

GUIDE TO POST-ACUTE AND LONG-TERM CARE CODING, REIMBURSEMENT, AND DOCUMENTATION 2025



POST-ACUTE AND LONG-TERM CARE
MEDICAL ASSOCIATION

TABLE OF CONTENTS

<u>Introduction</u>	3
<u>Documenting the Visit</u>	5
<u>History/Exam</u>	5
Level of E/M Services.....	7
Medical Decision Making.....	7
Time.....	8
Prolonged Services.....	9
Split/Shared visits.....	10
<u>Nursing Facility Services</u>	11
Comprehensive Nursing Facility Assessments.....	11
Subsequent Nursing Facility Care.....	16
Nursing Facility Discharge Services	23
Transitional Care Management Services.....	25
Chronic Care Management Services.....	28
Complex Chronic Care Management.....	29
Behavioral Health Services	31
Advance Care Planning Services	32
Telehealth Services.....	34
<u>Frequently Asked Questions About Coding</u>	36
General Issues	36
Nonphysician Practitioners.....	42
Hospice	44
Subacute	46
Discharge Issues	48
Assisted Living	49
Consultation Services	49
Prolonged Service	50
Transitional Care Management Services.....	50
Chronic Care Management Services.....	53
Advance Primary Care Management Services.....	57
Advance Care Planning Services.....	58
G-Code 2211.....	59
Caregiver codes.....	60
2025 Valuation on Nursing Facility Codes.....	62
<u>Basic Documentation Tips for Beginners</u>	63
<u>Guidelines for Charting</u>	65

INTRODUCTION

Coding and documentation have presented challenges for post-acute and long-term care physicians over the years, particularly as the continuum of care has expanded to include assisted living, subacute, and home care settings. This guide is designed to enable you to code appropriately for your visits to patients in these varied settings. Detailed vignettes and tips on effective documentation and guidelines on charting are included.

In 1992, with the advent of the Medicare Physician Fee Schedule and the Resource Based Relative Value Scale, the Post-Acute and Long-Term Care Medical Association (PALTmed) took the opportunity to help re-define the codes for nursing facility visits. At that time, six codes were approved. The rationale behind them was that they should reflect the work required by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) regulations and the Minimum Data Set (MDS).

In 1997, PALTmed participated in an American Medical Association (AMA)/Specialty Society Relative Values Scale Update Committee (RUC) survey of two additional Current Procedural Terminology (CPT™) codes for nursing facility discharge planning. The results of this survey were used to establish the work relative value units (RVUs) for services provided when discharging a patient from a nursing facility. These codes were implemented the following year.

In 2005, PALTmed submitted a proposal to the AMA's CPT™ Editorial Panel to redefine the original six nursing facility codes in order to keep pace with the changing model of the post-acute and long-term care continuum. Since the major revision of the codes in 1992, two developments had prompted a need for their revision. First, as hospital stays have become shorter, increased acuity of illness in nursing facility patients makes them more like the hospital population. Second, the CPT™ codes, which were tied to The Centers for Medicare & Medicaid Services (CMS) nursing facility regulations were not easily understood, unlike hospital visit codes which are familiar to most primary care physicians. To meet these developments, the codes were not only redefined but were given completely new numbers. New vignettes were provided and the

family of codes was expanded by the addition of two new codes. One new code re-established the annual assessment Minimum Data Set (MDS) update service (which had been displaced by the redefining of the Comprehensive Assessment codes). A second new code was added to the family of Subsequent Nursing Facility services to cover visits requiring comprehensive acute visits with high medical decision-making complexity.

In 2020, there was a large change in E/M codes. Following the implementation of the revisions to the Office/Outpatient E/M visits for the CPT™ 2021 code set, the AMA CPT/ RUC work group on E/M met to standardize the rest of the E/M sections in the CPT™ code set including the Nursing Facility Visits. CPT™ code 99318, the annual nursing facility assessment code was deleted, and the rest of the code set was revised to better align with the principles included in the E/M office visit services by documenting and selecting level of service based on total time or medical decision making (MDM). Effective January 1, 2023, the CPT codes reflect these updates with new descriptors indicating the level of care based on either the level of medical decision making or total time of the encounter.

THE CODES ARE AS FOLLOWS:	
Initial Nursing Facility Care (New or Established Patient)	99304, 99305, 99306
Subsequent Nursing Facility Care (New or Established Patient)	99307, 99308, 99309, 99310
Nursing Facility Discharge Services	99315, 99316
Prolonged Services	G0317

The information contained in this Guide to Post-Acute and Long -Term Care Coding, Reimbursement, and Documentation is designed to assist you to code appropriately for your services for post-acute and long-term care. Although care was taken in preparing this Guide, Post-Acute and Long-Term Care Medical Association (PALTmed) does not and cannot guarantee the accuracy of all the information contained in this Guide or that you will be reimbursed appropriately by the insurer you rely on if you rely on the information in this Guide. PALTmed expressly disclaims responsibility and liability for any losses, damage or other consequences resulting from the use of any of the information contained in this Guide.

DOCUMENTING THE VISIT

The following information is provided as an introduction to clinical vignettes and documentation guidelines for each of the nursing facility codes.

HISTORY / EXAM

As of January 1, 2023, a medically appropriate history and/or exam remains a required element for all nursing facility services but will not be a factor in the selection of the level of service. Note the importance of the history and exam in establishing medical necessity.

A comprehensive history includes reason for visit/chief complaint, history of present illness, medications, allergies, review of systems, and past, family, and/or social history all of which will help support and determine medical necessity. Although these are no longer factors in determining the level of service they must be performed and documented as medically appropriate to ensure a proper evaluation of the patient. Initial visits and higher levels of subsequent codes will typically need more in-depth history to demonstrate medical necessity"

Examples of history/exam components:

Chief Complaint (CC): A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words. Alternatively, one can use The Reason for Visit, a concise reason for the visit. This is helpful for federally mandated visits or Initial Visits where a chief complaint is less pertinent

History of Present Illness (HPI): A chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. HPI includes inquiring on the following elements: location, quality, severity, duration, timing, context, modifying factors, and

associated signs and symptoms, and helps support medical necessity.

Review of Systems (ROS): 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. A ROS is still very useful for a comprehensive visit but can also be accomplished through the history of present illness documentation.

Past, Family, and/or Social History (PFSH): The PFSH consists of a review of three areas: Past history (the patient's past experiences with illnesses, operations, injuries and treatments); family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and social history (an age appropriate review of past and current activities).

LEVELS OF E/M SERVICES

Selecting the appropriate level of services should be based on:

1. The level of the medical decision making as defined for each service; OR
2. The total time for E/M services performed on the date of the encounter.

MEDICAL DECISION MAKING

There are four types of medical decision making (MDM): Straight-forward, Low, Moderate, and High. Medical Decision Making includes establishing diagnoses, assessing the status or prognosis of a condition, and/or selecting among one or more management options. Each level of medical decision making is composed of three components:

- **Number and complexity of problem(s) that are addressed during the encounter.**
 - (In addition to the items listed in the [MDM table](#), there is a specific definition of high-level medical decision making for only the Initial Nursing Facility Service: “MULTIPLE MORBIDITIES REQUIRING INTENSIVE MANAGEMENT: A set of conditions, syndromes or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. the patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital. The definitions and requirements related to the amount and/or complexity of data to be reviewed and analyzed and the risk of complications and/or morbidity or mortality of patient management are unchanged.”)
- **Amount and/or complexity of data to be reviewed and analyzed**
- **Risk of complications and/or morbidity or mortality of patient management**

To meet the definition of a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Medical Decision-Making (MDM) Table

- [CLICK HERE](#) to access the new medical decision-making table.

While the categories of straightforward, low, moderate, and high are not new, the MDM table is needed to fully understand what qualifies as defining each of these four categories. The four types of decision making require two of the three elements to be met or exceeded:

- **Straightforward**—Minimal (one) number of complex problems addressed at encounter; minimal or no amount and/or complexity of data to be reviewed; minimal risk of complications and/or morbidity from additional diagnostic testing or treatment.
- **Low** —Limited number of diagnoses or management options; limited amount and/or complexity of data to be reviewed; low risk of complications and/or morbidity or mortality.
- **Moderate** —Multiple number of diagnoses or management options; moderate amount and/or complexity of data to be reviewed; moderate risk of complications and/or morbidity or mortality.
- **High** —Extensive number of diagnoses or management options; extensive amount and/or complexity of data to be reviewed; high risk of complications and/or morbidity or mortality.

TIME

When time is used for nursing facility services, the time defined in the code descriptor is to be used for selecting the level of service. Time for these services includes the total time on the date of the encounter. If selecting code based on time the indicated total time must be met or exceeded. Time includes both face-to-face and non-face-to-face time with the patient and/or family caregiver. Selecting time includes time regardless of the location of the physician or other qualified health care professional. It does not

have to be continuous, so long as the total time spent on the day of the face-to-face E/M service. Time may not be counted towards travel, general teaching not limited to discussion that is required for the management of a specific patient, or other services that are reported separately.

PROLONGED SERVICE

Prolonged nursing facility services are reportable using prolonged services code G0317. Prolonged nursing facility services beyond the total time for the primary service (when the primary service has been selected using time on the date of primary service); each additional 15 minutes with or without patient contact (list separately in addition to codes 99306 or 99310). Do not report G0317 on the same date of service as other prolonged services or for any time less than 15 minutes. Because CMS recognizes pre-service and post-service time as integral to most sites of service including nursing facilities, the threshold time to report prolonged nursing facility services is actually longer than the intra-service time on the date of service plus 15 minutes. The following table displays the threshold times to report prolonged nursing facility services:

Required Time Thresholds to Report Other E/M Prolonged Services

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed time frame)
Initial NF Visit (99306)	G0317	95 minutes	1 day before visit + date of visit +3 days after
Subsequent NF Visit (99310)	G0317	85 minutes	1 day before visit + date of visit +3 days after
NF Discharge Day Management	n/a	n/a	n/a
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after

SPLIT/SHARED VISITS

A split or shared visit is an Evaluation and Management (E&M) visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner (NPP), such as a physician assistant or nurse practitioner. In the Medicare Physician Fee Schedule Final Rule, published in November 2022, changes to the definition of “Substantive Visit” were postponed. Thus, the definition remains unchanged in 2023.

