 1995 Documentation Guidelines for Evaluation and Management Services or 1997 Documentation Guidelines for Evaluation and Management Services.

Medication Reconciliation and Management

You must furnish medication reconciliation and management on or before the date of your face-to-face visit.

BILLING TCM SERVICES

This list provides billing TCM services information:

- Only one health care professional may report TCM services.
- Report services once per beneficiary during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. The required face-to-face visit may not take place on the same day you report discharge day management services.
- Report reasonable and necessary evaluation and management (E/M) services (except the required face-to-face visit) to manage the beneficiary's clinical issues separately.
- You may not bill TCM services and services within a post-operative global surgery period (Medicare does not pay TCM services if any of the 30-day TCM period falls within a global surgery period for a procedure code billed by the same practitioner).

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Transitional Care Management Services — MLN Fact Sheet

- When you report CPT codes 99495 and 99496 for Medicare payment, do not report the following codes during the TCM service period:
  - Care Plan Oversight Services
  - Home health or hospice supervision: HCPCS codes G0181 and G0182 End-Stage Renal
  - Disease services: CPT codes 90951–90970
  - Chronic Care Management (CCM) services (CCM and TCM service periods cannot overlap)
  - Prolonged E/M Services Without Direct Patient Contact (CPT codes 99358 and 99359) Other
  - services excluded by CPT reporting rules
- At a minimum, document the following information in the beneficiary's medical record: Beneficiary
  - discharge date
  - Beneficiary/Care Giver interactive contact date
  - Face-to-face visit date
  - Medical complexity decision making (moderate or high)

BILLING TCM SERVICES FAQs

For more information on billing the PFS for TCM services, refer to FAQs about Billing the PFS for TCM Services.

RESOURCES

Table 2. TCM Resources

For More Information About…	Resource
Building an Organizational Response to Health Disparities	CMS.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Guide.pdf
E/M Services	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html
Guide to Reducing Disparities in Readmissions	CMS.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf
Medicare Learning Network® Catalog of Products	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf
TCM Services	FederalRegister.gov/d/2014-26183

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Transitional Care Management Services — MLN Fact Sheet

Table 2. TCM Resources (cont.)

For More Information About…	Resource
Telehealth Services	CMS.gov/Medicare/Medicare-General-information/telehealth CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

Table 3. Hyperlink Table

Embedded Hyperlink	Complete URL
1995 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
1997 Documentation Guidelines for Evaluation and Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf
American Medical Association Store	https://commerce.ama-assn.org/store
Building an Organizational Response to Health Disparities	https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Guide.pdf
FAQs about Billing the PFS for TCM Services	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf
Global Surgery Period	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1256840.html
Guide to Reducing Disparities in Readmissions	https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf
Medicare Rules and Regulations	https://www.ecfr.gov/cgi-bin/text-idx?SID=33784afa5665f473e5981f0e67d77957&mc=true&node=pt42.2.410&rgn=div5#se42.2.410_126

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mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

CHRONIC CARE MANAGEMENT SERVICES

Find it HERE!!

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals.

In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions.

This booklet provides background on payable CCM service codes, identifies eligible practitioners and patients, and details the Medicare PFS billing requirements. Beginning January 1, 2019, the CCM codes are:

Please note: Information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

CCM

CPT 99490

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, 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

Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline

Comprehensive care plan established, implemented, revised, or monitored

Assumes 15 minutes of work by the billing practitioner per month.

CPT 99491

Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, 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

Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline

Comprehensive care plan established, implemented, revised, or monitored

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COMPLEX CCM

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

Chronic conditions 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

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 directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).

Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.

CCM (sometimes referred to as "non-complex" CCM) and complex CCM services share a common set of service elements (summarized in Table 1). They differ in the amount of clinical staff service time provided; the involvement and work of the billing practitioner; and the extent of care planning performed.

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PRACTITIONER ELIGIBILITY

Physicians and the following non-physician practitioners may bill CCM services:

- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants

NOTE: CCM may be billed most frequently by primary care practitioners, although in certain circumstances specialty practitioners may provide and bill for CCM. The CCM service is not within the scope of practice of limited-license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, although practitioners may refer or consult with such physicians and practitioners to coordinate and manage care.

Only one practitioner may be paid for CCM services for a given calendar month.

This practitioner must only report either complex or non-complex CCM for a given patient for the month (not both).

CPT code 99491 includes only time that is spent personally by the billing practitioner. Clinical staff time is not counted towards the required time threshold for reporting this code.

CPT codes 99487, 99489, and 99490 – Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month.

CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the direction of the billing practitioner on an "incident to" basis (as an integral part of services provided by the billing practitioner), subject to applicable state law, licensure, and scope of practice. The clinical staff are either employees or working under contract to the billing practitioner whom Medicare directly pays for CCM.

SUPERVISION

The CCM codes describing clinical staff activities (CPT 99487, 99489, and 99490) are assigned **general supervision** under the Medicare PFS. 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.

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PATIENT ELIGIBILITY

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, are eligible for CCM services.

- Billing practitioners may consider identifying patients who require CCM services using criteria suggested in CPT guidance (such as number of illnesses, number of medications, or repeat admissions or emergency department visits) or the profile of typical patients in the CPT prefatory language.
- There is a need to reduce geographic and racial/ethnic disparities in health through provision of CCM services. Table 2 provides a number of resources for identifying and engaging subpopulations to help reduce these disparities.

The billing practitioner cannot report both complex and regular (non-complex) CCM for a given patient for a given calendar month. In other words, a given patient receives either complex or non-complex CCM during a given service period, not both. Do not report 99491 in the same calendar month as 99487, 99489, 99490.

