INTEGRATION OF PALLIATIVE CARE IN RURAL COMMUNITIES

PAT JUSTIS, MA
Pat Justis
Executive Director
Rural Health/Office of Community Health Systems
Introduction

- Brief overview of the WA Rural Palliative Care Initiative; why serious illness care matters.
- The overall goal for today: relevant to any health system who cares for patients with serious illness.
  - Principles and concepts that generalize to other conditions and scenarios.
"You've got six months, but with aggressive treatment we can help make that seem much longer."

Why palliative care?
All hospice is palliative care but not all PC is hospice

**Hospice**
- Medicare benefit
- End of life care; 6 months
- Must give up curative treatments

**Palliative care**
- Increasing in community settings
- Patchwork of applicable codes but few named benefits
- Concurrent with curative care
- At any stage in a serious illness
Washington Rural Palliative Care Initiative

objectives

- Assist rural health systems and communities to integrate palliative care in multiple settings, to better serve patients with serious illness in rural communities.
- Move upstream to serve patients with serious illness earlier in their experience of illness.
- Develop funding models for sustainable services
Washington Rural Palliative Care Initiative Model

Community engagement

Fiscal sustainability

Clinical telemedicine

Clinical skills and culture change

Telehealth case consultation
Sustainability

- Increase revenue generating skills across the team
- Negotiate value based contracts with shared savings incentives
- Contribute to policy changes
- Demonstrate alignments with ACHs
- Build philanthropic support
- Seek grant funding
- Collaborate with payers to build benefits
- Metrics to demonstrate the value and business case
- Build volunteer contributions
2020

- Five web based education events open to all rural health teams
- Opening a Cohort 2 in Q1-6-8 slots with a likely RFQ “lite” process to select participants
- Will request letters of interest widely to open a communication loop on the opportunity.
THE TEAM THAT DOES NOT KNOW IT IS A TEAM:

FROM DOCUMENTING TO CODING TO DENIALS TO REVENUE TO VALUE

Tammy Norville
November 7, 2019
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.
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.
Some Parameters

• Please turn sound off on electronic devices (but I hope you have one with you!)

• Please ask questions – If it’s something that needs additional information/etc. You will receive follow up after the session.

• Feel free to take a break when you need one – there’s only one “scheduled” break (about 10 AM)

• The session is divided into two parts... Some content is duplicated with a little different perspective
Road Map

- Getting to Know Each Other
- Introduction
- The Reason We Do What We Do
- Documentation, Coding & Billing
- Scenarios
- Components & the Revenue Cycle
- A Quick Commercial Break
- More Scenarios
- Conclusion
- Resources
- Contact Info
Getting to Know Each Other
A Little About You!

• CEOs?
• CFOs?
• Other C-Suite folks?
• Providers?
• Clinical Managers?
• Office Managers?
• Coding/Billing folks?
• Others?
A Little About Me!

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

Ryder
Buster
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.
Power of Rural Campaign

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!

Nominate your stars!

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.
Important Reminder

I am not clinical.
1. Introduction

Level the Playing Field
Background
A Few Questions

Who is currently providing Palliative Care Services?

Who is billing for these services?

Who is receiving reimbursement for these services?
Operational Perspective

Connection to Value
Operational Perspective

CODING

BILLING

DOCUMENTATION

COMPONENTS
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.”

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”

Team??

National Organization of State Offices of Rural Health
It Takes A Village
Who Is On The Team?
2. The Reason We Do
What We Do

Eye on the Prize
Medical Necessity

It's the right thing to do!

National Organization of State Offices of Rural Health
Medical Necessity

Need to answer:

- *What service is needed?*
- *Why are we performing the service?*
- *How will the service be performed?*
- *Who will perform the service?*
- *Where will the service be performed?*
Medical Necessity

Important

LOCATION... Does it matter?

National Organization of State Offices of Rural Health
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.