Such visits may be billed under the National Provider Identifier (NPI) of the physician or non-physician practitioner (NPP) who performs the substantive portion of the visit that includes either:

- Performs and documents, in its entirety, either the history, exam, or medical decision-making for the visit; OR
- Provides more than 50% of the service time

Only skilled nursing facility services, not nursing facility visits, can be billed as split/shared services, except for the federally mandated nursing home visits which are required to be performed only by a physician (via Conditions of Participation).

The split/shared visit rules do not apply to office visits (place of service 11); instead, these visits may be billed ‘incident to’ if the requirements are satisfied (established patient, established plan of care/condition, direct supervision). CMS has signaled that it will be reviewing the incident to rules in future rulemaking.

CMS will require the use of a new modifier, -FS, to identify all claims for split/shared visits.

Documentation in the medical record must identify the two individuals (physician and NPP) who performed the visit. If using service time to define the substantive visit, it is important to clearly document time spent by each practitioner in the medical record.

COMPREHENSIVE NURSING FACILITY

ASSESSMENTS NEW OR ESTABLISHED PATIENTS

The initial nursing facility codes, 99304–99306, are used to report evaluation and management services to patients in nursing facilities. The Centers for Medicare & Medicaid Services (CMS) distinguishes between the skilled nursing facility (SNF) and nursing facility (NF) settings, as it is required to do by mandate of the Social Security Act at §1819(b)(6)(A) (which governs SNFs) and §1919(b)(6)(A) (which governs NFs). A SNF setting is to be noted as Place of Service Code 31 (POS 31) for patients in a Part A SNF stay. A Nursing Facility is to be noted as a Place of Service Code 32 (POS 32) for patients who do not have Part A SNF benefits, and patients who are in a NF or non-covered SNF stay. (Refer to Section 30.6.13 of Chapter 12 of the Medicare Claims Processing Manual available at <https://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>).

According to CPT™ (and consistent with Medicare payment policy), when a patient is admitted to a nursing facility as part of an encounter in another site of service (e.g., emergency department, physician's office, etc.) the services provided are considered part of the initial nursing facility care — when performed on the same date of service. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service, as well as in the nursing facility setting.

An exception to this policy exists for certain hospital discharge services. If a hospital inpatient or observation discharge service (99238 or 99239) is performed on same day as initial nursing facility visit both services may be separately reported when they are reported by the same physician on the same date of service.

Initial Nursing Facility Service visits by consultants and physicians other than the principal physician of record can be reported with the Initial Nursing Facility Service codes (99304-99306). The principal physician of record must append the modifier “-AI”, (Principal Physician of Record), to the initial nursing facility care code. This modifier will identify the physician who oversees the patient's care from other physicians who may be furnishing specialty care.

The following vignettes were developed by PALTmed to enable you to code appropriately for your visits to patients in the facility setting. Detailed vignettes and tips on effective documentation and guidelines on charting are included. These vignettes are not approved by the AMA. Note that the vignettes are not intended to be examples of chart entries that would meet the E/M documentation guidelines. Rather, they are intended to provide examples of the type of medical problems and situations typically associated with a particular level of service. Of utmost importance is that these vignettes are simply examples. A particular patient encounter, depending on the specific circumstances, must be judged by the services provided by the physician for that particular patient. Simply because the patient's complaints, symptoms, or diagnoses match those of a particular clinical example, does not automatically assign that patient encounter to that particular level of service.

99304

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

- **When using total time on the date of the encounter, 25 minutes must be met or exceeded.**

99304

Vignette 1:

Initial nursing facility admission visit for a 94-year-old resident with vascular dementia and glaucoma who is no longer safe at home due to the development of wandering behavior. She takes eye drops for her glaucoma and no other medications. There were no changes in the medication plan and previous diagnostic work ups were complete.

The number/complexity is moderate (dementia and glaucoma), amount/complexity reviewed -analyzed is low- likely an independent historian - and risk etc. is low (prescription drug management needs active management and not just continuing the same med)

Vignette 2:

Initial nursing facility admission for an 82-year-old resident with progressive Alzheimer's disease with functional but no behavioral impairments and well-controlled Type II Diabetes Mellitus. She takes Glipizide twice daily for her diabetes, which has been well-controlled, with her most recent HbA1C 7.0% the week prior to admission. She is on no other medications. Glipizide will be continued, and no further diagnostic work up is necessary.

For MDM, the 3 elements are the same as in the example above.

99305

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

- **When using total time on the date of the encounter, 35 minutes must be met or exceeded.**

99305

Vignette 1:

Initial skilled nursing facility admission visit for an 82-year-old slightly confused white female who had an open reduction internal fixation on a hip fracture from a fall at her assisted living facility. The patient has a history of limited chronic hypertension and osteoarthritis, well- controlled on hydrochlorothiazide, and acetaminophen. She has post- surgical pain and has been provided a prescription for hydrocodone/ acetaminophen and an order for physical and occupational therapy.

The number and complexity addressed is moderate (2 or more stable chronic illnesses), amount - complexity to be reviewed / analyzed is likely low to moderate depending on number of tests, documents or independent historian involved, and risk of complications/M&M is moderate given a controlled substance prescription by the provider. At least 2 categories are moderate, so the level is moderate.

Vignette 2:

Initial admission visit to the long-term care unit for an 89-year-old female transferred from a distant NF to be nearer to her daughter, who lives in the area. The patient has a history of hypertension, coronary artery disease, dementia, diabetes, hyperlipidemia, osteoarthritis, osteoporosis, burned out rheumatoid arthritis, and had fallen four months ago at the previous facility, which had caused a fracture of her hip that required ORIF. The patient is in her usual state of pleasant and mild confusion. Her medications are reviewed, and a proton pump inhibitor was stopped due to lack of apparent need, substituting an H2 blocker for the interim while observing for symptoms. Her previous physician was contacted and her management discussed.

Number and complexity of problems is moderate (2 or more stable conditions), amount/complexity of data reviewed /analyzed is moderate (category 3, discussion of management with external physician) and risk/MM is moderate (prescription drug management)

99306

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

- **When using total time on the date of the encounter, 45 minutes must be met or exceeded.**

Note: For services 95 minutes or longer, use prolonged services code G0317.

99306

Vignette 1:

Initial nursing facility admission visit for an 88-year-old resident, who is being admitted for long-term care after a hospitalization for urosepsis, respiratory failure, delirium, and hyperglycemia, complicated by a worsening gait disorder, exacerbated by prolonged bed rest. His hospitalization was complicated by the development of *Clostridium difficile* colitis and a stage III sacral pressure ulcer. The resident was mildly forgetful prior to hospitalization, but developed delirium while septic, and remains

profoundly confused, although improved over the last two weeks. He requires the completion of intravenous antibiotics for his urosepsis, the completion of oral antibiotics for *Clostridium difficile* colitis, monitoring and adjustment of the insulin regimen, daily wound dressing changes, as well as daily skilled rehabilitation services. He is on a total of fourteen medications, including two antidepressants and two psychotropic medications.

Number/complexity addressed=high (either the nursing home multiple comorbidities or 1 acute illness that poses a threat to life or bodily function, data. Amount/complexity data likely moderate to high depending in number of tests ordered and consultation with external provider if done. Risk = likely high given monitoring blood sugars/insulin, response to antibiotics and need to reevaluate psychoactive medication

Vignette 2:

Initial nursing facility admission visit for a 78-year-old resident, who is being admitted for long-term care because of increasing urinary incontinence and wandering. His medical history includes hypertension, coronary artery disease with a history of a myocardial infarction 12 years ago, mild chronic obstructive pulmonary disease, glaucoma, osteoarthritis, hypothyroidism, benign prostatic hyperplasia, and chronic atrial fibrillation. His medication regimen, which has been unchanged for several years, includes donepezil 10 mg daily, memantine 10 mg twice daily, atenolol 50 mg daily, hydrochlorothiazide 25 mg daily, lisinopril 10 mg daily, tamsulosin 0.4 mg daily, finasteride 5 mg daily, fentanyl patch 25 mcg every three days, levothyroxine 50 mcg daily, warfarin 2 mg daily, celexib 200 mg daily, albuterol/ipratropium inhaled four times daily, albuterol inhaled every four hours as needed, and latanoprost ophthalmic 0.005% solution in each eye daily. He appears bradycardic and dehydrated on admission. A CBC, CMP, INR and UA are obtained and separate clinical management conversations are held with the family and prior PCP. Medications are tentatively changed, and a code status conversation yields a change in code status. Amount and complexity of data is high by virtue of number of diseases posing threat to life or bodily function. Amount and complexity of data is extensive (category 1 and 3 met), and risk is high due to multiple medication changes and warfarin requiring monitoring for toxicity and the code status change.

SUBSEQUENT NURSING FACILITY CARE

NEW OR ESTABLISHED PATIENTS

The following codes are used to report the subsequent services provided to residents of nursing facilities at both the skilled and non-skilled levels. The Centers for Medicare & Medicaid Services (CMS) distinguishes between the skilled nursing facility (SNF) and nursing facility (NF) settings, as it is required to do by mandate of the Social Security Act at §1819(b)(6)(A) (which governs SNFs) and §1919(b)(6)(A) (which governs NFs). A SNF setting is to be noted as Place of Service Code 31 (POS 31) for patients in a Part A SNF stay. A nursing facility is to be noted as a Place of Service Code 32 (POS 32) for patients who do not have Part A SNF benefits, and patients who are in a NF or non-covered SNF stay. (Refer to Section 30.6.13 of Chapter 12 of the Medicare Claims Processing Manual available at <https://www.cms.hhs.gov/manuals/Downloads/clm104c12.pdf>).

The following vignettes were developed by PALTmed to guide physicians in coding and documenting subsequent nursing facility services. These vignettes are not approved by the American Medical Association.