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
- Infectious diseases such as HIV/AIDS
-
-

INITIATING VISIT

For new patients or patients not seen within 1 year prior to the commencement of CCM, Medicare requires initiation of CCM services during a face-to-face visit with the billing practitioner (an Annual Wellness Visit [AWV] or Initial Preventive Physical Exam [IPPE], or other face-to-face visit with the billing practitioner). This initiating visit is not part of the CCM service and is separately billed.

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Practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code 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]). G0506 is reportable once per CCM billing practitioner, in conjunction with CCM initiation.

PATIENT CONSENT

Obtaining advance consent for CCM services ensures the patient is engaged and aware of applicable cost sharing. It may also help prevent duplicative practitioner billing. A practitioner must obtain patient consent before furnishing or billing CCM. 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 SERVICE ELEMENTS – HIGHLIGHTS

The CCM service is extensive, including structured recording of patient health information, maintaining a comprehensive electronic care plan, managing transitions of care and other care management services, and coordinating and sharing patient health information timely within and outside the practice. **Table 1 summarizes the CCM service elements, which apply to both complex and non- complex CCM unless otherwise specified.** CCM services are typically provided outside of face-to- face patient visits, and focus on characteristics of advanced primary care such as a continuous relationship with a designated member of the care team; patient support for chronic diseases to achieve health goals; 24/7 patient access to care and health information; receipt of preventive care; patient and caregiver engagement; and timely sharing and use of health information.

STRUCTURED RECORDING OF PATIENT HEALTH INFORMATION

- Record the patient's demographics, problems, medications, and medication allergies using certified Electronic Health Record (EHR) technology. This means a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year. For more information, visit Promoting Interoperability.

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COMPREHENSIVE CARE PLAN

- 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)

Provide the patient and/or caregiver with a copy of the care plan

Ensure the electronic care plan is available and shared timely within and outside the billing practice to individuals involved in the patient's care

Care planning tools and resources are publicly available from a number of organizations (see Resources in Table 2)

Comprehensive 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 identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialists outside the practice are directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan

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ACCESS TO CARE & CARE CONTINUITY

- Provide 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified health care professionals or clinical staff, including providing patients (and caregivers as appropriate) with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week

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)

COMPREHENSIVE CARE MANAGEMENT

- Systematic assessment of the patient's medical, functional, and psychosocial needs
- System-based approaches to ensure timely receipt of all recommended preventive care services
- Medication reconciliation with review of adherence and potential interactions
- Oversight of patient self-management of medications
- Coordinating care with home- and community-based clinical service providers

TRANSITIONAL CARE MANAGEMENT

- Manage transitions between and among health care providers and settings, including referrals to other clinicians, follow-up after an emergency department visit, or facility discharge
- Timely create and exchange/transmit continuity of care document(s) with other practitioners and providers

CONCURRENT BILLING

The billing practitioner cannot report both complex CCM and non-complex CCM for a given patient for a given calendar month. Do not report 99491 in the same calendar month as 99487, 99489, 99490.

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CCM cannot be billed during the same service period by the same practitioner as HCPCS codes G0181/G0182 (home health care supervision/hospice care supervision), or CPT codes 90951–90970 (certain End-Stage Renal Disease services). CCM should not be reported by the same practitioner for services furnished during the 30-day transitional care management service period (CPT 99495, 99496). Complex CCM and prolonged Evaluation and Management (E/M) services cannot be reported the same calendar month by the same practitioner. Consult CPT instructions for additional codes that cannot be billed concurrent with CCM. There may be additional restrictions on billing for practitioners participating in a CMS-sponsored model or demonstration program. Time that is reported under or counted towards the reporting of a CCM service code cannot also be counted towards any other billed code.

PAYMENT

CMS pays for CCM services separately under the Medicare PFS. To find payment information for a specific geographic location by code, access the Medicare Physician Fee Schedule Look-Up Tool.

CCM AND OTHER CMS ADVANCED PRIMARY CARE INITIATIVES

The CCM service codes provide payment of care coordination and care management for a patient with multiple chronic conditions within the Medicare Fee-For-Service Program. Medicare will not make duplicative payments for the same or similar services for patients with chronic conditions already paid for under the various CMS advanced primary care demonstration and other initiatives, such as the Comprehensive Primary Care (CPC) Initiative. For more information on potentially duplicative billing, consult the CMS staff responsible for demonstration initiatives.

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Table 1. CCM Service Summary

Initiating Visit – Initiation during an AWV, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of CCM services.
Structured Recording of Patient Information Using Certified EHR Technology – Structured recording of demographics, problems, medications, and medication allergies using certified EHR technology. A full list of problems, medications, and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care.
24/7 Access & Continuity of Care •Provide 24/7 access to physicians or other qualified health care professionals or clinical staff, including providing patients/caregivers with means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week •Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
Comprehensive Care Management – Care management for chronic conditions including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self- management of medications.
Comprehensive Care Plan •Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed. •Must at least electronically capture care plan information and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the patient's care. •A copy of the plan of care must be given to the patient and/or caregiver.
Management of Care Transitions •Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow- up after discharges from hospitals, skilled nursing facilities, or other health care facilities

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Table 1. CCM Service Summary (Cont.)

Home- and Community-Based Care Coordination • Coordination with home- and community-based clinical service providers • Communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record **Enhanced Communication Opportunities** – Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.
Patient Consent • Inform the patient of the availability of CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM services at any time (effective at the end of the calendar month) Document in the patient's medical record that the required information was explained and whether the patient accepted or declined the services **Medical Decision-Making** – Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner).