<table>
<thead>
<tr>
<th>Place of Service Code(s)</th>
<th>Place of Service Name</th>
<th>Place of Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Pharmacy**</td>
<td>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)</td>
</tr>
<tr>
<td>02</td>
<td>Telehealth</td>
<td>The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)</td>
</tr>
<tr>
<td>03</td>
<td>School</td>
<td>A facility whose primary purpose is education. (Effective January 1, 2003)</td>
</tr>
<tr>
<td>04</td>
<td>Homeless Shelter</td>
<td>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)</td>
</tr>
<tr>
<td>05</td>
<td>Indian Health Service Free-standing Facility</td>
<td>A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (Effective January 1, 2003)</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
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</tr>
<tr>
<td>06</td>
<td>Indian Health Service Provider-based Facility</td>
<td>A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (Effective January 1, 2003)</td>
</tr>
<tr>
<td>07</td>
<td>Tribal 638 Free-standing Facility</td>
<td>A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization. (Effective January 1, 2003)</td>
</tr>
<tr>
<td>08</td>
<td>Tribal 638 Provider-based Facility</td>
<td>A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (Effective January 1, 2003)</td>
</tr>
<tr>
<td>09</td>
<td>Prison/Correctional Facility</td>
<td>A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (Effective July 1, 2006)</td>
</tr>
<tr>
<td>10</td>
<td>Unassigned</td>
<td>N/A</td>
</tr>
<tr>
<td>11</td>
<td>Office</td>
<td>Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides</td>
</tr>
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National Organization of State Offices of Rural Health
<table>
<thead>
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<tr>
<td></td>
<td></td>
<td>health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.</td>
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<tr>
<td>12</td>
<td>Home</td>
<td>Location, other than a hospital or other facility, where the patient receives care in a private residence.</td>
</tr>
<tr>
<td>13</td>
<td>Assisted Living Facility</td>
<td>Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (Effective October 1, 2003)</td>
</tr>
<tr>
<td>14</td>
<td>Group Home*</td>
<td>A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration). (Effective October 1, 2003)</td>
</tr>
<tr>
<td>15</td>
<td>Mobile Unit</td>
<td>A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. (Effective January 1, 2003)</td>
</tr>
<tr>
<td>16</td>
<td>Temporary Lodging</td>
<td>A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (Effective January 1, 2008)</td>
</tr>
<tr>
<td>17</td>
<td>Walk-in Retail Health Clinic</td>
<td>A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.</td>
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<td>Place of Service Code(s)</td>
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<td>Place of Service Description</td>
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<tr>
<td>(This code is available for use immediately with a final effective date of May 1, 2010)</td>
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<tr>
<td>18</td>
<td>Place of Employment-Worksite</td>
<td>A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013)</td>
</tr>
<tr>
<td>19</td>
<td>Off Campus-Outpatient Hospital</td>
<td>A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)</td>
</tr>
<tr>
<td>20</td>
<td>Urgent Care Facility</td>
<td>Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. (Effective January 1, 2003)</td>
</tr>
<tr>
<td>21</td>
<td>Inpatient Hospital</td>
<td>A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.</td>
</tr>
<tr>
<td>22</td>
<td>On Campus-Outpatient Hospital</td>
<td>A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
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<td>Place of Service Description</td>
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<tr>
<td>23</td>
<td>Emergency Room - Hospital</td>
<td>A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.</td>
</tr>
<tr>
<td>24</td>
<td>Ambulatory Surgical Center</td>
<td>A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.</td>
</tr>
<tr>
<td>25</td>
<td>Birthing Center</td>
<td>A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.</td>
</tr>
<tr>
<td>26</td>
<td>Military Treatment Facility</td>
<td>A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).</td>
</tr>
<tr>
<td>27-30</td>
<td>Unassigned</td>
<td>N/A</td>
</tr>
<tr>
<td>31</td>
<td>Skilled Nursing Facility</td>
<td>A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.</td>
</tr>
<tr>
<td>32</td>
<td>Nursing Facility</td>
<td>A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.</td>
</tr>
<tr>
<td>33</td>
<td>Custodial Care Facility</td>
<td>A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
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<td>Place of Service Description</td>
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<tr>
<td>34</td>
<td>Hospice</td>
<td>A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.</td>
</tr>
<tr>
<td>35-40</td>
<td>Unassigned</td>
<td>N/A</td>
</tr>
<tr>
<td>41</td>
<td>Ambulance – Land</td>
<td>A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.</td>
</tr>
<tr>
<td>42</td>
<td>Ambulance – Air or Water</td>
<td>An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.</td>
</tr>
<tr>
<td>43-48</td>
<td>Unassigned</td>
<td>N/A</td>
</tr>
<tr>
<td>49</td>
<td>Independent Clinic</td>
<td>A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only. (Effective October 1, 2003)</td>
</tr>
<tr>
<td>50</td>
<td>Federally Qualified Health Center</td>
<td>A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.</td>
</tr>
<tr>
<td>51</td>
<td>Inpatient Psychiatric Facility</td>
<td>A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.</td>
</tr>
<tr>
<td>52</td>
<td>Psychiatric Facility – Partial Hospitalization</td>
<td>A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.</td>
</tr>
<tr>
<td>53</td>
<td>Community Mental Health Center</td>
<td>A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly.</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
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</tr>
<tr>
<td>54</td>
<td>Intermediate Care Facility/Individuals with Intellectual Disabilities</td>
<td>A facility which primarily provides health-related care and services above the level of custodial care to individuals but does not provide the level of care or treatment available in a hospital or SNF.</td>
</tr>
<tr>
<td>55</td>
<td>Residential Substance Abuse Treatment Facility</td>
<td>A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.</td>
</tr>
<tr>
<td>56</td>
<td>Psychiatric Residential Treatment Center</td>
<td>A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.</td>
</tr>
<tr>
<td>57</td>
<td>Non-residential Substance Abuse Treatment Facility</td>
<td>A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing. (Effective October 1, 2003)</td>
</tr>
<tr>
<td>58-59</td>
<td>Unassigned</td>
<td>N/A</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
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</tr>
<tr>
<td>60</td>
<td>Mass Immunization Center</td>
<td>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.</td>
</tr>
<tr>
<td>61</td>
<td>Comprehensive Inpatient Rehabilitation Facility</td>
<td>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.</td>
</tr>
<tr>
<td>62</td>
<td>Comprehensive Outpatient Rehabilitation Facility</td>
<td>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.</td>
</tr>
<tr>
<td>63-64</td>
<td>Unassigned</td>
<td>N/A</td>
</tr>
<tr>
<td>65</td>
<td>End-Stage Renal Disease Treatment Facility</td>
<td>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.</td>
</tr>
<tr>
<td>66-70</td>
<td>Unassigned</td>
<td>N/A</td>
</tr>
<tr>
<td>71</td>
<td>Public Health Clinic</td>
<td>A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.</td>
</tr>
<tr>
<td>72</td>
<td>Rural Health Clinic</td>
<td>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.</td>
</tr>
<tr>
<td>73-80</td>
<td>Unassigned</td>
<td>N/A</td>
</tr>
<tr>
<td>Place of Service Code(s)</td>
<td>Place of Service Name</td>
<td>Place of Service Description</td>
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</tr>
<tr>
<td>81</td>
<td>Independent Laboratory</td>
<td>A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.</td>
</tr>
<tr>
<td>82-98</td>
<td>Unassigned</td>
<td>N/A</td>
</tr>
<tr>
<td>99</td>
<td>Other Place of Service</td>
<td>Other place of service not identified above.</td>
</tr>
</tbody>
</table>

* Revised, effective April 1, 2004.

** Revised, effective October 1, 2005.
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.”
Switching Gears...
3. Documentation, Coding & Billing

Quick Course
Is there an ICD-10 code for Palliative Care?
What is Coding?

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

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
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.)*
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
Palliative Care vs. Hospice Care

Similar but Different

**Palliative Care**
- Focuses on relief from physical suffering. The patient may be being treated for a disease or may be living with a chronic disease, and may or may not be terminally ill.
- Addresses the patient’s physical, mental, social, and spiritual well-being, is appropriate for patients in all disease stages, and accompanies the patient from diagnosis to cure.
- Uses life-prolonging medications.
- Uses a multi-disciplinary approach using highly trained professionals. Is usually offered where the patient first sought treatment.

**Hospice Care**
- Available to terminally ill Medicaid participants. Each State decides the length of the life expectancy a patient must have to receive hospice care under Medicaid. In some States it is up to 6 months; in other States, up to 12 months. Check with your State Medicaid agency if you have questions.
- Makes the patient comfortable and prepares the patient and the patient’s family for the patient’s end of life when it is determined treatment for the illness will no longer be pursued.
- Does not use life-prolonging medications.
- Relies on a family caregiver and a visiting hospice nurse. Is offered at a place the patient prefers such as in their home; in a nursing home; or, occasionally, in a hospital.

**Combined Care**
Hospices are the largest providers of palliative care services in the country. Many organizations work together to offer the patient a seamless continuum of care over the course of a serious illness.