99307

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

- **When using total time on the date of the encounter, 10 minutes must be met or exceeded.**

99307

Vignette 1:

Subsequent visit to evaluate a patient who nursing reports is sneezing more often. They have a history of perineal allergies, have no reports of any sign or symptoms of infection, have a

new roommate who uses a scented spray for "odors", and have an unused prn cetirizine. Orders for nursing to discuss use of fragrance with roommate and encouragement of prn cetirizine are left.

Number and complexity of problems is straightforward, amount and complexity of data is also straightforward, and risk is minimal.

Vignette 2:

Subsequent visit to evaluate an established patient who has been reported to have developed a macular rash on his back. History and exam quickly establish this is a heat related rash due to constant contact with the bed or chair with no threat to skin integrity. Nursing is asked to have the patient repositioned more often to keep the area cool and dry.

Number and complexity of problems is minimal, amount and complexity of data is none, and risk is minimal.

99308

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

- **When using total time on the date of the encounter, 15 minutes must be met or exceeded.**

99308

Vignette 1:

Subsequent nursing facility (NF) visit to evaluate an established 80-year-old patient with COPD on long-acting muscarinic antagonist and steroid inhalers who has had an increase in her chronic cough. Nursing and patient note no fever, purulent sputum, change in appetite or other concerns. Vital signs are stable, and the patient is in no distress. Pulmonary exam demonstrates only a slight prolonged expiratory phase and a few end expiratory wheezes; otherwise the exam is stable / unremarkable. Treatment consists

of encouraging the prn inhaled beta agonist.

Number and complexity of problems is moderate (1 chronic problem with exacerbation), amount and complexity of data is minimal, and risk is low given no changes in medication were made.

Vignette 2:

Subsequent NF visit to evaluate an established 79-year-old patient who has a reported new stage 2 pressure ulcer on her right ischium. Exam shows a stage 2 pressure ulcer 2x3 cm with no erythema, warmth, or drainage. The patient is alert afebrile and expresses no distress or pain. The facility standard protocol for stage 2 ulcers has already been initiated by the nursing staff, and the provider concurs this only is needed at this time.

Number and complexity of problems is moderate (1 acute illness), amount and complexity of data is minimal, and risk is low given no changes in medication were made and only an established protocol was used.

Regulatory Visit Vignette:

Subsequent NF visit to meet regulatory requirements to evaluate the following chronic medical conditions in a 93-year-old patient who has been in the nursing home for one and a half years: Alzheimer's dementia, hypertension, and osteoarthritis on a cholinesterase inhibitor, a beta-blocker and acetaminophen, as needed. There has been no interval change in status of these problems and no emergence of a new problem since the previous regulatory visit. Exam is unchanged. No new medications are prescribed. No new interventions are needed.

Number and complexity of problems is moderate (2 or more chronic problems), amount and complexity of data is minimal, and risk is low given no changes were made.

99309

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

- **When using total time on the date of the encounter, 30 minutes must be met or exceeded.**

99309

Regulatory Visit Vignette: Subsequent visit provided to meet regulatory requirements for an 85-year-old patient with multiple chronic health problems which include decreased vision and hearing, past history of LLL pneumonia, angina, and a CVA with left hemiparesis. Active problems include hypertension, CHF, GERD, constipation, ESRD, osteoarthritis, Parkinsonism, depression, anemia of chronic disease and Type 2 diabetes. Exam reveals Temp 98.2°, BP 130/70, P 80, and Respiratory rate of 18. The physical examination revealed a frail, tremulous, apathetic, mildly confused 72-year-old with an ectropion, no oropharyngeal findings except for being edentulous, no rales or wheezes, no change in murmur or pedal edema, abdomen soft without tenderness or masses, severe osteoarthritic changes, significant kyphosis, left sided weakness, ataxia, and pedal rubor and boggy edema. There were no acute changes or evidence of discomfort or distress. Minor adjustments in prescription medications were made.

Number and complexity of problems is moderate (2 or more chronic problems), amount and complexity of data is minimal, and risk is moderate (drug management)

Vignette 2:

Subsequent visit to evaluate an established patient with a history of pulmonary fibrosis, atrial fibrillation, CHF, hypertension, hypothyroidism, cerebrovascular disease, an old CVA and TIAs who is reported by nursing staff to have increased dyspnea, new difficulty speaking and swallowing, increased pedal edema, and increased anxiousness and confusion. There is no cough. Exam reveals Temp 97.5°, BP 110/60, P110, and Respiratory rate of 24. The cachetic, dyspneic patient is not Cyanotic, has bilateral wheezing, fine bibasilar rales with no rubs or rhonchi, no discernible increase in JVP, but does have newly increased pedal edema, cardiac exam reveals a possible S3 gallop. Mental status exam reveals mild delirium. The remainder of the exam is at

baseline. There are no new lateralizing neurological signs including evaluation of the cranial nerves. The patient, although on O2 at 5L via mask, is running a pO2 saturation of 96%. CBC, BMP, BNP, and CXR ordered, but results not yet available. An initial dose of furosemide is administered pending results of the diagnostic work up.

Number and complexity of problems is at least moderate, Amount and complexity of data is moderate (category 1), and risk is moderate (prescription drug management)

99310

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

- **When using total time on the date of the encounter, 45 minutes must be met or exceeded.**

Note: For services 85 minutes or longer, use prolonged services code G0317.

99310

Vignette 1:

Subsequent nursing facility visit, emergent, for the evaluation and management of a 75-year-old chronic care resident with moderate dementia, diabetes mellitus, hypertension, obesity, chronic lymphedema, and a recent viral upper respiratory infection felt to be improving, who presents with an abrupt change of condition consisting of diffuse mental status changes with chest pain and moderate dyspnea. Blood pressure is lower than normal at 98/50, respiratory rate 28 and mildly labored, P 100, temperature 98° and O2 sat on RA 86%. Physical exam shows diminished breath sounds with a few rhonchi at both lung bases, distant heart sounds with frequent ectopy, benign abdomen, 3+ edema to knees right

worse than left with mild erythema and tenderness worse than baseline. The family request that while the patient is not to be intubated or cardioverted in an emergency, they wish all possible diagnostic tests and treatment be performed at the facility. Diagnostic testing including a CBC CMP and CXR are ordered, and IV fluids and antibiotics are administered.

Number and complexity of problems is high, amount and complexity of data is moderate (Category 1 only) and risk is high (medications + decision not to send to hospital)

Vignette 2:

Subsequent visit to evaluate an established 81-year-old BF with a history of mild Alzheimer's disease, atrial fibrillation, cerebrovascular disease with a L sided CVA, but no residual lateralizing signs, frequent UTI's and urinary incontinence, hypothyroidism, Type II diabetes with peripheral neuropathy, and depression who was reported by nursing staff to have suffered two, non-injury, but unobserved falls within the last 24 hours. The patient is not able to relate the causes of the falls. Nursing staff evaluation concluded that there has been a recent decrease in appetite and intake, no change in bowel or bladder function, no change in vital signs including no orthostatic changes or recent change in medication regimen, but the patient is on an anti-coagulant associated with her atrial fibrillation. PE reveals Temp 98.6°, BP 110/50, P 82 and respiratory rate of 24. Patient is delirious, but in no acute distress. No sign of head trauma. HEENT and respiratory systems reveal no active pathology, and her CV status remains stable with no change in her grade ii bruit over both carotids, ii/vi systolic murmur, S4, and slight pedal edema. Abdomen is soft, but there is some supra-pubic discomfort. Unable to determine CVA tenderness since any significant ROM or strength evaluation elicits general discomfort. Patient has several bruises including R shoulder and back area and L knee. Skin is intact. Patient cranial nerves reveal no acute changes. CBC, CMP, UA and CXR are ordered, and an urgent outpatient head CT is arranged. Tentative plans depending on results are discussed with family and with the patient's neurologist from the previous stroke, with tentative agreement on various course of action including potential surgery if a subdural is found.

Amount and complexity of problems is high. Amount and complexity of data is also extensive (high) given the tests ordered and review with external provider (category 1 and 3). Risks high due to nature of event and discussion of possible surgery

NURSING FACILITY DISCHARGE SERVICES

The nursing facility discharge day management codes (99315 and 99316) are to be used to report the total duration of time for the final nursing facility discharge of a patient. Discharge day management services include, as appropriate, final examination of the patient, discussion of the nursing facility stay, instructions for continuing care to licensed caregivers, preparation of discharge records, prescriptions, and referral forms. Code selection is based on total time spent on the date of discharge management (face-to-face encounter is required), not the actual date of discharge from the facility.

99315

30 minutes or less total time on date of the encounter.

Vignette 1:

Subsequent and final planned nursing facility visit for the evaluation, management, and discharge planning of a chronic care patient with out of town family that plans to move the resident to a facility near them. The resident has stable moderate dementia, osteoarthritis, and hypertension. The patient is examined, medications are reviewed, and discharge plans reviewed with nursing staff and the social worker. Forms relevant for appropriate transition of care and a discharge summary are prepared. A time of less than 30 minutes is documented (in the record) in performing these activities.

Vignette 2:

A 99-year-old female with a history of long standing dementia and arteriosclerotic heart disease who has a DNR order, is seen after being found by nursing personnel without vital signs. The patient is personally examined and confirmed to have no spontaneous respirations or pulse and is pronounced dead at 9:05 am. The patient's family is contacted, and advised of the circumstances of the death, and the patient's previous personal physician is also contacted and advised. A brief discussion is held with the on-call coroner responding regarding this out of the hospital death. A time of less than 30 minutes is documented (in the record) in performing these activities.

More than 30 minutes total time on the date of the encounter.

Vignette 1:

An 82-year-old male is seen, who was admitted from the hospital after having pneumonia with associated debility and underwent rehabilitation therapy. His only other medical problems are mild osteoarthritis, compensated congestive heart failure, and Type II Diabetes Mellitus on oral medication. The patient is to be discharged back to his home in the next three days. Any level of physical exam is performed. The patient is a long-standing outpatient of yours. A review of the nursing facility stay with the patient and family, instructions for office follow-up, preparation of discharge records, prescriptions for eight medicines, and arrangements for short term PT and home health care is performed. A time of more than 30 minutes is documented (in the record) in performing these activities.