Table 2. CCM Resources

Resource	Website
CCM Materials for Physicians (FAQs and other materials) – Click on "Care Management"	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched
CCM Materials for FQHCs and RHCs	CMS.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html
CCM Materials for Hospital Outpatient Departments	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS
Care planning tools and resources	• Integrationacademy.ahrq.gov/products/playbook/develop-shared-care-plan • IHI.org/resources/Pages/Tools/MySharedCarePlan.aspx • Catalyst.nejm.org/making-the-comprehensive-shared-care-plan-a-reality

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Table 2. CCM Resources (Cont.)

Resource	Website
Chronic Conditions	CMS.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions
Chronic Conditions Data Warehouse	CCWDATA.org/web/guest/home
Governing Regulation	• CY 2014 Medicare PFS Final Rule (CMS-1600-FC) pages 74414-74427: Govinfo.gov/content/pkg/FR-2013-12-10/pdf/2013-28696.pdf • CY 2015 Medicare PFS Final Rule (CMS-1612-FC) pages 67715-67730: Govinfo.gov/content/pkg/FR-2014-11-13/pdf/2014-26183.pdf • CY 2015 Medicare PFS Final Rule; Correction Amendment (CMS-1612-F2), page 14853: Govinfo.gov/content/pkg/FR-2015-03-20/pdf/2015-06427.pdf • CY 2017 Medicare PFS Final Rule (CMS-1654-F) pages 80243-80251: Govinfo.gov/content/pkg/FR-2016-11-15/pdf/2016-26668.pdf
Health Disparities & CCM	• Mapping Medicare Disparities Tool - Interactive map for the identification of disparities between subgroups of Medicare patients (for example, by geography, race/ethnicity) in chronic conditions, health outcomes, utilization, and spending. Can assist in targeting populations and geographies for CCM. CMS.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities.html • Building an Organizational Response to Health Disparities Resource and concepts for improving equity and responding to health disparities. Concepts include data collection, data analysis, culture of equity, quality improvement, and interventions. CMS.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Guide.pdf
Medicare Administrative Contractor (MAC) Contact Information	Go.CMS.gov/MAC-website-list

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Table 3. Hyperlink Table

Embedded Hyperlink	Complete URL
Physician Fee Schedule Look-Up Tool	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup
Promoting Interoperability	https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms

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mln FACT SHEET

KNOWLEDGE • RESOURCES • TRAINING

ADVANCE CARE PLANNING

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The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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The Centers for Medicare & Medicaid Services (CMS) pays for **voluntary** Advance Care Planning (ACP) under the Medicare Physician Fee Schedule (PFS) and the Hospital Outpatient Prospective Payment System (OPPS).

ACP helps Medicare patients make important decisions about the type of care they get and where and when they get it. This fact sheet includes:

- Provider and patient eligibility information
- How to code ACP services
- How to bill ACP services
- An example of ACP in practice
- Resources

WHAT IS VOLUNTARY ACP?

Voluntary ACP is a face-to-face service between a Medicare physician (or other qualified health care professional) and a patient to discuss the patient's health care wishes if they become unable to make decisions about their care. As part of this discussion, the provider may talk about advance directives with or without completing relevant legal forms. An **advance directive** is a document that appoints an agent and/or records the person's wishes about their medical treatment based on personal values and preferences, to be used at a future time if the individual is unable to speak for themselves. "Advance directive" is a general term that refers to various documents such as a living will, instruction directive, health care proxy or health care power of attorney. State attorney generals' offices post forms on their websites.

PATIENT ELIGIBILITY

Medicare pays for ACP as either:

- An optional element of a patient's Annual Wellness Visit (AWV)
- A separate Medicare Part B medically necessary service

There are no limits on the number of times you can report ACP for a given patient in a given period. When billing this patient service multiple times, document the change in the patient's health status and/or wishes regarding their end-of-life care.

When a patient elects to get ACP services outside of the AWV, we encourage practitioners to notify the patient that Part B cost sharing applies as it does for other physicians' services.

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PROVIDER AND LOCATION ELIGIBILITY

Physicians and non-physician practitioners (NPPs) may bill ACP services if their scope of practice and Medicare benefit category include the services described by the Current Procedural Terminology (CPT) codes in Table 1.

There are no place-of-service limitations on ACP services. You can appropriately provide ACP services in **facility and non-facility settings**. Medicare does not limit ACP services to a particular physician specialty.

Some people may need ACP multiple times in a year if they are very ill and/or their circumstances change. Others may not need the service at all in a year.

DIAGNOSIS

CMS does not require a specific diagnosis to bill the ACP codes. Report the condition you are counseling the patient about using an International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code to reflect an administrative examination, or a well exam diagnosis when given as part of the Medicare AWV.

CODING

Hospitals, physicians, and NPPs should use the CPT codes in Table 1 to file claims for ACP services.

Table 1. CPT Codes and Descriptors

CPT Codes	Billing Code Descriptors
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)

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BILLING

Medicare waives the coinsurance and the Medicare Part B deductible for ACP when you meet all the following:

- Provided on the same day as a covered AWV
- Furnished by the same provider as a covered AWV
- Billed with modifier –33 (Preventive Services)

Voluntary ACP is a preventive service when billed on the same claim with the AWV (HCPCS codes G0438 or G0439) on the same day by the same provider, so CMS waives the deductible and coinsurance for the service. If the AWV is denied for exceeding the once-per-year limit, Medicare can still make the ACP payment. In that case, CMS applies the deductible and coinsurance to the ACP service.

The deductible and coinsurance DOES APPLY when ACP is provided outside the covered AWV.

NOTE: Critical Access Hospitals (CAHs) may bill ACP services using type of bill 85X with revenue codes 96X, 97X, and 98X. Medicare bases the CAH Method II payment on the lesser of the actual charge or the facility-specific Medicare PFS.