Follow us on Twitter: @MedicaidIntegrity

National Organization of State Offices of Rural Health
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)
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.
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)
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.
History of Present Illness

• Location
• Timing
• Quality
• Context
• Severity - Modifying factors
• Associated signs & symptoms significantly related to the presenting problem(s)
Review of Systems – “An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.”
Review of Systems

- Constitutional symptoms (fever, weight loss, etc.)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal

- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic
Past, Family, Social History

- **Past** – a review of past experiences with illnesses, injuries, and treatments including significant information about:
  - Prior major illnesses and injuries
  - Prior operations
  - Prior hospitalizations
  - Current medications
  - Allergies (e.g., drug, food)
  - Age appropriate immunization status
  - Age appropriate feeding/dietary status
• **Family** – a review of medical events in the patient’s family that includes significant information about:
  
  • The health status or cause of death of parents, siblings, and children
  
  • Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness and/or System Review
  
  • Diseases of family members which may be hereditary or place the patient at risk
• **Social** – An age appropriate review of past and current activities that includes significant information about:
  
  • Marital status and/or living arrangements
  • Current employment
  • Occupational history
  • Use of drugs, alcohol, and tobacco
  • Level of education
  • Sexual history
  • Other relevant social factors
History Component

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.
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)
• **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)
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.
5 Types of Presenting Problems

• **Minimal** – may not require the presence of the physician, but service is provided under the 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.
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
Examination Performed – 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.
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)
CPT Recognized Body Areas

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

- Eyes
- Ears, Nose, Mouth, & Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary

- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic
LET'S PARTY!

LIKE IT'S 1995!!

National Organization of State Offices of Rural Health
### 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
How do you code an encounter?

Select a level of E/M service

- Identify the category and subcategory of service
- Review the reporting instructions
- Review the level of E/M service descriptors
  - history, exam, medical decision making, counseling, coordination of care, nature of presenting problem, & time
How do you code an encounter?

Another way to say it...

• 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
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
How do you determine medical decision making???
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).

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

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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.
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.
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.

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

Elements for Each Level of Medical Decision Making

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.
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.
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.
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**

<table>
<thead>
<tr>
<th>LEVEL OF RISK</th>
<th>PRESENTING PROBLEM(S)</th>
<th>DIAGNOSTIC PROCEDURE(S) ORDERED</th>
<th>MANAGEMENT OPTIONS SELECTED</th>
</tr>
</thead>
</table>
| **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 |
<table>
<thead>
<tr>
<th>LEVEL OF RISK</th>
<th>PRESENTING PROBLEM(S)</th>
<th>DIAGNOSTIC PROCEDURE(S) ORDERED</th>
<th>MANAGEMENT OPTIONS SELECTED</th>
</tr>
</thead>
</table>
| 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 |
What’s The Big Deal?

Improper coding results in the practice

• Loss of revenue
• Refunds
• Fines
• Accusations of Fraud
• Medicare – OIG
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).
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.

## 21 Chapters of the ICD-10-CM

<table>
<thead>
<tr>
<th>A00-B99 Certain Infections &amp; Parasitic Diseases</th>
<th>L00-L99 Diseases of the Skin &amp; Subcutaneous Tissue</th>
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</thead>
<tbody>
<tr>
<td>C00-D49 Neoplasms</td>
<td>M00-M99 Diseases of the Musculoskeletal System</td>
</tr>
<tr>
<td>D50-D89 Diseases of the Blood &amp; Blood-forming Organs &amp; Certain Disorders involving Organs &amp; Certain Disorders involving the Immune Mechanism</td>
<td>N00-N99 Diseases of the Genitourinary System</td>
</tr>
<tr>
<td>E00-E89 Endocrine, Nutritional &amp; Metabolic Diseases</td>
<td>O00-O9a Pregnancy childbirth &amp; the Puerperium</td>
</tr>
<tr>
<td>F01-F99 Mental &amp; Behavioral Disorders</td>
<td>P00-P96 Certain Conditions Originating in the Perinatal Period</td>
</tr>
<tr>
<td>G00-G99 Diseases of the Nervous System</td>
<td>Q00-Q99 Congenital Malformations, Deformations &amp; Chromosomal Abnormalities</td>
</tr>
<tr>
<td>H00-H59 Diseases of the Eye &amp; Adnexa</td>
<td>R00-R99 Symptoms, Signs &amp; Abnormal Clinical &amp; Laboratory Findings, Not elsewhere Classified</td>
</tr>
<tr>
<td>H60-H95 Diseases of the Ear and Mastoid Process</td>
<td>S00-T88 Injury, Poisoning &amp; Certain Other Consequences of External Causes</td>
</tr>
<tr>
<td>I00-I99 Diseases of the Circulatory System</td>
<td>V00-Y99 External Causes of Morbidity</td>
</tr>
<tr>
<td>J00-J99 Diseases of the Respiratory System</td>
<td>Z00-Z99 Factors Influencing Health Status &amp; Contact With Health Services</td>
</tr>
<tr>
<td>K00-K94 Diseases of the Digestive System</td>
<td></td>
</tr>
</tbody>
</table>

The Medical Management Institute

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National Organization of State Offices of Rural Health
Coding

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

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

Medical Claim Denied
How might ....

• How might Clinical documentation result in a denied or rejected claim?

• How might Medical Necessity result in a denied or rejected claim?

• Other reasons
  • Patient not covered
  • Non-covered service
  • Others?
Related Services

Transitional Care
Chronic Care Management
Advanced Care Planning
Prolonged Services
TRANSITIONAL CARE MANAGEMENT SERVICES

Target Audience: Medicare Fee-For-Service Providers

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

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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.