Vignette 2:

A 67-year-old female is seen, who was admitted six weeks ago with a fractured hip from a fall and an ORIF at the hospital and underwent rehabilitation therapy. Her other medical problems are mild hypertension, well-controlled with hydrochlorothiazide and an ace inhibitor, as well as significant peripheral vascular disease. The patient is to be discharged back to her home within the next week. Any level of physical exam is performed. A call is placed to the patient's primary care physician to discuss her status and discharge plans. Discussion of the nursing facility stay with the patient and family, instructions for continuing care to licensed caregivers, preparation of discharge records, prescriptions for six medicines, and referral forms is done. A time of more than 30 minutes is documented (in the record) in performing these activities.

TRANSITIONAL CARE MANAGEMENT SERVICES (TCM) 99495 and 99496

Transitional care management (TCM) services are provided when persons are transitioned from an acute hospital (inpatient or observation), rehabilitation hospital, long-term acute care hospital, partial hospital, skilled nursing facility, or nursing facility to a community setting (home or residence, including assisted living). These services are for persons requiring moderate (99495) or high (99496) level medical decision making during the 30 days following discharge. Unlike traditional E/M services these codes include both an initial face-to-face visit and non-face-to-face services provided by the physician or qualified health professional and/or their clinical staff under his/her direction. Unlike traditional E/M codes they cover a global period including the date of discharge from the facility and the subsequent 29 days. Only one provider may report TCM services per 30 days from discharge period.

Transitional care management codes cannot be used for patients entering the nursing home even if transitioning from the SNF to NF setting. Because these codes are 30-day global services, other codes used for coordination, review and oversight of the patient cannot be used concurrently with these codes during the 30-day period of the service. Such codes include chronic complex care management, care plan oversight medical team conferences, medication therapy management services, anticoagulation management, prolonged services without direct patient contact, education and training, end stage renal disease, telephone services, online medical evaluation, analysis of data, and preparation of special reports (many of which are not currently reimbursed).

TCM includes a required face-to-face visit within 7 days for persons needing high level decision making (99496) and within 14 days for persons needing moderate level decision making (99495). Both require medication reconciliation no later than the date of the first face-to-face visit. TCM also requires direct communication within two business days of discharge with the person or caregiver. This can be face-to-face, or by phone or

electronic means. Other E/M services within the global 30-day period which are not part of the initial visit can be reported separately if medically necessary.

TCM does cover a variety of non-face-to-face services provided by the physician/qualified health professional and/or their clinical staff that they direct. Physician/qualified health professionals services addressing medical and psychosocial needs may include but are not limited to: reviewing medical records; ensuring pending and/or needed medical testing is done; interacting with other health professionals involved in the patient's care; establishing referrals, and patient and/or family education. Services that clinical staff would address may include: communication with patient, caregivers, surrogates, home health agencies / other service providers; medication management and compliance; education; and/or assisting with obtaining needed community services.

99495

Vignette 1:

Transitional Care Management Services, Moderate Complexity, provided to an 83-year-old patient, who was admitted to the hospital for exacerbation of congestive heart failure, and is discharged home after a 5 day stay. She has a history of hypertension, type II diabetes mellitus, hypothyroidism, and gout. The practice's nurse calls her the day after discharge, reviews her discharge instructions and her medications. The physician sees her in her office 10 days after discharge, at which time she reviews her discharge summary, performs a medication reconciliation and an interval history and physical. She has lost 10 pounds since discharge. The physician adjusts her medication and instructs the clinical staff to refer her to the heart failure program. During the 29-day period following discharge, the physician and clinical staff coordinate and manage her various medical subspecialists, home health agency and the heart failure program.

Vignette 2:

Transitional Care Management Services, High Complexity, provided to a 92-year-old patient, who was admitted to the hospital for urosepsis and delirium, was transferred to skilled nursing for rehabilitation and is discharged to her assisted living facility. She has a history of type II diabetes mellitus, chronic kidney disease

stage III, hypertension, atrial fibrillation, neurogenic bladder, moderate dementia, peripheral vascular disease, depression, heart failure with preserved ejection fraction, and anemia of chronic kidney disease. Clinical staff called to obtain the hospital discharge summary and the nursing home discharge summary and called the patient's daughter two days following discharge. The patient remains confused following discharge and despite an appointment 6 day following discharge, the daughter cannot bring her in until 5 days later. At the appointment, the physician performs the medication reconciliation, streamlining and clarifying the regimen. During the 29 days following discharge, the physician and clinical staff coordinate care with the various specialists, review the results of the outpatient work-up, coordinate community agencies and refer the daughter to the Alzheimer's Association. [NOTE: Because the face-to-face visit did not take place until 11 days following discharge, this meets criteria for 99495, rather than 99496, despite medical decision-making being high complexity.]

99496

Vignette:

Transitional Care Management Services, High Complexity, provided to a 92-year-old patient, who was admitted to the hospital for sepsis and delirium, was transferred to skilled nursing for rehabilitation and is discharged to her assisted living facility. She has a history of type II diabetes mellitus, chronic kidney disease stage III, hypertension, atrial fibrillation, neurogenic bladder, moderate dementia, peripheral vascular disease, depression, heart failure with preserved ejection fraction, and anemia of chronic kidney disease. Clinical staff called to obtain the hospital discharge summary and the nursing home discharge summary and called the patient's daughter two days following discharge. The patient remains confused following discharge. At the appointment, 6 days following discharge, the physician performs the medication reconciliation, streamlining and clarifying the regimen and educates the daughter about dementia and delirium. During the 29 days following discharge, the physician and clinical staff coordinate care with the various specialists, review the results of the outpatient work-up, coordinate community agencies and refer the daughter to the Alzheimer's Association.

Chronic Care Management Services (CCM)

Chronic Care Management (CCM) services can be provided by a physician or non-physician practitioner and their clinical staff. Services are provided to patients with multiple, two or more, chronic conditions expected to last at least 12 months or until the death of the patient. Only one practitioner can bill CCM per service period (monthly).

Included services for CCM are use of a certified electronic health record (EHR), continuity of care with designated care team member, comprehensive care management and care planning, transitional care management, coordination with home-and-community based clinical services providers, 24/7 access to address urgent needs, enhanced communication (e.g., email), and advance consent.

All CCM services, including G0506, 99487, 99489, and 99490 have the same practice requirements.

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

Vignette:

The patient is an 82-year-old man with moderate dementia, COPD, and moderate congestive heart failure who has been 2 exacerbations of COPD and congestive heart failure treated in the facility in the last year. Care planning includes 3xweek weights with parameter for extra diuretic and physician practice notification, regular lab test monitoring, restorative therapy, regular assessment of cardiopulmonary status and parameters for reporting changes

99439

each additional 20 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)

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. Same required elements as 99490.

99437

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

G0506 (add on to CCM initiating visit)

For new patients or patients not seen within one year prior to the commencement of CCM, Medicare requires initiation of CCM services during a face-to-face visit with the billing practitioner. When extensive assessment and CCM services are provided outside the usual components of the initiating visit code, the physician or other qualified health care provider may also bill HCPCS code G0506. G0506 is reportable once per CCM billing practitioner, in conjunction with CCM initiation.

(Add-on code, list separately in addition to primary service).
NOTE: It requires physician or other qualified health care professional services, not clinical staff services like 99487-99490.

Coding Tip: When initiating a plan of care for the purposes of the monthly Chronic Care Management services, either G0506 or prolonged services may be reported, assuming the requirements for both are met. According to CMS, in association with the CCM initiating visit, a billing practitioner may choose to report either prolonged services or G0506 (if requirements to bill both are met) but cannot report both a prolonged service code and G0506. Complex Chronic Care Management Services (CCCM)

Complex Chronic Care Management services share a common set of service elements with the CCCM service, but they

differ in the amount of time clinical staff time provided; the involvement and work of the billing practitioner; and the extent of care planning performed. These services include criteria for CCM as well as:

- establishment or substantial revision of a comprehensive care plan
- medical functional and/or psychological problems requiring medical decision making of moderate or high complexity
- clinical staff care management services for at least 60 minutes, under the direction of a physician or other qualified health care professional.

99487

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

Vignette:

The patient is an 83-year-old male with moderate dementia with paranoid and depressive features, congestive heart failure, and diabetes mellitus with peripheral neuropathy who has recurrent falls due to combined physical and mental incapacities with minor to moderate associated injuries to date. Care planning includes frequent reevaluation of medications used to treat his medical and psychiatric status, frequent reevaluation of non-pharmacologic behavioral interventions, frequent review of fall interventions with the interdisciplinary team, frequent monitoring of vital signs and physical status with pertinent call parameters for his medical diagnosis, monitoring of psychosocial status, and regular communication with a consulting psychiatrist.

99489 (Add-on, use with 99487)

CPT™ code 99489 is a complex CCM add-on code for each additional 30 minutes of clinical staff time.

Vignette:

The above-mentioned patient develops a urinary tract infection which causes decompensation of both his congestive heart failure and psychiatric status. The physician and staff had typically spent 75 minutes with the patient in previous months, but now spends an additional 25 minutes this month due to intensified monitoring and communication with the facility.

Behavioral Health Services

Starting January 1, 2017, CMS began reimbursing for a set of new behavioral health integration (BHI) billing codes. 99492, 99493, and 99494 are codes provided under the psychiatric Collaborative Care Model (CoCM) by a primary care team consisting of a treating physician or other qualified healthcare professional and a behavioral health care manager working on collaboration with a psychiatric consultant. These codes can be billed regardless of setting of practice including the skilled nursing facility and nursing facility.