ACP EXAMPLE

A 68-year-old male with heart failure and diabetes is on multiple medications. He sees his physician for the Evaluation and Management (E/M) of these two diseases and the physician adjusts medications if appropriate.

While discussing short-term treatment options, the patient wants to discuss long-term treatment options. The doctor and patient talk about a possible heart transplant if his congestive heart failure worsens. They also discuss ACP, including the patient's desire for care and treatment if he suffers a health event that adversely affects his decision-making abilities, and the physician helps him complete the form from his state attorney general's office.

In this case, the physician reports a standard E/M code for the E/M service and one or both of the ACP codes depending on the duration of the ACP service. The ACP service in this example does not have to occur on the same day as the E/M service.

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RESOURCES

Table 2. ACP Resources

Resource	Website
42 Code of Federal Regulations, Part 489, Subpart I (policy governing Advance Directives)	eCFR.gov/cgi-bin/text-idx?SID=2925ab372ec5eb080d597363ee17a6cc&mc=true&node=pt42.5.489&rgn=div5#sp42.5.489.i
2016 Hospital Outpatient Prospective Payment Systems Final Rule (OPPS policy governing ACP services) Pages 70469–70470	FederalRegister.gov/d/2015-27943
2016 Medicare Physician Fee Schedule Final Rule (Medicare PFS policy governing ACP services) Pages 70955–70959	FederalRegister.gov/d/2015-28005
ACP Frequently Asked Questions	CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf
Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV), MLN Matters® Article MM9271	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9271.pdf
Advance Care Planning: An Introduction for Public Health and Aging Services Professionals (free course offering continuing education credit)	CDC.gov/Aging/AdvanceCarePlanning/Care-Planning-Course.htm
Advance Care Planning (ACP) Implementation for Outpatient Prospective Payment System (OPPS) Claims, MLN Matters Article MM9862	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9862.pdf
Advance Care Planning (information for Medicare patients)	Medicare.gov/Coverage/Advance-Care-Planning
A Physician's Guide to Talking About End-of-Life Care, Journal of General Internal Medicine	NCBI.NLM.NIH.gov/PMC/Articles/PMC1495357
Billing for Advance Care Planning (ACP) Claims, MLN Matters Article MM10000	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10000.pdf

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Table 2. ACP Resources (cont.)

Resource	Website
Medicare Administrative Contractor Contact Information	Go.CMS.gov/MAC-website-list
Medicare Benefit Policy Manual Chapter 15, Covered Medical and Other Health Services, Section 280.5.1	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
Medicare Claims Processing Manual Chapter 18, Preventive and Screening Services, Section 140.8	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf
National Hospice and Palliative Care Organization (download your state's advance directives)	NHPCO.org/patients-and-caregivers/advance-care-planning/advance-directives
National Institute on Aging Advance Care Planning	NIA.NIH.gov/Health/Caregiving/Advance-Care-Planning

Table 3. Hyperlink Table

Embedded Hyperlink	Complete URL
Annual Wellness Visit	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1246474.html
Evaluation and Management	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html
International Classification of Diseases, Tenth Revision, Clinical Modification	https://www.cms.gov/Medicare/Coding/ICD10
Medicare Part B	https://www.medicare.gov/what-medicare-covers/what-part-b-covers

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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 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. 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, resthome, 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
99324	***20***	***50***	***95***

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Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99325	***30***	***80***	***105***
99326	***45***	***75***	***120***
99327	***60***	***90***	***135***
99328	***75***	***105***	***150***
99334	***15***	***45***	***90***
99335	***25***	***55***	***100***
99336	***40***	***70***	***115***
99337	***60***	***90***	***135***
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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Find it HERE!!

CMS Manual System	Department of Health & Human Services (DHH)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1490	**Date: April 11, 2008**
	Change Request 5972

NOTE: Transmittal 1490, dated April 11, 2008, is being re-issued to correct the Effective Date. The correct date is July 1, 2008. The correct date is July 1, 2008. In addition, in the manual instruction, §30.6.15.1.B, the words "and Subsequent Hospital Care," was added before the codes 99223-99223, 99232- 99233. Also in Section G, the table, "Threshold Time for Prolonged Visit Codes 99356 and/or 99357 Billed with *Inpatient Setting* Codes," the last 5 codes 99307-99318, a calculation error was made. The Transmittal Number, Date Issued and all other information remain the same.

SUBJECT: Prolonged Services (Codes 99354 - 99359)

I.SUMMARY OF CHANGES: This transmittal updates Chapter 12, §§30.6.15.1 and 30.6.15.2. Several code changes, code deletions, and typical/average time units have changed in the American Medical Association Current Procedural Terminology (*CPT*) coding system since the manual section was first written. Physician visits for counseling and/or coordination of care are based on typical/average time units necessitating a section explaining current Medicare policy. The time approximation must meet or exceed the typical/average time of a specific code and shall not be "rounded" to the next higher level. Prolonged services may only be reported with the highest code level in a code family for counseling and/or coordination of care services based on time. The tables for threshold times are corrected and updated.

New / Revised Material Effective Date: July 1, 2008
Implementation Date: July 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated) R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	12/30/30.6.15.1/Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes)
R	12/30/30.6.15.2/Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359)

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III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

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Attachment - Business Requirements

Pub. 100-04	Transmittal: 1490	Date: April 11, 2008	Change Request: 5972

NOTE: Transmittal 1490, dated April 11, 2008, is being re-issued to correct the Effective Date. The correct date is July 1, 2008. The correct date is July 1, 2008. In addition, in the manual instruction, §30.6.15.1, B, the words "and Subsequent Hospital Care," was added before the codes 99221-99223, 99232-99233. Also in Section G, the table, "Threshold Time for Prolonged Visit Codes 99356 and/or 99357 Billed with *Inpatient Setting* Codes," the last 5 codes 99307-99318, a calculation error was made. The Transmittal Number, Date Issued and all other information remain the same.