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### Table 1. Elements for Each Level of Medical Decision Making

<table>
<thead>
<tr>
<th>Type of Decision Making</th>
<th>Number of Possible Diagnoses and/or Management Options</th>
<th>Amount and/or Complexity of Data to Be Reviewed</th>
<th>Risk of Significant Complications, Morbidity, and/or Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
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</tr>
</tbody>
</table>

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).
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

<table>
<thead>
<tr>
<th>For More Information About…</th>
<th>Resource</th>
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<tr>
<td>Building an Organizational Response to Health Disparities</td>
<td><a href="#">CMS.gov/About-CMS/Agency-Information/OMH/</a></td>
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<td></td>
<td><a href="#">Downloads/Health-Disparities-Guide.pdf</a></td>
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<tr>
<td>E/M Services</td>
<td><a href="#">CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/</a></td>
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<td></td>
<td><a href="#">MLNProducts/MLNPublications-Items/</a></td>
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<td></td>
<td><a href="#">CMS1243514.html</a></td>
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<tr>
<td>Guide to Reducing Disparities in Readmissions</td>
<td><a href="#">CMS.gov/About-CMS/Agency-Information/OMH/</a></td>
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<td><a href="#">Downloads/OMH_Readmissions_Guide.pdf</a></td>
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<td>Medicare Learning Network® Catalog of Products</td>
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<td></td>
<td><a href="#">Downloads/MLNCatalog.pdf</a></td>
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<tr>
<td>TCM Services</td>
<td><a href="#">FederalRegister.gov/d/2014-26183</a></td>
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Table 2. TCM Resources (cont.)

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Table 3. Hyperlink Table

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<tr>
<td>FAQs about Billing the PFS for TCM Services</td>
<td><a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf">https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf</a></td>
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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:

**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.
**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.

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.

**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.
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
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.
Chronic Care Management Services

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.
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.
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 1. CCM Service Summary (Cont.)

<table>
<thead>
<tr>
<th>Home- and Community-Based Care Coordination</th>
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<tr>
<td>• Coordination with home- and community-based clinical service providers</td>
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Document in the patient’s medical record that the required information was explained and whether the patient accepted or declined the services.

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<table>
<thead>
<tr>
<th>Resource</th>
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<tr>
<td>CCM Materials for Physicians (FAQs and other materials) – Click on “Care Management”</td>
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<td>CCM Materials for FQHCs and RHCs</td>
<td>CMS.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html</td>
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<tr>
<td>CCM Materials for Hospital Outpatient Departments</td>
<td>CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS</td>
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</table>
| 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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<tr>
<td>Chronic Conditions Data Warehouse</td>
<td>CCWDATA.org/web/guest/home</td>
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</table>
| 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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Find it HERE!!
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.
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.

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

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Billing Code Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>99497</td>
<td>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</td>
</tr>
<tr>
<td>99498</td>
<td>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)</td>
</tr>
</tbody>
</table>

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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.
## RESOURCES

### Table 2. ACP Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 Code of Federal Regulations, Part 489, Subpart I (policy governing Advance Directives)</td>
<td>eCFR.gov/cgi-bin/text-idx?SID=2925ab372ec5e080d597363ee17a6cc&amp;mc=true&amp;node=pt42.5.489&amp;rgn=div5#sp42.5.489.i</td>
</tr>
<tr>
<td>2016 Hospital Outpatient Prospective Payment Systems Final Rule (OPPS policy governing ACP services)</td>
<td>FederalRegister.gov/d/2015-27943</td>
</tr>
<tr>
<td>2016 Medicare Physician Fee Schedule Final Rule (Medicare PFS policy governing ACP services)</td>
<td>FederalRegister.gov/d/2015-28005</td>
</tr>
<tr>
<td>ACP Frequently Asked Questions</td>
<td>CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf</td>
</tr>
<tr>
<td>Advance Care Planning (ACP) as an Optional Element of an Annual Wellness Visit (AWV), MLN Matters® Article MM9271</td>
<td>CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9271.pdf</td>
</tr>
<tr>
<td>Advance Care Planning: An Introduction for Public Health and Aging Services Professionals (free course offering continuing education credit)</td>
<td>CDC.gov/Aging/AdvanceCarePlanning/Care-Planning-Course.htm</td>
</tr>
<tr>
<td>Advance Care Planning (ACP) Implementation for Outpatient Prospective Payment System (OPPS) Claims, MLN Matters Article MM9862</td>
<td>CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9862.pdf</td>
</tr>
<tr>
<td>Advance Care Planning (information for Medicare patients)</td>
<td>Medicare.gov/Coverage/Advance-Care-Planning</td>
</tr>
<tr>
<td>A Physician’s Guide to Talking About End-of-Life Care, Journal of General Internal Medicine</td>
<td>NCBI.LNIH.gov/PMC/Articles/PMC1495357</td>
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### Table 2. ACP Resources (cont.)

<table>
<thead>
<tr>
<th>Resource</th>
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<tbody>
<tr>
<td>Medicare Administrative Contractor Contact Information</td>
<td>Go.CMS.gov/MAC-website-list</td>
</tr>
<tr>
<td>Chapter 15, Covered Medical and Other Health Services, Section 280.5.1</td>
<td></td>
</tr>
<tr>
<td>Chapter 18, Preventive and Screening Services, Section 140.8</td>
<td></td>
</tr>
<tr>
<td>National Hospice and Palliative Care Organization (download your state's advance directives)</td>
<td>NHPCO.org/patients-and-caregivers/advance-care-planning/advance-directives</td>
</tr>
<tr>
<td>National Institute on Aging Advance Care Planning</td>
<td>NIA.NIH.gov/Health/Caregiving/Advance-Care-Planning</td>
</tr>
</tbody>
</table>

### Table 3. Hyperlink Table

<table>
<thead>
<tr>
<th>Embedded Hyperlink</th>
<th>Complete URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Classification of Diseases, Tenth Revision, Clinical Modification</td>
<td><a href="https://www.cms.gov/Medicare/Coding/ICD10">https://www.cms.gov/Medicare/Coding/ICD10</a></td>
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</table>

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

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

A summary of these manual changes follow.

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99354</th>
<th>Threshold Time to Bill Codes 99354 and 99355</th>
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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.
Table 2  
Threshold Time for Prolonged Visit Codes 99356 and/or 99357  
Billed with Inpatient Setting Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99356</th>
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<td>99318</td>
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</tr>
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</table>

**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.**
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
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 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](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html).

**Document History**

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<td>March 7, 2017</td>
<td>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.</td>
</tr>
<tr>
<td>July 12, 2013</td>
<td>The article was updated, to reflect current Web addresses.</td>
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<tr>
<td>April 29, 2008</td>
<td>Article released</td>
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</table>

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This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2007 American Medical Association.
NOTE: Transmittal 1490, dated April 11, 2008, is being re-issued to correct the Effective Date. 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)

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.