99492: Initial psychiatric collaborative care management for the first 70 minutes in the first calendar month satisfying the following elements:

- Patient outreach and engagement by the treating physician
- Initial assessment of the patient and development of an individualized treatment plan
- Review of the treatment plan by a psychiatric consultant and modification of the plan if recommended
- Entry of the patient in a registry, follow-up tracking, and participation in weekly caseload consultation with the psychiatric consultant
- Brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies

99493: Subsequent psychiatric collaborative care management for the first 60 minutes in a subsequent month satisfying the following elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation
- Weekly caseload consultation with the psychiatric consultant
- Ongoing collaboration and coordination of patient mental health care by the treating physician and any other treating mental health providers
- Additional review of progress and recommendations for treatment changes

- Brief interventions using evidence-based techniques
- Monitoring of patient outcomes using validated rating scales, along with relapse prevention planning as the patient achieves remission of symptoms or other treatment goals

99494: Additional 30 minutes of behavioral health care manager activities in a calendar month, in consultation with a psychiatric consultant and directed by the treating physician.

General Behavioral Assessment

99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month.

Assessment and Care Planning for Patients With Cognitive Impairment

99483 Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, by the physician or other qualified health care professional in office or other outpatient setting or home or domiciliary or rest home.

Advance Care Planning Services

CPT™ codes 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, with the patient, family member(s), or surrogate); and 99498 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure). The visit may be face-to-face or using telemedicine including audio only.

For additional information on Advance Care Planning Services, see: <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=58664>

99497

Vignette:

A 68-year-old cognitively intact resident with ALS has no advance directives and wants to discuss her prognosis and advance care plans with her family, who have variable feeling of approach the latter stages of her disease. 25 minutes are spent discussing her condition, her wishes and formulating an advance care plan that expresses her desires.

99498

Vignette:

Same circumstances as above except now the family and patient dynamics require extensive discussion and assistance with a total of 48 minutes being spent.

TELEHEALTH VISITS

As of January 1, 2023, nursing facility codes 99304-99316 are available to use via telehealth visits, some on a provisional basis. It should be noted that required regulatory visits, including the required regulatory Initial Nursing Facility Assessment Visit, must be performed in person. A practitioner may continue to conduct any telehealth visit and bill as allowed. However, they must see the resident in-person within the timelines specified above to be compliant with the CMS requirements. For example, a practitioner may conduct visit 99304 via telehealth as a first visit to a resident of a SNF, but to meet the regulatory requirement for the initial comprehensive nursing facility assessment, the practitioner must visit the resident in-person within the first 30 days following admission. Thereafter, they must continue to conduct at least one in-person regulatory visit every 30 days for the next 60 days, and at least once every 60 days thereafter.

99304	Nursing facility care init	Provisional use until March 31, 2025
99305	Nursing facility care init	Provisional use until March 31, 2025
99306	Nursing facility care init	Provisional use until March 31, 2025
99307	Nursing fac care subseq	Can be billed without 14 day limit until December 31, 2025
99308	Nursing fac care subseq	Can be billed without 14 day limit until December 31, 2025
99309	Nursing fac care subseq	Can be billed without 14 day limit until December 31,

		2025
99310	Nursing fac care subseq	Can be billed without 14 day limit until December 31, 2025
99315	Nursing fac discharge day	Provisional use until March 31, 2025
99316	Nursing fac discharge day	Provisional use until March 31, 2025
99497	Advance Care Planning- first 30 minutes (Audio Only)	Permanent
99498	Advance Care Planning- each additional 30 minutes (Audio Only)	Permanent

WHAT MORE DO I NEED TO KNOW?

FREQUENTLY ASKED QUESTIONS ABOUT CODING AND THEIR ANSWERS

GENERAL ISSUES

Will my Medicare fees be reduced if I see more than one patient?

No. Medicare payments for physician visits are based on the Medicare physician fee schedule. Assuming all visits are medically necessary and you have documentation to support this, you will be reimbursed the full fee schedule amount for each patient visit you make.

I worry about being audited for seeing the same patient more than once a month. What can I do to protect myself?

The key is good documentation to justify to outside reviewers why these visits were medically necessary. You need to document why you made the visit, what you did, what changes were made in the patient's plan of care, and to whom you spoke. It also is important to make the family aware of what you're doing, what services and procedures will be or were performed and will be billed to Medicare (or to another payer), especially additional items, such as EKGs and ultrasounds.

How do I figure out what level of care to apply?

To determine the level of care, please refer to the section on page 5 entitled “Documenting the Visit.”

How do I determine complexity of medical decision making?

To determine a patient’s level of complexity, please refer to the section on page 5 entitled “Documenting the Visit.”

Do I use the same codes for a visit to a congregate housing facility or board and care home as I use in a nursing facility?

Any residence other than a nursing facility or skilled nursing facility requires the Home or Residence Services Codes 99341-99350, effective 2023. So clinicians making home visits and assisted living facility visits would use the same code set for either.

What code do I use when I take over the care of another physician’s nursing facility patient that is not a new admission?

It depends. If the physician is in the same practice and specialty, a subsequent nursing facility care code would be used. If the physician is not in the same practice, the Initial Nursing Facility Care codes 99304-99306 may be reported. According to CPT, an initial service may be reported when the patient has not received any face-to-face professional services for the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay.

If I live in a rural area, is it true that I can get a higher reimbursement?

Physicians providing services in either rural or urban Health Professional Shortage Areas (HPSAs) are eligible for an incentive payment of 10 percent of the amount the carrier actually paid for a service. Medicare carriers do not include the incentive payment with each claim payment. Rather, payments are made on a quarterly basis by the carriers.

Eligibility for receiving the 10 percent bonus payment is based on whether the specific location at which the service is furnished is within an area that is designated as a HPSA. In the past, physicians have been responsible for indicating their eligibility for the bonus on their Medicare claims by attaching a modifier to the service codes. Effective January 1, 2005, the bonus will automatically be paid without the submission of any modifiers in most cases. However, this payment cannot be made automatically in some areas (e.g., ZIP codes that overlap HPSA and non-HPSA areas), and the billing of modifiers may still be required in these situations.

A recent change in the law created an additional five percent bonus payment system based on Physician Scarcity Areas (PSA). Eligible physicians who furnish services in an area that is qualified as a PSA and HPSA would be entitled to receive both incentive payments; that is, a 15 percent bonus payment.

Physicians are advised to contact their carriers for information about the areas where provided services would be eligible for bonus payments. General information may be found on the CMS website at <https://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/>.

Will Medicare Part B pay for initial and subsequent nursing facility visits furnished by telehealth?

Effective January 1, 2021, the Centers for Medicare & Medicaid Services approved the addition of subsequent nursing facility care services (99307–99310) to the list of Medicare telehealth services with the limitation of one telehealth subsequent nursing facility care service every 14 days. (NOTE: As of January 2023, under the public health emergency there is no limitation on telehealth visits. Once the PHE is expired and after December 31, 2024, it will return to once every 14 days for subsequent visits and initial visits will not be allowed.) The initial visit and Federally-mandated periodic visits [as defined by 42 CFR §483.40(c)] should be conducted in-person and may not be furnished through telehealth. Medicare beneficiaries are eligible for telehealth services only if they are in an originating site (skilled nursing facilities are an authorized originating site) located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area.

As a condition of payment, an interactive audio and video telecommunications system must be used that permits real-time communication between a physician or practitioner at the distant site and the beneficiary at the originating site. The exception is the advance directive code which can be audio only.

See also the [Telehealth section](#) of this guide.

Should I bill for a patient as “new” if I have changed practices and have seen the patient within the past three years at my old medical group?

For office or outpatient services or Home or Residence Services, the determining factor is whether you provided professional services to the patient within the last three years, regardless of where you provided those services. If you did provide such services, the patient is considered an established patient—even though you have changed practices since you last saw the patient. Of course, every time this same patient is admitted or readmitted to the nursing home, they are eligible for an initial visit. This "3-year rule" is most applicable in the residential or office settings

For Hospital Inpatient or Observation Services or Nursing Facility Services, code selection is determined by whether the visit is an Initial Visit or a Subsequent Visit, regardless of whether the patient is defined as new or established. If the patient is readmitted to the Hospital or Nursing Facility after previously being discharged, the first visit is considered an Initial visit.

Is there a limit to how many visits per month to a patient in a nursing facility are covered for reimbursement?

You may see a patient as frequently as is medically necessary. For example, if you need to see a patient daily for the first few days, he or she is in the facility due to medical instability, these visits would be covered if, e.g., there is some indication of instability. The key is clear and thorough documentation supporting the medical necessity of the visit.

Can Care Plan Oversight codes be used for care of nursing facility patients?

There are two CPT™ codes for Care Plan Oversight Services for nursing facility patients. They are 99379 Physician supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities, 15–29 minutes; and 99380 for services of 30 minutes or more.

Medicare considers payment for these services to be bundled into the payment for the nursing facility services so separate payment is not made for these services. However, other payers may pay for these services, in which case, documentation is important. Care plan oversight activities include services between visits such as phone calls, filling out required forms, prescription refills, and family conferences. Some physicians have set up a special system to document each activity as it is performed and how much time is spent. It is important to remember that to bill the higher level of care plan oversight, these activities must add up to a minimum of 30 minutes spent on a patient. Also, payment for care plan oversight generally will not be made if you have seen that patient during the same month.

Since code 99318 has been deleted, how may I bill for an annual Nursing Facility assessment visit?

There is no federal regulatory requirement for an Annual Nursing Facility assessment or visit, although some state Medicaid programs may require it. It is a good idea, however, to periodically perform a comprehensive assessment on nursing facility visits. This can be reported with either a Subsequent Nursing Facility Care code 99307-99310, depending on either total time or medical decision making, or, alternatively, with a Medicare Wellness Visit code (G0402, G0438, G0439), so long as the requirements are met. Requirements for the three Medicare Wellness Visit types can be found at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html>

State Medicaid programs may require some form of annual assessment. You should familiarize yourself with your state's Medicaid program requirements.

When I provide acute medical care to a nursing home resident, is this service covered?