SUBJECT: Prolonged Services (Codes 99354 – 99359) Effective Date: July 1, 2008

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: This transmittal updates Chapter 12, §30.6.15.1 and §30.6.15.2. Several code changes, code deletions and typical/average time units have changed in the American Medical Association Current Procedural Terminology (CPT) coding system since the manual section was first written. Physician visits for counseling and/or coordination of care are based on typical/average time units necessitating a section explaining current Medicare policy.

B. Policy: The Prolonged Services definition and required evaluation and management companion codes are explained. The explanations are in keeping with current Medicare payment policy for physician presence, supporting documentation and in recognition of code changes that have occurred since last revised. The tables for threshold times are corrected and updated to reflect code changes and current typical/average time units associated with the CPT levels of care in code families. A new subsection (30.6.15.1 (H) is added to 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. The time approximation must meet or exceed the typical/average time of a specific CPT code billed and shall not be "rounded" to the next higher level. Prolonged Services may only be reported with the highest code level in a code family for counseling and/or coordination based on time. New examples are provided.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CAR RIER	RHH	Shared-System Maintainers: FISS	MCS	VMS	CWF	OTHER
5972.1	Contractors shall instruct physicians and qualified	X			X						

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Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CAR RIER	RHH	Shared-System Maintainers: FISS	MCS	VMS	CWF	OTHER
	nonphysician practitioners (NPPs) on the definition and correct use of prolonged services for direct face-to-face patient contact with codes 99354 – 99357 as explained in §30.6.15.1 (A) and (E).										
5972.2	Contractors shall instruct physicians and qualified NPPs on the required evaluation and management companion codes to use with prolonged services codes, 99354 – 99357 as explained in §30.6.15.1 (B).	X			X						
5972.3	Contractors shall instruct physicians and qualified NPPs that time spent reviewing charts or a discussion of the patient with house medical staff and not with direct face-to-face patient contact does not meet the requirement for prolonged hospital services as explained in §30.6.15.1 (C).	X			X						
5972.4	Contractors shall instruct physicians and qualified NPPs that the medical record must be appropriately and sufficiently documented by the physician or qualified NPP to show direct face-to-face patient contact and enter the dated start and end times of the prolonged service as explained in §30.6.15.1 (D).	X			X						
5972.5	Contractors shall instruct physicians and qualified NPPs to apply the threshold times for codes 99354 and 99355 for the office or outpatient setting as identified in the table in §30.6.15.1 (F).	X			X						
5972.6	Contractors shall instruct physicians and qualified NPPs to apply the threshold times for codes 99356 and 99357 for the inpatient setting as identified in the table in §30.6.15.1 (G).	X			X						

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Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CAR RIER	RHH	Shared-System Maintainers: FISS	MCS	VMS	CWF	OTHER
	that prolonged services without direct face-to-face [illegible] and 99359, are not separately payable and are included in the payment for										
III. PRO	**[illegible]**										

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CAR RIER	RHH	Shared-System Maintainers: FISS	MCS	VMS	CWF	OTHER
5972.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information [illegible] within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						
IV. SUPP											
Section A: Fo	**any recommendations and supporting information associa**	**ted**	**with**	**lis**	**ed**	**requirem**	**ents,**	**u se t**	**he**		
has below: Use *"Should"*	*to denote a recommendation.*										

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X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space:

The American Medical Association Current Procedural Terminology (CPT), 2008, Evaluation and Management Section, pp. 9 – 29.

V. CONTACTS

Pre-Implementation Contact(s): Kit Scally (Cathleen.Scally@cms.hhs.gov)

Post-Implementation Contact(s): Appropriate Regional Office staff

VI. FUNDING

Section A: ***For Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs) use only one of the following statements:***

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: ***For Medicare Administrative Contractors (MACs), use the following statement:***

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

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30.6.15.1 - Prolonged Services *With Direct Face-to-Face Patient Contact Service* (Codes 99354 - *99357*) (ZZZ codes)

(Rev.1490, Issued: 04-11-08, Effective: 07-01-08, Implementation: 07-07-08)

A.Definition

Prolonged *physician* services (*CPT code* 99354) *in the office or other outpatient setting with direct face-to-face patient contact which require one hour beyond the usual service* are payable when billed on the same day by the same physician *or qualified nonphysician practitioner (NPP)* as the companion evaluation and management codes. *The time for usual service refers to the typical/average time units associated with the companion evaluation and management service as noted in the CPT code. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99355.*

Prolonged physician services (code 99356) in the inpatient setting, with direct face-to- face patient contact which require one hour beyond the usual service are payable when they are billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. 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.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.

Code 99355 or 99357 may be used 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.

B.Required Companion Codes

- The companion *evaluation and management* codes for 99354 are *the Office or Other Outpatient visit codes* (99201 - 99205, 99212 – 99215), *the Office or Other Outpatient Consultation codes* (99241 – 99245), *the Domiciliary, Rest Home, or Custodial Care Services codes (99324 – 99328*, *99334 – 99337)*, *the Home Services codes* (99341 - 99345, 99347 – 99350);
- The companion codes for 99355 are 99354 and one of the evaluation and management codes required for 99354 to be used;
- The companion *evaluation and management* codes for 99356 are *the Initial Hospital Care codes and Subsequent Hospital Care codes (*99221 - 99223, 99231 –99233), *the Inpatient Consultation codes (*99251 – 99255); Nursing Facility Services codes (99304 -99318) or
- The companion codes for 99357 are 99356 and *one* of the evaluation and management codes required for *99356* to be used.