<table>
<thead>
<tr>
<th>R/N/D</th>
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<tr>
<td>R</td>
<td>12/30/30.6.15.1/Prolonged Services With Direct Face-to-Face Patient Contact Service (Codes 99354 - 99357) (ZZZ codes)</td>
</tr>
<tr>
<td>R</td>
<td>12/30/30.6.15.2/Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359)</td>
</tr>
</tbody>
</table>
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.*
Attachment - Business Requirements

NOTE: Transmittal 1490, dated April 11, 2008, is being re-issued to correct the Effective Date. 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

<table>
<thead>
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<td>Contractors shall instruct physicians and qualified</td>
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OTHER
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<td>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).</td>
<td>A D F C R S Shared-Maintainers System M C W F OTHER</td>
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<tr>
<td>5972.2</td>
<td>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).</td>
<td>X X</td>
</tr>
<tr>
<td>5972.3</td>
<td>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).</td>
<td>X X</td>
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<tr>
<td>5972.4</td>
<td>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).</td>
<td>X X</td>
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<tr>
<td>5972.5</td>
<td>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).</td>
<td>X X</td>
</tr>
<tr>
<td>5972.6</td>
<td>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).</td>
<td>X X</td>
</tr>
</tbody>
</table>
that prolonged services without direct face-to-face patient contact, CPT codes 99358 and 99359, are not separately payable and are included in the payment for

III. PROVIDER EDUCATION TABLE

<table>
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III. PROVIDER EDUCATION TABLE

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<td>C C W F</td>
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</table>

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 about it in a listserv message 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.

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: Use “Should” to denote a recommendation.

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.
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.
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.
# Threshold Time for Prolonged Visit Codes 99354 and/or 99355

Billed with Office/Outpatient and Consultation Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99354</th>
<th>Threshold Time to Bill Codes 99354 and 99355</th>
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<td>99350</td>
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</table>

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.**
<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99356</th>
<th>Threshold Time to Bill Codes 99356 and 99357</th>
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</table>

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.
**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.

**I. 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.
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.
Prolonged Services Without Direct Face-to-Face Patient Contact Separately Payable Under the Physician Fee Schedule (Manual Update)

Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9905 provides that the Centers for Medicare & Medicaid Services (CMS) revises Chapter 12, Section 30.6.15.2 of the “Medicare Claims Processing Manual” to indicate that beginning Calendar Year (CY) 2017, Current Procedural Terminology (CPT) codes 99358 and 99359 (prolonged services without face-to-face contact) are separately payable under the Medicare Physician Fee Schedule. Make sure your billing staffs are aware of these CPT code changes.

Background

Prior to CY 2017, CPT codes 99358 and 99359 (prolonged services without face-to-face contact) were not separately payable, and were included for payment under the related face-to-face Evaluation and Management (E/M) service code. Practitioners were not permitted to bill the patient for services described by these codes, since they are Medicare covered services and payment was included in the payment for other billable services.

The CPT prefatory language and reporting rules apply for the Medicare billing of these codes, for example, CPT codes 99358 and 99359:

• Cannot be reported during the same service period as complex Chronic Care
Management (CCM) services or transitional care management services

- Are not reported for time spent in non-face-to-face care described by more specific codes having no upper time limit in the CPT code set

CMS has posted a file at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html) that notes the times assumed to be typical, for purposes of Physician Fee Schedule (PFS) rate-setting. While these typical times are not required to bill the displayed codes, CMS would expect that only time spent in excess of these times would be reported under CPT codes 99358 and 99359. Further, CMS notes: 1) that these codes can only be used to report extended qualifying time of the billing physician or other practitioner (not clinical staff); and 2) Prolonged services cannot be reported in association with a companion E/M code that also qualifies as the initiating visit for CCM services. Practitioners should instead report the add-on code for CCM initiation, if applicable.

**Additional Information**


If you have any questions, please contact your MAC at their toll-free number. That number is available at [https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/)

Disclaimer

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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?
Let’s Talk

INTENSITY
Importance of...
Switching Gears...
4. Scenarios
Operational Perspective

CODING
BILLING
DOCUMENTATION
COMPONENTS
Qualifier!

I am not clinical.
Scenario #1

• 90-year-old we enrolled on PC who suffered from severe pain related to prostate cancer/cipro tx more than 2 years ago. He was in remission when I saw him. He had worked for 8 months with the UW chronic pain management service, (e.g. IV lidocaine at a distant clinic which was 5 hours round trip away monthly X 3)) with little relief. He decided to Voluntarily Stop Eating and Drinking (VSED) and was enrolled in hospice. Other than some terminal pain control challenges, he died peacefully 5 days later. We did a lot of work around goals of care and this was the best option for him. He felt like he had exhausted all pain treatment options and he was ‘done’. He had full thinking capacity. He had a good visit with the Lookout Chaplain 3 days before his death.

• Wife and children present for discussion about his choices and were fully supportive. Their Scandanavian background contributed to their stoicism. When it was presented that VSED was legal and hospice could help him, he stated ‘it was the happiest day of his life’.
Scenario #2

• 59-year-old with a 5 year of history of early onset Parkinson’s. He wanted a PC consult to map out his future (goals of care) because his 'movement doctor' at Swedish would not engage in these discussion; just wanted to talk about more and more tx options, including what to do when treatment is no longer possible. At the time I the request, he was on treatment (not known) and stable physically with some limitation but minimal symptoms. His father used VSED and wanted the ability to make his own choices ‘when the time came’

• Excellent understanding of the natural course of early onset Parkinson’s Disease
Scenario #3

• 51 y.o. female admitted to hospital 9/2/19, established with PC team 6/13/19; with primary sclerosis cholangitis with likely worsening stricture. Hx of ulcerative colitis, pain and anxiety; chronic biliary stenosis (previous colectomy) with multiple stents placed in past-last 2 weeks ago, with increasing abdominal pain/nausea/vomiting/inability to keep food down. No definite intrahepatic biliary dilatation. Otherwise negative unenhanced abdomen pelvis CT in this patient with previous colectomy. Completed 2 weeks of antibiotics following recent stent placement. This is her 4th admission this year for similar problem. Afebrile, alkaline phosphatase elevated at 621 (best since June 415). Has a gastro specialist in Spokane. Adopted, 2nd marriage, retired clinic biller, mom died recently
Scenario #3  (continued)

• 9/3/19 Found in morning to be agitated and manic with confusion (found chewing on fentanyl patch and does not recall this) and tangential thinking-given 2.5 mg Zyprexa-delirium cleared by afternoon. Received Ativan the night prior which may have caused confusion per spouse, stating has happened before.

• Understands that condition appears to be worsening and that she could die from this.

• Not walking as much, is more tired, and recognizes more depressed since mom died.