Medicare covers medically necessary evaluation and management of acute medical conditions. It may be difficult for Medicare carriers and contractors to recognize which visit is the regulatory visit and which is a visit for care of acute problems when claims are submitted. The regulatory visit must include a review of the resident's total program of care, including medications and treatments, whereas a visit for an acute change of condition may require a more limited service. The diagnosis listed is one way to identify the purpose of the visit. However, if the acute problem is an exacerbation of a chronic medical condition, the diagnosis often will be the same. Establishing medical necessity in the progress note and carefully and thoroughly documenting the change in care plan is necessary for the carrier to determine appropriateness of multiple visits.

Care of an acute condition may require a single visit or multiple visits, depending on the initial severity, subsequent progress of the condition and the treatment regimen. Instructions in Section 30.6.13 of Chapter 12 of the Medicare Claims Processing Manual state: "Under Medicare Part B payment policy, other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit." (available at <https://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>).

If a patient dies in a nursing facility, what is the appropriate service to report when the attending physician pronounces the patient's death, completes the death summary, and talks with the deceased patient's family?

The pronouncement of death is a covered Medicare service. Instructions in Section 30.6.13 of Chapter 12 of the Medicare Claims Processing Manual state: "The Discharge Day Management Service may be reported using CPT™ code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement" (available at <https://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>).

NONPHYSICIAN PRACTITIONERS

Can nursing home or home/residence services be reported by a nonphysician practitioner (NPP, including nurse practitioners and physician assistants)?"

Medicare law provides, generally, that coverage is available for any service that is within the NPP's scope of practice under state law assuming it is:

- the type of service that is considered a physician service;
- otherwise covered by Medicare (e.g., is not excluded from coverage); and
- reasonable and medically necessary for the patient.

Among the services the Medicare Carriers Manual specifically allows NPPs to perform (assuming state law permits) are physical examinations, minor surgery, reviewing x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition.

Medicare does not specifically identify services or procedures by code that NPPs can provide. Instead, it allows each carrier to make that determination, based on the laws of the state where the service is provided. You will need to review the scope of practice laws in your state to determine what limitations there are, if any, on NPPs.

Prescriptive authority, in particular, varies enormously from one state to another. PALTmed has published the Long-Term Care Information Series on Clinical Collaboration in the Long-Term Care Setting. The publication contains state information on NPP scope of practice. The publication is available for purchase through the PALTmed website at:

<https://paltmed.org/products/clinical-collaboration-post-acute-long-term-care-setting>

Medicare policy for skilled nursing facilities requires that the initial visit required by regulation be performed personally by a physician. After that, all required federally mandated visits to skilled nursing facility patients can be performed by NPPs

alternating with the physician if the NPP is not employed by the facility. Medicaid or non-skilled nursing facility admissions may be performed by the NPP if the state permits and, again, the NPP is not employed by the facility. (Refer to Section 30.6.13 of Chapter 12 of the Medicare Claims Processing Manual available at <https://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>). Additionally, a nonphysician practitioner may make a “medically necessary” visit to a Medicare patient in a nursing facility prior to the initial, regulatory physician visit and report an Initial Nursing Facility Care service 99304-99306. This does not substitute for the required initial visit by the physician. States vary on the time frame required for the initial regulatory physician visit and can be more stringent than the Medicare requirement of within 48-hours prior to admission or 30-days after admission.

Medicare policy allows NPPs to sign certifications and re-certifications of the continued need for skilled nursing facility care and rehabilitation services, again, if the NPP is not employed by the facility.

NPPs use the same CPT™ codes that physicians use, but the reimbursement for the services is set by statute at 85 percent of the physician fee schedule payment.

CMS released in its publication Medlearn Matters (number SE1308) answers to frequently asked questions on Medicare rules surrounding the role of nonphysician practitioners related to billing, signing orders, and the relationship between employers and employees. The FAQs may be found on the web at: www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SE1308.pdf

CMS also issued a survey and certification memo: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-15-.pdf>

Frequently, an NP or PA performs an “admission note” visit. This is generally a fairly comprehensive first visit to a nursing home resident prior to the physician's required regulatory Initial Comprehensive Visit. Since a nonphysician is not permitted to perform the regulatory Initial Comprehensive

Visit, a “admission note” visit is done when there may be several days before the physician can get to the facility. How do we code these “admission note” visits? (NOTE: The term “admission note” or “holding visit” is not official CPT language and this type of visit can be referred to in many different terms.)

In a skilled nursing facility, the federally required Initial Nursing Facility Comprehensive Assessment must be performed by a physician. Nonphysician practitioners, such as nurse practitioners or physician assistants, may report initial comprehensive nursing facility visits for nursing facility level of care patients, if allowed by state law or regulation. The principal physician or other qualified health care professional may work with others (who may not always be in the same group) but are overseeing the overall medical care of the patient, to provide timely care to the patient. Medically necessary assessments conducted by these professionals prior to the initial comprehensive visit are reported using subsequent care codes (99307, 99308, 99309, 99310)."

Therefore, any NP or PA visiting the nursing home patient/resident prior to the principal/attending physicians regulatory Initial Nursing Facility Comprehensive Visit should use the subsequent nursing facility care codes. The attending physician, who subsequently performs the federally required Initial Nursing Facility Assessment may report the service using the Initial Nursing Facility Care codes (99304, 99305, 99306), appending the code with modifier -AI to denote the principal treating physician.

HOSPICE

How is the attending physician reimbursed for hospice care?

If the attending physician is not salaried by the hospice caring for the patient, Medicare Part B is billed directly by the physician for services provided unless it is for a problem related to the terminal illness. If the service is related to the terminal illness, the hospice is billed by the attending physician for the service. If the physician is an employee of the hospice providing the care, the hospice itself bills Medicare for the service provided. If an associate of the attending physician sees the patient, he or she must bill Medicare or the hospice under the primary physician's (i.e., the attending

physician on record) name and provider number. This associate then will be paid by the physician. CMS receives a record of the name of each attending physician for each hospice patient, so the agency knows who the primary physician is and who is an associate for reimbursement.

There are two billing modifiers that may be used for hospice care. Modifier “GV” is used for attending physicians who are not employed or paid under arrangement by the Hospice. Modifier “GW” is used for services not related to the hospice patient’s terminal condition. Information related to physician services for hospice patients may be found in Chapter 11 of the Medicare Claims Processing Manual available at

<https://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf>.

What is the role of nonphysician practitioners in the Medicare hospice program? What type of services can they provide? How should their services be billed?

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), amended the Social Security Act to include nurse practitioners in the definition of an attending physician for beneficiaries who have elected the hospice benefit. With certain exceptions described below, Medicare pays for services provided by a nurse practitioner to Medicare beneficiaries who have elected the hospice benefit and have selected the nurse practitioner as his/her attending physician. Note this amendment applies only to nurse practitioners and does not include physician assistants or other nonphysician practitioners whose services can be covered under other provisions of the Social Security Act.

When a Medicare beneficiary elects hospice coverage he/she may designate an attending physician, who may be a nurse practitioner, not employed by the hospice, in addition to receiving care from hospice- employed physicians. The professional services of a non-hospice affiliated attending physician, who may be a nurse practitioner, for the treatment and management of a hospice patient’s terminal illness are not considered “hospice services.” These attending physician services are billed to the carrier, provided they were not furnished under a payment arrangement with the hospice. The attending physician, who may

be a nurse practitioner, codes services with the GV modifier “Attending physician not employed or paid under agreement by the patient’s hospice provider” when billing his/her professional services furnished for the treatment and management of a hospice patient’s terminal condition. Carriers pay for these attending physician services rendered by nurse practitioners at the lesser of actual charges or 85 percent of the physician fee schedule.

Services provided by a nurse practitioner that are medical in nature must be reasonable and necessary, be included in the plan of care, and must be services that, in the absence of a nurse practitioner, would be performed by a physician. If the services performed by a nurse practitioner are such that a registered nurse could perform them in the absence of a physician, they are not considered attending physician services and are not separately billable. Also, services that are duplicative of what the hospice nurse would provide are not separately billable.

Nurse practitioners cannot certify a terminal diagnosis or the prognosis of six months or less, if the illness or disease runs its normal course, or re-certify terminal diagnosis or prognosis. In the event that a beneficiary’s attending physician is a nurse practitioner, the hospice medical director and/or physician designee may certify or re-certify the terminal illness.

Additional information regarding the hospice benefit, including the services of attending physicians and nurse practitioners may be found in Chapter 11 of the Medicare Claims Processing Manual available at:

<https://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf>.

SUBACUTE

Are there specific codes to use for “subacute” care?

The term “Subacute” is a vernacular term usually referring to Part A Skilled Nursing Facility level of care, but the word does not appear anywhere in the regulations. There are no specific codes for “subacute” POS 32 refers to long term care patients. Visits to

patients in the hospital should be billed with inpatient or observation hospital billing codes and visits to patients in the nursing facility should be billed with the nursing facility visit codes.

The nursing facility CPT™ codes were developed to allow for the appropriate care of the wide spectrum of patients present in long term care settings.

At the PALTmed's prompting, CMS has adopted a policy of allowing medically necessary visits, with no limitation on frequency. This policy allows billing for as many medically necessary visits as needed to provide adequate care for nursing facility patients/residents.

Although there is no limitation on the frequency of visits, CMS does not permit payment for more than one nursing facility E/M service per patient per day. It is important to note that even though one cannot bill more than once per day for a nursing facility E/M service, all the E/M services provided in a given day may be cumulative, even if discontinuous and in different locations, resulting in a higher level of service, plus, possibly, prolonged service codes depending on the total duration of time spent on that day. Careful and complete documentation of medical necessity is crucial to assuring appropriate payment. The time spent during each encounter should be documented as well if time is a factor in selecting the appropriate code (e.g., prolonged services).

I am a medical director of a dedicated skilled nursing unit and am responsible for daily guidance and assistance to nurses and therapists. We have weekly team conferences that include the nursing staff, pharmacists, and therapists to discuss all patients and set new goals and establish outcomes. We also have weekly family conferences with the patient, family members, and members of the care team, where we discuss the patient's progress and our discharge recommendations. Are there codes that I can use for these conferences?