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Prolonged services codes 99354 – *99357* are not paid unless they are accompanied by *the* companion codes *as indicated.*

C. Requirement for Physician Presence

Physicians may count only the duration of direct face-to-face contact between the physician and 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. In the case of prolonged office services, time spent by office staff with the patient, or time the patient remains unaccompanied in the office cannot be billed. In the case of prolonged hospital services, time spent *reviewing charts or discussion of a 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 cannot be billed as prolonged services.

D. Documentation

Documentation is not required to accompany the bill for prolonged services unless the physician has been selected for medical review. Documentation is required in the medical record about the duration and content of the *medically necessary* evaluation and management *service and prolonged services* billed. *The medical record must be appropriately and sufficiently documented by the physician or qualified NPP* to show that the physician *or qualified NPP* personally furnished the *direct face-to-face* time *with the patient* specified in the *CPT* code *definitions*. *The start and end times of the visit shall be documented in the medical record along with the date of service.*

E. Use of the Codes

Prolonged services codes can be billed only 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). If the total duration of direct face-to- face time does not equal or exceed the threshold time for the level of evaluation and management service the physician *or qualified NPP* provided, the physician *or qualified NPP* may not bill for prolonged services.

F. 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, the physician should bill the *evaluation and management* 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, the physician 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. *Contractors* use the following threshold times 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.*

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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
99324	*20*	*50*	*95*
99325	*30*	*60*	*105*
99326	*45*	*75*	*120*
99327	*60*	*90*	*135*
99328	*75*	*105*	*150*
99334	*15*	*45*	*90*
99335	*25*	*55*	*100*

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Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99336	*40*	*70*	*115*
99337	*60*	*90*	*135*
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

Add 30 minutes to the threshold time for billing codes 99354 and 99355 to get the threshold time for billing code 99354 and *two* units of code 99355. For example, to bill code 99354 and *two* units of code 99355 when billing a code 99205, the threshold time is 150 minutes.

G. **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, the physician should bill the visit and code 99356. *Contractors* do 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, the physician bills 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. *Contractors* use the following threshold times to determine if the prolonged services codes 99356 and/or 99357 can be billed with the *inpatient setting* codes.

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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*

Add 30 minutes to the threshold time for billing codes 99356 and 99357 to get the threshold time for billing code 99356 and *two* units of 99357.

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H.Prolonged Services Associated With Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)

When an evaluation and management 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 qualified NPP and the patient in the office/clinic or the floor/ time (in the scenario of an inpatient service), then the evaluation and management 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 evaluation and management code) and should not be "rounded" to the next higher level.

In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.

1.Examples of Billable Prolonged Services EXAMPLE 1

A physician performed a visit that met the definition of *an office* visit code 99213 and the total duration of the direct face-to-face services (including the visit) was 65 minutes. The physician bills 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 code *99327* and the total duration of the direct face-to-face contact (including the visit) was *140* minutes. The physician bills 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 should report CPT code 99215 and one unit of code 99354.

J.Examples of Nonbillable 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.

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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.

30.6.15.2 - Prolonged Services Without *Direct* Face-to-Face *Patient Contact* Service (Codes 99358 -99359)

(Rev.1490, Issued: 04-11-08, Effective: 07-01-08, Implementation: 07-07-08)

Contractors may not pay prolonged services codes 99358,and 99359, which do not require any direct patient *face-to-face* contact *(e.g., telephone calls).* Payment for these services is included in the payment for direct face-to-face services that physicians bill. The physician cannot bill the patient for these services since they are Medicare covered services and payment is included in the payment for other billable services.

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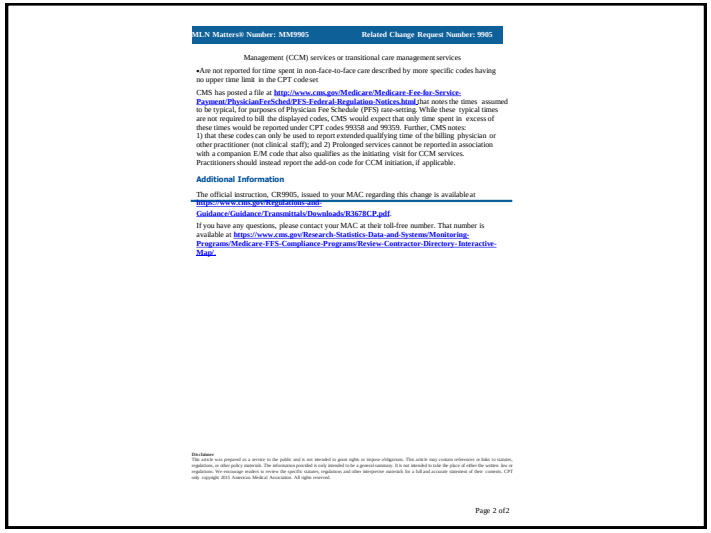

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Questions to Ponder

- Do any of these related services incorporate/include services provided in the current palliative care program of your organization?
- Is this how you're paying for/covering the cost of providing these services now?
- If no, could you within allowable guidelines?

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Importance of....

TEAM

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Switching Gears…

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Components & the Revenue Cycle

A Crash Course

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Operational Perspective

COMPONENTS

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Reimbursement 101

- Step 1. Document the details necessary for payment.
- Step 2. Assign medical codes.
- Step 3. Submit the claim electronically.
- Step 4. Interpret the payer's response.
- Step 5. Prepare for post-payment actions (audits, document requests, etc.).