• As child, attended Baptist church but no longer involved – does state has a relationship with God but has not found a church in local community to get involved with
Scenario #4

• 84-year-old man Significant CAD with triple CABG in 2009, STEMI in 2018, and a NSTEMI in 2019 with stents placed. CHF, CKD, COPD. Multiple ER visits, hospitalizations.

• Patient has a poor memory and a very poor understanding of his conditions, how to prevent them, how to manage them, and how to treat them. He is really no longer a good surgical candidate but continues to believe that he can just be “fixed” with surgical interventions. He lives with his daughter, who works swing shift and cannot be reached. She does not return calls. Sometimes she accompanies patient to his appointments. He has another daughter who is easier to get hold of, but she lives out of the area.
• Patient just wants to feel better. He doesn’t want to have chest pain or be short of breath. Again, he doesn’t really understand how to manage his symptoms, but he tends to be fairly disinterested and disengaged with any attempts at education, and also does not retain it well.

• TCM calls after each hospitalization, follow up hospital appointments, calls to his cardiologist and working with his PCP to ensure all medications on his list are what he is supposed to be taking, printing out his medication list and writing on it in laymen’s terms how to take each medication and providing this to his daughter, attempted (unsuccessful) calls to reach his daughter to discuss the patient and how to help him, and most recently, set up pill boxes at his pharmacy to hopefully increase medication compliance. However, unsure if patient will even follow through going to the pharmacy every week to make that work and haven’t been able to get hold of his daughter to enlist her assistance. Attempted to set him up with home health, but he (nor his daughter) ever followed up so it apparently didn’t happen.
Scenario #4

- Haven’t even gotten to this level of rapport with the patient. Really just trying to teach some self-management methods.
- Tried home health, tried med management, tried pill boxes with pharmacy, tried contacting daughters. Have had multiple discussions with PCP.
Scenario #5

- Pt. is a 56 year old female who lives in a nursing home with ESRD receiving dialysis 3 times a week. She also has CHF, DM type 1 and COPD. She has had 4 ER visits with 3 admissions in 2019 due to missing dialysis appts. and staff thought it was because pt. liked getting a “mini vacation” away from the facility.

- Pt. stated she was missing appts. due to feeling terrible afterwards. Hospital care management staff contacted us to see if pt. would be agreeable to a palliative care consult. She has been more compliant with dialysis in the last 2 months.
Scenario #5

• Lives in NH and uses w/c for mobility.

• Patient able to make decisions and be involved in planning care. She expressed what makes her happy is visiting with her 2 sisters and participating in NH activities of bingo, gardening and coloring, reading and watching scary movies.

• Pt. has good understanding of her diagnosis and the importance of going to dialysis. She gets tired of all the needles and being poked. She says if she lived with her sister, she knows she wouldn’t take her meds.
Scenario #5

- No cultural aspects to consider

- Amlodipine, carvedilol, clonidine. Coumadin, gabapentin, Humalog, hydralazine, Lispro insulin, lantus, levothyroxine, sodium bicarb, sevalamer carb, tizanidine, venlafaxine, Lasix, oxycodone PRN, vitamin D, Zofran, ranitidine, Spiriva, Ventolin inhaler

- Diabetic hard candy and mouth sponges for moisture to relieve dry mouth
Scenario #5

- RN contacted Nephrologist regarding the muscle cramping after dialysis and her dry mouth due to fluid restriction of 1200cc. MD is afraid of pt. being hospitalized again with acute hypoxic respiratory failure with volume overload and does not want to change her diuretic meds. RN has had communication with NH staff to discuss pt. concerns and nurse states the Tizanidine is given PRN and it helps some, but pt. is noncompliant with the fluid restriction and her diet and that is why she feels miserable. NH staff also told us that pt. has visitors who may be bringing in drugs to her but they do not have proof.

- Communication is difficult for phone calls into facility to speak with pt. and the staff need more education on Palliative Care
Scenario #6

- 57-year-old male with underlying HIV, seizure disorder, hypertension, and ongoing ETOH use with multiple emergency room visits (27 visits in 2019) for a kaleidoscope of complaints. Also with recurrent admissions for self-care deficits, electrolyte abnormalities, recurrent falls, and worsening functional decline. Repeatedly leaves AMA. Recent loss of his partner of 15 years to end-stage alcoholic liver cirrhosis, now with ongoing grief and severe depression. Currently on fluoxetine, but not really helping. Resistant to mental health therapies. Work-up for abdominal pain, shortness of breath, chest pain, syncope, neurological symptoms, and abdominal pain has consistently been negative. Patient quit drinking heavily after his partner died but admits to continued ETOH use. Marijuana use several times a week by patient report. Ongoing tobacco use.
Scenario #6 (continued)

- HIV status has been stable on antiretroviral medications. Last admission was 5/13/2019 for chest pain rule out; Palliative care consult completed on 5/8/2019.
- The patient's physician is an HIV specialist that he rarely sees. He frequently sees the nurse practitioner and feels he has good rapport with her, but her schedule is limited due to the fact that she travels from Spokane to conduct a satellite clinic in our area. This may be contributing to his high emergency room usage.
• Pt goals of care include remaining in his home, maintaining his current level of health/functional status, and having a caregiver in his home. Pt has his sister-in-law as his DPOAHC, has a neighbor who has been his friend and caregiver but currently has stepped back as he is feeling manipulated by pt, and pt is very rigid about how/where/when he will accept help.

• Pt has been resistant to counseling as his sister-in-law is a well-known counselor in the area and the agency she works at is where he can easily get counseling. Pt also is very reluctant to leave home and wants all services to come to him. He has applied for Medicaid but when the financial worker called him, he apparently sounded unengaged in the process so, they dropped his case. We have worked with Medicaid SW and local Area Agency on Aging and will resubmit an application once financial information needed is obtained.
Scenario #6 (continued)

• Patient has poor insight into his depression and grief process. He continues to be unwilling to undergo any kind of mental health therapies.

• Patient is homosexual.