CPT™ codes 99366 and 99367 are available for reporting team conferences. Unfortunately, Medicare payment for these codes is bundled into the payment for the nursing facility services and no separate payment is made for 99366 or 99367. However, if you participate in a care team conference about your patient/resident

on the same day as an E/M visit was performed, you may count that time as part of the total time of the encounter or include it in the determination of medical decision making. Alternately, if you participate in a care team conference about your patient/residence during the specified days before or after the day of the E/M, you may be able to report G0317 Prolonged Nursing Facility Services, if the reported E/M visit was the highest Initial or Subsequent level by total time and other time requirements are met.

DISCHARGE ISSUES

How do I bill for work related to nursing facility discharge?

Physicians have two codes to use for nursing facility discharges (99315 and 99316). These codes are to be used to report the total duration of time spent by a physician for the final nursing facility discharge of a patient, including final examinations, discussion of the facility stay, instructions given for continuing care to all relevant caregivers, preparation of discharge records, prescriptions, and referral forms. The choice of which code to submit is dependent on the duration of the visit. Use 99315 for visits of 30 minutes or less and 99316 for visits of longer than 30 minutes. Both of these codes require a face-to-face visit. The visit shall be reported for the actual date of the discharge visit, even if the patient is discharged from the facility on a different date.

Can I bill for hospital discharge services and the nursing facility admission services, when they are provided on the same date?

According to the [Medicare Claims Processing Manual, Chapter 12, Section 30.6.9.2D](#), Medicare will pay the hospital inpatient/observation discharge code (codes 99238 or 99239) in addition to a nursing facility admission code when they are billed by the same physician with the same date of service.

Can you always use the Initial Nursing Facility Service codes: 99304–99306 for readmissions? Are there guidelines for when you can use the 99304–99306 codes vs. using the subsequent visit codes 99307–99310 for

readmissions to the nursing home?

You must use the 99304–99306 for all readmissions. This means that the patient must have formally been discharged from the facility and then readmitted into the facility. Merely being admitted to the hospital does not necessarily constitute a discharge. If the patient was not discharged, then you must use the follow-up codes 99307–99310. For further explanation, please refer to the Chapter 12, Section 30.6.13 of the Medicare Claims Processing Manual, which states “A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.” For more information, it is available at <https://www.cms.hhs.gov/manuals/Downloads/clm104c12.pdf>.

ASSISTED LIVING

What are the appropriate codes for evaluation and management services in the assisted living setting?

As of 2023, assisted living facility services are reported with Home or Residence Services codes 99341-99350. The Domiciliary/Rest Home codes 99324-99337 are deleted, effective 2023. This means that practitioners will use the same set of codes, regardless of whether the patient resides at home or in an assisted living facility.

CONSULTATION SERVICES

Effective January 1, 2010, the consultation codes are no longer recognized for Medicare Part B payment. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs. As of 2023, level of service is selected based on either total time or medical decision making. In the inpatient hospital setting and the nursing facility setting, physicians (and qualified nonphysician practitioners where permitted) may bill the most appropriate initial hospital care code (99221-99223), subsequent hospital care code (99231 and 99232), initial nursing facility care code (99304-99306), or subsequent nursing facility care code (99307-99310) that reflects the services the physician or practitioner furnished.

The principal physician of record is identified in Medicare as the physician who oversees the patient's care from other physicians who may be furnishing specialty care. The principal physician of record shall append modifier "-AI" (Principal Physician of Record), in addition to the E/M code. Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits."

Refer to [Medical Claims Processing Manual, Chapter 12.](#)

PROLONGED SERVICE

Can I include work done 2 days prior to the patient arrival? I reviewed hospital records late Friday of a patient being admitted Monday when I saw them. Can I count this time?

No, Prolonged service codes only include the time spent 1 day prior to the patient visit and includes related activity for the next 3 days.

How do I handle it when a patient / situation is complex and multiple issues arise after the patient is seen over the next 3 days. Do I have to address all these non-face to face concerns without seeing the patient?

It depends. If the patient is generally stable and improving, then there is probably not medical necessity for a revisit. If however the patient is unstable, not improving or developing ancillary or new problems, medical necessity may be met for a new visit with the appropriate documentation

TRANSITIONAL CARE MANAGEMENT SERVICES (TCM)

Can the Transitional Care Management (TCM) Services codes be used when a patient is discharged home from a skilled nursing facility or nursing facility?

Yes. 99495 and 99496 are used to report face-to-face and non-face- to-face Transitional Care Management (TCM) Services

provided to new or established patients being discharged from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital or skilled nursing facility/nursing facility to a community outpatient setting (home, domiciliary, rest home or assisted living).

Can the TCM Codes be used to report services provided to patients transferred from the hospital to a skilled nursing facility?

No. Codes 99495 and 99496 may be reported only when a patient is transferred from an inpatient setting to an outpatient setting.

When do TCM services commence?

TCM services commence upon the day of discharge and continue for the next 29 days for a total of 30 days.

Can the TCM code be billed at the same time as an office visit, home and domiciliary codes?

If the office/outpatient or home/residence visit, including assisted living, is the first face-to-face visit, within 7 or 14 days, depending on the complexity, then the visit cannot be billed separately and must be billed as part of TCM. However, additional medically necessary E/M services provided on subsequent dates after the first face-to-face visit may be reported separately. Thus, once the first face-to-face visit takes place, subsequent office/outpatient and home/residence visits may be reported separately.

Can the TCM code be billed with other codes within the 30-day period (including SNF codes)?

Yes. TCM codes can be billed with other codes within the 30-day period if there was a distinct and separate medical need that arises. (It is important to note that the TCM service requires an initial face-to-face visit.) If a hospitalized patient who was eligible for SNF services elected not to initially utilize them and visited the physician within the required 7- or 14-day period, then elected to go into the SNF after that TCM office visit, both the TCM code and SNF visit could be made. More commonly if a new medical condition develops that requires another visit to the office within the 30-day TCM period, an appropriate office code can be billed.

What are the required activities that comprise TCM Services?

TCM Services require initial interactive patient contact (face-to-face, telephonic or electronic), a face-to-face visit and medication reconciliation within specified time frames. Both TCM services require an initial interactive patient contact with the patient/caregiver within two business days of discharge. The complexity of medical decision making during the entire 30-day period and the date of the first face-to-face visit determine the appropriate code selection. Medical decision making is defined by the E/M Guidelines.

Type of Medical Decision Making	Face-to-Face Visit within 7 Days	Face-to-Face visit within 8-14 days
Moderate Complexity	99495	99495
High Complexity	99496	99495

Non-face-to-face services provided during the 30-day period may be provided by clinical staff, under the direction of the physician or other qualified health care professional and include the coordination and management of the multiple disciplines and community service agencies required for a safe discharge plan.

For a more detailed list of activities included in TCM Services, see the official CPT™ Manual.

For more information on billing TCM services, please visit:
<https://www.cms.gov/files/document/mln908628-transitional-care-management-services.pdf>

If medical decision making is high complexity, but the patient is unable to schedule a face-to-face visit until more than 7 days after discharge, can I still report 99496?

No. Even though medical decision making during the 30-day reporting period is high complexity, a face-to-face visit occurring after 7 days but prior to 14 days would meet the criteria only for 99495.

When does medication reconciliation have to be completed?

Medication reconciliation must take place no later than the face-to-face visit.

Chronic Care Management Services

How do Care Management Services differ from Transitional Care Management Services?

Whereas Transitional Care Management (TCM) Services are performed and reported within the 30 days following inpatient discharge, Care Management Services represent management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient residing at home or other residence, including an assisted living facility. Unlike TCM Services, in which the codes are determined by the time of the first face-to-face visit and the complexity of medical decision making during the 30 days following inpatient discharge, Care Management Services are determined by the cumulative staff time directed by a physician or other qualified health care professional, per calendar month.

What is the difference between Chronic Care Management Services and Complex Chronic Care Management services?

Among its other requirements, Complex Chronic Care Management Services (99487, 99489) require medical decision making of moderate or high complexity during the calendar month, in which services are provided, whereas Chronic Care Management Services (99490) has no required level of complexity.

Both services require that the patient have at least two or more chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation or functional decline. However, whereas Chronic Care Management Services require that a comprehensive care plan be established, implemented, revised or monitored, Complex Chronic Care Management Services require that a comprehensive care plan be either established or substantially revised.

In addition, Chronic Care Management Services can be reported when at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional is provided per calendar month, whereas Complex Care Management Services require at least 60 minutes of clinical staff time per calendar month in order to be reported.

Can CCM and Complex CCM services be billed in skilled nursing facilities, nursing facilities, assisted living or other facility settings?

Yes, both CCM and Complex CCM are priced in both facility and non-facility settings. The place of service on claims should be in the place where the billing practitioner would ordinarily provide face-to-face care to the beneficiary.

If a practitioner arranges to furnish CCM services to his/her patients “incident to” using a case management entity outside the billing practice, does the billing practitioner need to ever see the patient face-to-face?

Yes, for new patients or patients not seen within a year prior to the commencement of CCM services, CCM must be initiated by the

billing practitioner during a “comprehensive” E/M visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the CCM service and can be separately billed to the PFS but is required for the specified patients before CCM services can be provided directly or under other arrangements. The billing practitioner must discuss CCM with the patient at this visit. While informed patient consent does not have to be obtained during this visit, it is an opportunity to obtain the required consent. The face-to-face visit included in transitional care management (TCM) services (CPT™ 99495 and 99496) qualifies as a “comprehensive” visit for CCM initiation. Levels 2 through 5 E/M visits (CPT™ 99212 through 99215) also qualify; CMS is not requiring the practice to initiate CCM during a level 4 or 5 E/M visit. However, CPT™ codes that do not involve a face-to-face visit by the billing practitioner or are not separately payable by Medicare (such as CPT™ 99211, anticoagulant management, online services, telephone and other E/M services) do not meet the requirement for the visit that must occur before CCM services are furnished. If the practitioner furnishes a “comprehensive” E/M, AWV, or IPPE and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.

What services are included in Chronic Care Management Services?

Services may include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies and educating the patient or caregiver about the patient’s condition, care plan, and prognosis.

What is the role of the physician or other qualified health care provider?