Source: https://www.carecloud.com/continuum/how-healthcare-reimbursement-works/

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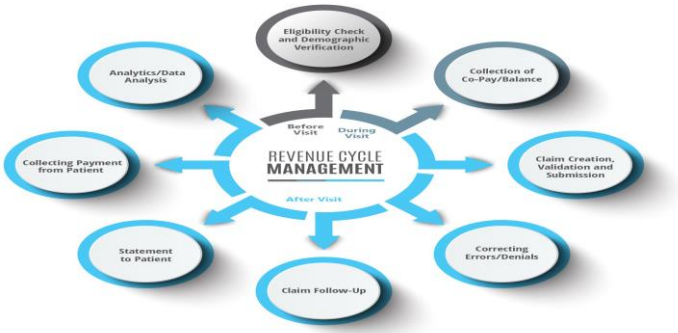
Revenue Cycle



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Reimbursement 101

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Telling the Story

- Use reports (aka, data) to tell the story of the services provided.
- Every service has a purpose – or don't do it, right? (aka, medical necessity)
- Why, How & What of the service
- Connect to value

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Don't Forget About Related Services When Telling Your Story!

Transitional Care
Chronic Care Management
Advanced Care Planning

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Like Dominoes

Incomplete documentation, leads to incomplete coding, leads to incomplete billing, leads to incomplete reimbursement.

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Documentation

The ***cornerstone*** of the business.

(aka, If it's not documented, it didn't happen and therefore cannot be coded nor billed for reimbursement.)

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Value-Based Defined

"Value-based care refers to the departure from a system in which providers were paid for the number of healthcare services provided (e.g., tests, visits, procedures), to a focus on an approach designed around patients, for improved health, quality delivery of care, and lower cost of care."

Source: https://nosorh.org/wp-content/uploads/2017/09/SORH-RHC-ENGAGEMENT-TOOLKIT-Final.pdf

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Value-Based Defined

"Value-based care focuses on:

- Provider payment incentives that reward value rather than volume
- Models of care delivery that coordinate and integrate clinical services for both patients and communities, with a focus on prevention and wellness
- Information sharing that creates transparency on the cost and quality of care to support better decision-making by providers and consumers"

Source: https://nosorh.org/wp-content/uploads/2017/09/SORH-RHC-ENGAGEMENT-TOOLKIT-Final.pdf

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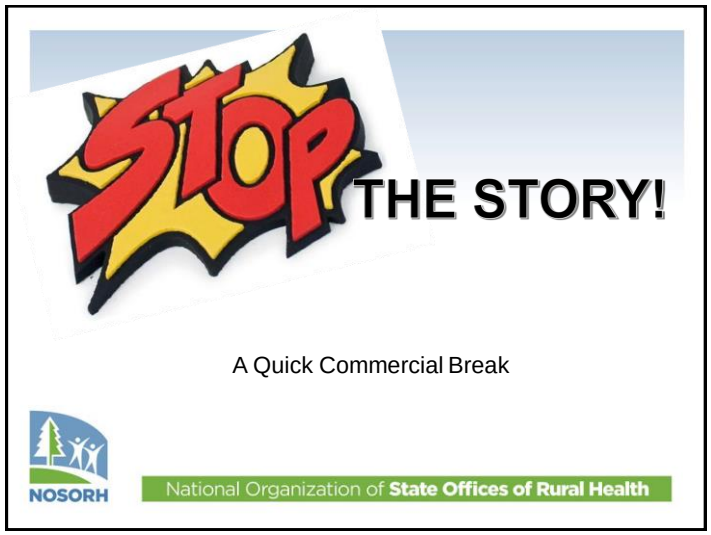

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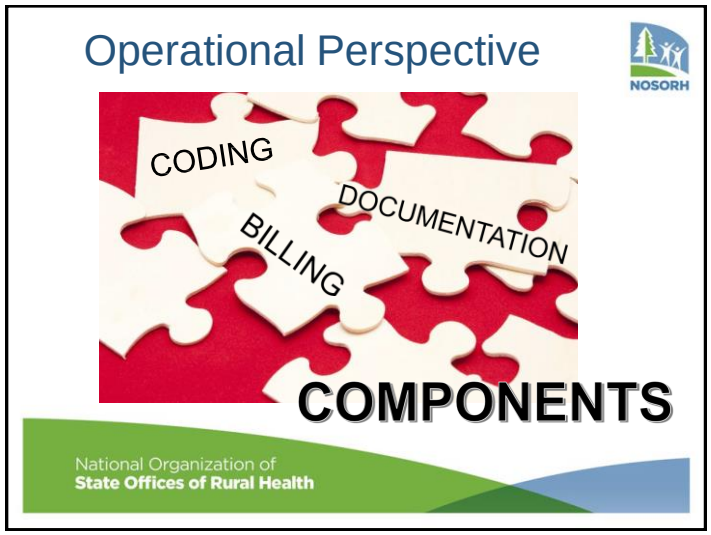

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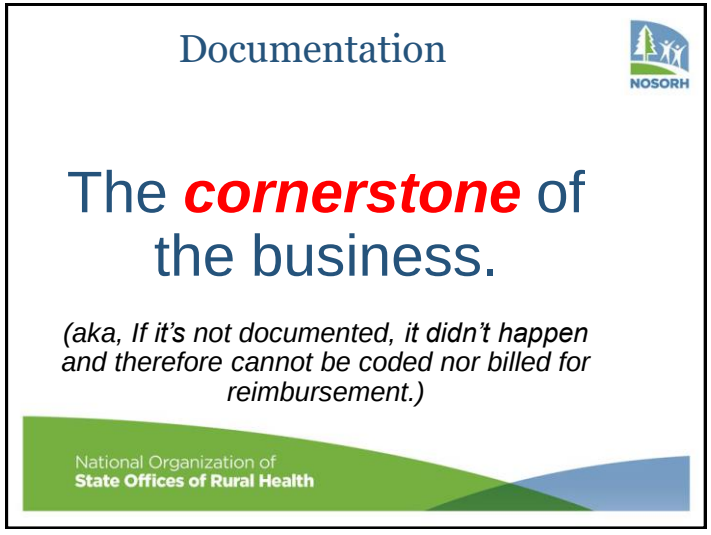