• Fluoxetine 60 mg every morning: Currently not effective.
Scenario #6 (continued)

- Attempted to assist patient with application for Medicaid so that he could receive in-home services: Currently his application is on hold due to patient being disengaged from the process.
- Attempted to facilitate caregiver assistance: Patient is now estranged from his neighbor who is his primary support.
- Offered mental health counseling: Patient continues to be unwilling to participate in any mental health therapies.
It’s Time For A Break
5. Components & the Revenue Cycle

A Crash Course
Operational Perspective

CODING

BILLING

DOCUMENTATION

COMPONENTS
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/
Revenue Cycle

1. Before Visit:
   - Eligibility Check and Demographic Verification
   - Collection of Co-Pay/Balance

2. During Visit:
   - Analytics/Data Analysis
   - Claim Creation, Validation and Submission

3. After Visit:
   - Collecting Payment from Patient
   - Statement to Patient
   - Correcting Errors/Denials
   - Claim Follow-Up

National Organization of State Offices of Rural Health
Revenue Cycle

National Organization of State Offices of Rural Health
Reimbursement 101
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
Don’t Forget About Related Services

- Transitional Care
- Chronic Care Management
- Advanced Care Planning
- Prolonged Services
TRANSITIONAL CARE MANAGEMENT SERVICES

**Target Audience:** Medicare Fee-For-Service Providers

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

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CHRONIC CARE MANAGEMENT SERVICES

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ADVANCE CARE PLANNING

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The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.
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.
NOTE: Transmittal 1490, dated April 11, 2008, is being re-issued to correct the Effective Date. 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)

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.

<table>
<thead>
<tr>
<th>R/N/D</th>
<th>Chapter / Section / Subsection / Title</th>
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<td>12/30/30.6.15.2/Prolonged Services Without Direct Face-to-Face Patient Contact Services (Codes 99358 - 99359)</td>
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Prolonged Services Without Direct Face-to-Face Patient Contact Separately Payable Under the Physician Fee Schedule (Manual Update)

Provider Types Affected

This MLN Matters® Article is intended for physicians and other providers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9905 provides that the Centers for Medicare & Medicaid Services (CMS) revises Chapter 12, Section 30.6.15.2 of the “Medicare Claims Processing Manual” to indicate that beginning Calendar Year (CY) 2017, Current Procedural Terminology (CPT) codes 99358 and 99359 (prolonged services without face-to-face contact) are separately payable under the Medicare Physician Fee Schedule. Make sure your billing staffs are aware of these CPT code changes.

Background

Prior to CY 2017, CPT codes 99358 and 99359 (prolonged services without face-to-face contact) were not separately payable, and were included for payment under the related face-to-face Evaluation and Management (E/M) service code. Practitioners were not permitted to bill the patient for services described by these codes, since they are Medicare covered services and payment was included in the payment for other billable services.

The CPT prefatory language and reporting rules apply for the Medicare billing of these codes, for example, CPT codes 99358 and 99359:

• Cannot be reported during the same service period as complex Chronic Care

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Switching Gears...
Like Dominoes

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

• How might Clinical documentation result in a denied or rejected claim?
• How might Medical Necessity result in a denied or rejected claim?
• Other reasons
  • Patient not covered
  • Non-covered service
  • Others?
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.)*
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.”

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”

6. A Quick Commercial Break
Operational Perspective

CODING

BILLING

DOCUMENTATION

COMPONENTS
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.)*
No Time Today For...

MODIFIERS!!

*A mention in passing…*

25
51
59
Team??

National Organization of State Offices of Rural Health
It Takes A Village
Who Is On The Team?
7. Scenarios

Take Two
Scenario #7

- 59 year old - End-Stage Renal Disease-Hemodialysis 3 days a wk related to Adenocarcinoma, kidney-on transplant list; Chronic pain, Back pain, Multiple-level cervical spondylosis with radiculopathy from MVA Neuropathic pain-left lower leg from Rhabdomyolysis Narcotic Dependence; Impaired mobility; Depression; Anxiety; Insomnia; History of Drug Abuse-currently clean and sober; Patient has caregiver assistance in the home- wheelchair bound-but very physically fit. Would to left toe that is almost healed with dressing changes and oral antibiotics.
Scenario #7 (continued)

• Patient is very aware of his health issues
• Family is estranged-3-children they do not speak to each other
• Patient is assigned a Health Home Case Worker through ALTC who outreached to us for Palliative Care Services in January 2018 Patient was first against Kidney transplant-did not feel he deserved one-has since changed mind and is now on a transplant list;
• Patients goals: try to get better control of chronic pain, anxiety, depression, insomnia, wants kidney transplant and a better way of life
• Very involved with their church, meditation, prayer, plays guitar
Current Medications:
• Aspirin 81mg daily
• Vitamin B Complex-1 Tab daily
• Vitamin D3 2000 units 2x a day
• Calcitriol 0.25mcg One Capsule 3 times a week
• Venofer 20mg/ml IV-50mg/week at Dialysis
• Renvela 800mg 3-tablets 3 x a day with meals
• Flomax 0.4mg daily
Scenario #7 (continued)

• Sertraline 100mg po daily (Feels not working-has appointment 6/10/19 with UW Psychiatry for recommendation of Mood stabilization for Depression and Anxiety)

• Melatonin 10mg at HS for Sleep

• Reglan 5mg po Q 6hrs PRN-Nausea-stats does not take very often

• Miralax Oral Powder 17gms in fluid daily-PRN Constipation
Scenario #7 (continued)

- Pain/Anxiety Medications:
- Clonazepam 1mg daily in the morning, 1mg at 12pm and 2mg at HS (This is for Anxiety/Insomnia)-
- Trazadone 100mg at HS for Insomnia
- Hydroxyzine HCL 25mg po 1 tab TID for anxiety, agitation, and insomnia
- Buprenorphine HCL 8mg SL 1-tab QID

Non-pharmacological: We have tried getting patient set up for acupuncture and massage-Insurance won’t cover; HH Coordinator says pt. refuses injections in his back; we have recommended a sleep hygiene program-not really following and refuses to wear a C-pap
Scenario #7 (continued)

• To receive medical care from one provider; instead of multiple entities (When we took this patient on they were seeing a PCP in Walla Walla, attending the Pain Clinic in Tri-cities, receiving counseling from another source in Walla Walla, plus seeing the Nephrologist for Dialysis). This was accomplished by focus on their goal to have a one stop shop for their health care services and not have so many appointments. At no time did we encourage the patient to stop seeing these providers, but ultimately it was their choice if they wanted to change providers. We did have a provider willing to take them on as a patient and help manage their pain. We also started providing in home behavioral health counseling on a weekly basis.
Scenario #7  (continued)

• Is now on the transplant list.-went to Spokane June 3 for pre-evaluation of transplant
• Recently married
• Providing in-home counseling; Working very closely with Health Home Coordinator; getting their primary care and pain management under one doctor-involving local pharmacist to assist with transition off of Fentanyl and Hydromorphone to Buphronorphine
Scenario #7 (continued)

• The patient has been quite the challenge but we do feel we have had made great progress. We have had numerous IDT meetings over the past 3-4 months-and really supporting patient and his new wife with medication changes.