The physician oversees the management and/or coordination of services for all medical conditions, psychosocial needs and activities of daily living, during the calendar month, in which Care Management Services are provided. Although required tasks may be delegated to clinical staff, the physician or other qualified health care provider must oversee and direct these activities.

Must there be a written plan of care?

Yes. The plan of care must be documented and shared with patient and/or caregiver. It must be based on a physical, mental, cognitive, social, functional, and environmental assessment of the patient and is a comprehensive plan of care for all health problems. The required elements of the written plan of care are outlined in the official CPT™ Manual.

How often may Care Management Services be reported?

Care Management Services may be reported only once per calendar month and only by the single physician or qualified health care provider who assumes the care management role for the calendar month.

What are the time requirements for Care Management Services?

Both face-to-face and non-face-to-face time spent by clinical staff involved in the activities listed above may be reported. When two or more clinical staff members are meeting with the patient, only count the time of one clinical staff member. Clinical staff time cannot be counted on a day when the physician or qualified health care provider reports an E/M service.

Are there specific office requirements for reporting Care Management Services?

Yes. These include 24/7 access to physicians or qualified health care providers, continuity of care, timely access and management for follow up after an emergency room visit or inpatient discharge and a certified electronic health record. Other requirements are outlined in both the official CPT™ Manual as well as the CMS Final Rule available at <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf>

In addition, CMS requires the practice to inform a beneficiary about the availability of Chronic Care Management services, to obtain a written agreement to have the services provided, including any

cost-sharing obligation, to document in the record that CCM was explained and note any decision to accept or decline the services. In addition, the practice must provide a written or electronic copy of the care plan to the patient, inform the beneficiary of the right to stop CCM at any time and that only one practitioner can perform the service and be paid during a calendar month.

ADVANCED PRIMARY CARE MANAGEMENT SERVICES (APCM)

The **Advanced Primary Care Management (APCM) Services** by CMS combine several existing care management and communication technology-based services into a single payment bundle. This includes:

- **Principal Care Management (PCM):** Disease-specific services for managing a single, complex chronic condition.
- **Transitional Care Management (TCM).**
- **Chronic Care Management (CCM).**
- **Communication Technology-Based Services:** Virtual check-ins, remote evaluations, and interprofessional consultations.

Starting January 1, 2025, physicians and non-physician practitioners (NPPs) can bill for APCM services monthly, simplifying billing and documentation while ensuring high-quality primary care. APCM services are primarily for primary care specialties like internal medicine, family medicine, geriatrics, and pediatrics.

Billing for Advanced Primary Care Management (APCM) services is designed to be straightforward and efficient. Here's a breakdown of the process:

Monthly Billing: You can bill for APCM services once per patient per calendar month. This simplifies the process compared to traditional care management codes, which often require time-based billing.

HCPCS Codes: There are specific HCPCS codes for APCM services:

- **G0556:** For patients with up to one chronic condition.
- **G0557:** For patients with two or more chronic conditions.
- **G0558:** For Qualified Medicare Beneficiaries with two or more chronic conditions.

Eligibility: Physicians, non-physician practitioners (NPPs), physician assistants (PAs), and clinical nurse specialists (CNSs) can bill for these services. The provider must be responsible for all of the patient's primary care services and act as the focal point for their healthcare needs.

Requirements: To bill for APCM services, providers must:

- Conduct an initiating visit (paid separately).
- Provide comprehensive care management.
- Coordinate care transitions.
- Meet practice-level requirements, including MIPS and "Value in Primary Care" MVP.

Patient Consent: Written or verbal consent from the patient is required to bill for APCM services.

NOTE: CMS has not clarified the site of service and if these are billable in the skilled nursing facility.

ADVANCE CARE PLANNING (ACP)

Voluntary ACP helps patients make important decisions that give them control over the type of care they receive and when they receive it. ACP includes the explanation and discussion of advance directives by the physician or other qualified health care professional face-to-face with the patient, family members, and/or surrogate.

Code 99497 can be used for the first 30 minutes and 99498 for each additional 30 minutes. Some patients may need ACP multiple times in a year if their circumstances keep changing while other may not need the service at all in a year.

Are there limits on the number of times ACP can be done per beneficiary?

Per CPT™, there are no limits on the number of time ACP can be reported for a beneficiary in any given period of time. If the services is billed multiple times there should be a documented change in the beneficiary's health and/or wishes regarding end-of-life care.

Who can bill ACP?

Physician and non-physician practitioners can bill regardless of place of service.

Where can ACP be billed?

There is no place of service requirements or limitations on the ACP codes. They can be billed in both facility and non-facility settings and are not limited to a physician specialty. ACP cannot be billed in the ICU including neonatal, as they are exclusively time-based code that already allow for such conversations to be included in the total time spent.

Can ACP be billed via telehealth?

Yes, starting in January 1, 2017, CMS added ACP services to the list of eligible telehealth services.

ADD ON CODE G2211

CMS has issued an [MLN Matters Article](#) on the new G2211 code.

- G2211 (definition below) is an add-on code to office and other outpatient services, 99202–99215.
- **G2211 cannot be used in SNF or NF**
- CMS believes it will be used by primary care and other specialties who treat a single, serious condition or a complex condition with a consistency and continuity over a long period of time. CMS is emphasizing the longitudinal relationship between the practitioner and the patient.
- G2211 is payable even if you report the base code with modifier 25 only when the service or other procedure requiring the

reporting of modifier 25 is an allowed Part B service. See CMS [Attachment 1](#) for the list of allowed services.

- With budget neutrality, there is pressure on Congress from some specialties not to allow implementation.

G2211-Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)

CAREGIVER CODES

(These codes could potentially be used in SNF or NF but given that most relevant services are provided by SNF/NF staff, it's unclear how appropriate they would be. These codes are appropriate for both office/outpatient and home/residence setting. The codes could be used in very select circumstances assuming the work was towards a discharge home (LTC patient now attempting to return home with family) AND the physician team spent the time and work described.)

Code	Definition	Service	Participants	Time
96202	Multiple-family group behavior management/ modification training for parent(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/ caregiver(s); initial 60 minutes	Behavior management/ modification training	Multiple sets of caregivers (regarding different patients)	Entire 60 minutes
96203	each additional 15 minutes	Behavior management/ modification training	Multiple sets of caregivers (regarding different patients)	Entire 15 minutes

97550	(Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes),	Functional performance of ADLs	One or more caregiver (s) for a single patient	Entire 30 minutes
97551	each additional 15 minutes	Functional performance of ADLs	One or more caregiver (s) for a single patient	Entire 15 minutes
97552	(Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers).	Functional performance of ADLs	Multiple sets of caregivers (regarding different patients)	Not timed

2025 VALUATION OF NURSING FACILITY CODES

Code	Total 2025 RVUs	2025 Payment Rate (CF 32.3465)
99304	2.4	\$77.65
99305	3.97	\$128.45
99306	5.44	\$176.02
99307	1.19	\$38.50
99308	2.22	\$71.83
99309	3.22	\$104.19
99310	4.6	\$148.84
99315	2.43	\$78.63
99316	3.9	\$126.19
G0317	0.9	\$29.12

BASIC DOCUMENTATION TIPS FOR BEGINNERS

Accurate and complete documentation of the services you provide is an important aspect of coding and reimbursement. The following tips, for handwritten notes, will help ensure that your documentation accurately reflects your work and enable you to apply the appropriate codes to your services:

For Paper Records:

- Chart promptly and include all necessary details.
- If you make an error, draw a line through the mistake so that the deleted information remains legible, and then write “error” or “mistake in entry”, then initial and date. Never white-out, erase, or write over errors.
- Never insert words into an already-written entry; this may look as though you altered the record and brings it into question. If it is necessary to provide an addendum or clarification to an already-written entry, provide a new entry.
- If there is no entry to be made in a specific area or space, write “NA” or draw a dash in the space to indicate that you did not accidentally overlook it.
- Write all entries legibly and in ink.
- Use only abbreviations designated as approved in your facility’s policy manual. If you initial anything on a form, write out your full signature somewhere on the same document.
- Follow any specific policy and procedures your facility has for completing resident charts.
- Test yourself periodically. Go back to an old chart. Read an entry at random, decided what CPT™ code applies, then look to see what code you billed. If the two codes don’t match up, you probably need to rethink how you document the care you provide.

For Electronic Medical Records note that:

- Entries into EMRs are often time-stamped behind the scene, and cutting and pasting sentences can be traced back to the source document
- Cloning entire notes is highly discouraged as it rarely accurately reflects the actual work done and the medical necessity of that day's visit.
- Errors in notes can be corrected without explanation only if actively writing the note. Once submitted, any change must be corrected by the erroring correction method described by the EMR.
- Follow any specific policy and procedures your facility has for completing resident charts.

GUIDELINES FOR CHARTING

The following guidelines and basic requirements should be used in recording or charting notes:

- Chronological sequence is important.
- It is essential to be brief and concise, avoiding the repetitious use of the term “resident.” Only approved abbreviations should be used to avoid misunderstanding.
- It is imperative that the unusual be recorded along with normals in areas of resident assessment that pertain to an individual resident (e.g., for CHF—good skin turgor, absence of pedal edema).
- Ambiguity makes interpretation liable to error.
- Vague statements (e.g., “turned at intervals”) usually are meaningless.
- Statements that are authentic and explicit may avert needless litigation.
- Omissions are considered as inaccurate as incorrect insertions.
- Charting should not be done for another person. If one signs a document, the person is attesting to personal knowledge of the information.
- Written notes must be identified by date, time, signature, and appropriate title (e.g., 10/1/78—2PM— L.Smith, MD).
- Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B.
- “Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.”—CMS at https://www.cms.gov/glossary?term=medically+necessary&items_per_page=10&viewmode=grid
- “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT

code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”

- Medicare Claims Processing Manual, Chapter 12, Physicians/Non-physician Practitioners
- The applicability of both physical/mental health assessment factors should be evaluated. If an item is important enough to spend time assessing, it should be charted. Otherwise, it is not worthwhile spending time assessing it. The key is documentation.