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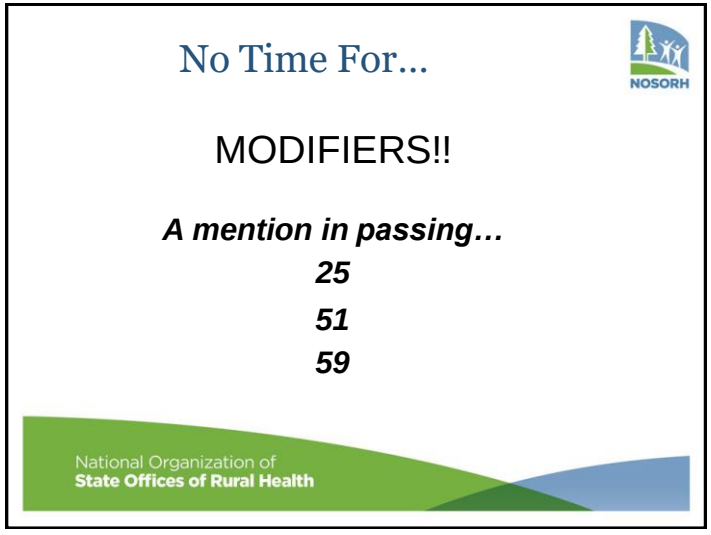

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Conclusion

Making the Pieces Fit

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Putting the Pieces Together

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Making it Fit & Making a Difference

TOGETHER!!

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Where Did We Start?

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What is Palliative Care?

Palliative care is specialized care for people living with serious illness. Care is focused on relief from the symptoms and stress of the illness and treatment—whatever the diagnosis. The goal is to improve and sustain quality of life for the patient, loved ones and other care companions. It is appropriate at any age and at any stage in a serious illness and can be provided along with active treatment. Palliative care facilitates patient autonomy, access to information, and choice. The palliative care team helps patients and families understand the nature of their illness, and make timely, informed decisions about care.

Source: https://waportal.org/partners/home/washington-rural-palliative-care-initiative

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Why do we provide these services?

Rural populations are disproportionately ill, disabled, poor, and older. Rural adults are more likely than their urban counterparts to have a range of chronic conditions.

Source: http://www.stratishealth.org/documents/Stratis-Health-Rural-Palliative-Care-2014-09.pdf

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How do we bring all this together – wrap it up with a pretty bow?

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Power of Rural Tenets

- Communicate
- Educate
- Collaborate
- Innovate

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It's Time

It's time for rural providers to prepare for quality-driven programs that will directly impact value and, therefore, reimbursement.

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Questions??

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Resources & Contact Information

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Resources

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https://nosorh.org/

The Power of Rural (#powerofrural)

http://www.powerofrural.org/

Stratis Health

http://www.stratishealth.org/expertise/longterm/palliative.html

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Resources

CMS Rural Health Clinic Center

https://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

CMS Critical Access Hospital Center

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs.html

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Resources

CMS ICD-10 Guidelines for Coding & Reporting 2019

https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf

Medicare Learning Network (MLN)

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

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Resources

Rural Providers and Suppliers Billing

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

Rural Health Value (RUPRI)

https://ruralhealthvalue.public-health.uiowa.edu/

Rural Health Information Hub

https://www.ruralhealthinfo.org/

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Resources

Acevedo Consulting Inc. (Private Consultants)

https://www.acevedoconsultinginc.com/hospice-palliative-care

Get Palliative Care

https://getpalliativecare.org

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Questions or Comments?

Thanks so much!
Your participation is appreciated!

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Mobile: 919.215.0220 (including text)
Email: tammyn@nosorh.org

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Stay Well & Be Safe!

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Ryder & Buster

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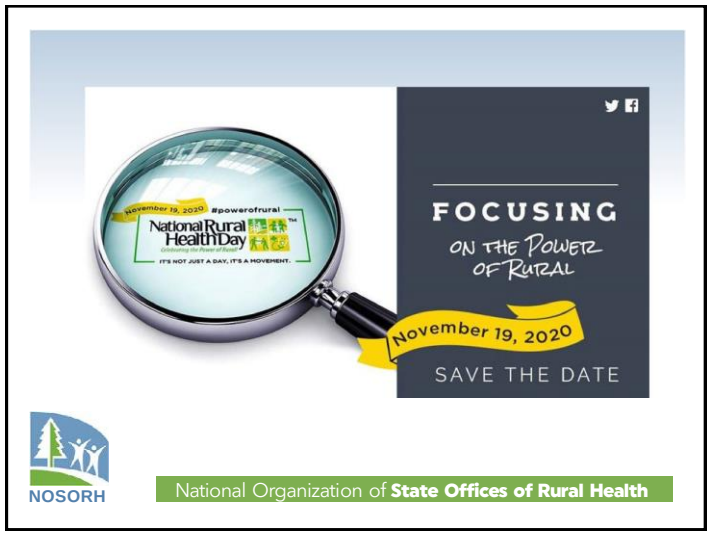

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Questions?

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Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety and serves as a trusted expert in facilitating improvement for people and communities.

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