• Continues to say pain, depression, anxiety are not relieved;

• This has improved over the past year
Scenario #7 (continued)

- Some guidance and strategies on pain control, anxiety issues, insomnia, and behavioral health guidance-
  Patient reports pain is better controlled 6/10-now that he has transitioned on to the Buprenorphine-first month did experience withdrawal symptoms that were pretty significant-

- Recommendations on medication management of anxiety and depression
Scenario #8

- Concerns regarding Benzodiazepine and Antipsychotic use together? What could be used as an alternative to the clonazepam?
- Frequent Panic Attacks-calls clinic frequently crying wanting more medication.
- Do you think alternative medicine would help with this patient such as acupuncture or massage to help manage anxiety?- unsure about finances
- Not affiliated with any church but does believe in a higher power- Recommendations on how to broach the conversation that maybe speaking with someone in regards to spirituality may help with anxiety?
- Frequent ED visits with a different complaint each time
Scenario #8

***This patient was first presented in Sept 2018 Case Consultation Session

- Patient is a 65-year-old female with Chronic Physical and Mental Health issues: several ED visits so far this year; visits consist of chief complaints of chest pain; SOB; Anxiety
- Chronic Fatigue-poor sleep
- Possible torn rotator cuff
- 1,000ml fluid restriction/day
- Hyponatremia
Scenario #8

- Chronic Anxiety
- PTSD, OCD
- HX of Bipolar
- Anoxic Brain Injury
- Depression
- COPD-O2 dependent at night
- CHF; CAD-MI in the past with CABG-
- Compression Fracture Spine
- Chronic Fatigue-poor sleep
- Possible Torn rotator cuff
- 1,000ml fluid restriction/day
- Hyponatremia
- Impaired Physical Mobility
- Chronic Recurrent Pancreatitis
- Long term Anticoagulant Therapy
- Vit. B and Vit. 12 D
- Childhood trauma-molestation and DV as an adult; recent death of brother being murdered
- Addison’s Disease (On Steroid Replacement)
- Chronic Pain Syndrome
- Obesity
- Psoriasis
Scenario #8

• Happily Married; has a very supportive care giver; unemployed; relationship with son
• Good-Living will, POA, and POLST all established
• Receiving Behavioral Health Counseling
• Involved in the UW Tele-psychiatry Program
• Started bead work and making jewelry to help focus on other things
• Wants to live
Scenario #8

- Lidodem 5%-patch on for 12 hours off for 12 hrs-shoulder pain
- Olanzapine 10mg po daily for mood
- Protonix 40mg po Daily
- Sucralfate 1gm-1 pill po 4x a day before meals
- Prednisone 5mg ½ tab in Am and PM
- Budesonide 1 NEB BID for SOB/Wheezing
- alprazolam 0.5mg Bid
- Stiolto Respomat 2.5 mcg/Act Inhal 2 puffs daily for COPD
- Benzonatate 200mg-1po TID PRN Cough
- Fludrocortisone Acetate 0.1mg po daily Adrenal Insufficiency
Scenario #8

- Coumadin 4.5 mg po Daily; 5mg on Thursday and Friday
- Portable Tens Unit for Chronic back Pain
- Flexeril 1-tab at HS PRN Back Spasms
- Sertraline 100mg po daily
- Lovastating 40mg po daily at HS
- Hydrocodone 10-325mg 1-tab up to 3xa day PRN Pain
- Furosemide 20mg po daily
- Ipratropium Albuterol ½ to 1 ampule Nebulizer TID-QID PRN SOB
- Ventolin HFA 2 puffs inhaled every 4 hours PRN SOB
- Olanzapine 10mg daily
Scenario #8

• Continue to see patient weekly in home this has prevented ER stays, patient is now on alpraloza pain is adequately controlled

• Chronic ED Use-frequent calls for anxiety/panic attacks-wanting more medication, patient continues having feelings of impending doom thinks she is dying has self-referred to hospice and cancels psyche appointments despite education weekly on disease process and hospice
8. Conclusion

Making the Pieces Fit
Putting the Pieces Together

CODING

BILLING

DOCUMENTATION

COMPONENTS
Making it Fit & Making a Difference

TOGETHER!!

National Organization of State Offices of Rural Health
Where Did We Start?
Operational Perspective

CODING
BILLING
DOCUMENTATION
COMPONENTS
Conclusion... The Deal Is...

Coding starts with Providers but is important to the entire team!

- Strong documentation in the medical record
- Meeting all components to assure coding at the appropriate level of service provided
- Assuring documentation is legible
- Assuring all documentation is signed and dated
- Assuring all procedures ordered are supported by a MEDICALLY NECESSARY diagnosis code that is as specific as possible (defining complexity/intensity)
How do we bring all this together – wrap it up with a pretty bow?
Power of Rural Tenets

• Communicate
• Educate
• Collaborate
• Innovate
It’s time for rural providers to prepare for quality-driven programs that will directly impact value and, therefore, reimbursement.
One Final Question

What’s one take away from today’s session?
Questions??
9. Resources & Contact Information

Ongoing Assistance
Resources

National Organization of State Offices of Rural Health (NOSORH)
https://nosorh.org/

The Power of Rural (#powerofrural)
http://www.powerofrural.org/

Stratis Health
http://www.stratishealth.org/expertise/longterm/palliative.html
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
Resources

CMS ICD-10 Guidelines for Coding & Reporting 2019

Medicare Learning Network (MLN)
Resources

Rural Providers and Suppliers Billing

Rural Health Value (RUPRI)
https://ruralhealthvalue.public-health.uiowa.edu/

Rural Health Information Hub
https://www.ruralhealthinfo.org/
Resources

Acevedo Consulting Inc. (Private Consultants)
https://www.acevedoconsultinginc.com/hospice-palliative-care

Get Palliative Care
https://getpalliativecare.org

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Ongoing Assistance
Goodbye, Thank you, Regards, Farewell, Ciao, Sayonara, Cheers, Adieu, Godspeed, Auf-Wiedersehen, Arrivederci, Toodle-oo, So Long, Adios, Coda, Envoy, Conclusion, Leave-Taking
Questions or Comments?

Thanks so much!
Your participation is appreciated!

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NATIONAL RURAL HEALTH DAY &
THE POWER OF RURAL!!