



KEY CONCEPTS OUTLINE

Module 7: Evaluation and Management Services

- I. In General
 - A. CPT-Based Billing
 - 1. Evaluation and management (E/M) services furnished to Medicare beneficiaries are usually (but not always) billed using the CPT E/M codes.
 - a. However, Medicare does not necessarily always follow the CPT E/M guidelines.
 - (i) **Caution** – individuals involved in billing for physician/practitioner services must be careful not to assume that a particular CPT E/M coding guideline applies to Medicare claims.
 - B. Evaluation and Management Recent Changes
 - 1. Effective January 1, 2023, CMS agreed to an alignment with the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel changes for E/M visits.
 - a. Exception: Prolonged service codes
 - b. The CY 2023 changes mirror changes that CMS adopted in CY 2021 for the office/outpatient E/M visit coding.
 - (i) The 2021 CMS adopted changes include:
 - (a) Deletion of CPT code 99201;
 - (b) Revisions to the E/M code descriptors;
 - (c) New time descriptors, where relevant; and

(d) Revision of CPT E/M guidelines for levels of medical decision making.

II. Level Selection of Evaluation and Management Services

A. Level selection is based on either medical decision-making or the total time of the visit.

B. Office/Outpatient Visits – CY 2021

1. Key components have been removed from the code descriptors.

a. Times found in the code descriptors have been revised to a time-range rather than a typical time.

(i) Example:

(a) CPT code 99213 has an associated time range of 20-29 minutes as opposed to the associated typical time in 2020 of 15 minutes.

C. For additional E/M visits revised in CY 2023

1. Key components have been removed from the code descriptors.

2. Typical times or time ranges were removed from the code descriptors. Code descriptors for E/M services with associated times now provide a time that must be exceeded.

a. Example: CPT 99221

(i) Initial hospital inpatient or observation 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 medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

III. Initial Hospital or Observation Care

- A. For CY 2023, hospital inpatient and observation visits were merged into a single code set. <2023 AMA CPT Manual>
 - 1. CPT codes 99221-99233 are reported for inpatient or observation care services.
 - a. CPT 99221 - **Initial hospital inpatient or observation 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 medical decision making. When using total time on the date of the encounter for code selection, **40 minutes must be met or**

IV. Prolonged Evaluation and Management Services <See *Medicare Claims Processing Manual*, Chapter 12, §30.6.15.3>

- A. In CY 2023, The AMA finalized the newly created prolonged service CPT code for inpatient and observation evaluation and management services.
 - 1. CPT 99418 - Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)
- B. Not in agreement with the AMA, CMS created alternate Medicare specific prolonged service codes based on service location.
- C. Prolonged Hospital Inpatient or Observation Services
 - 1. Reported with HCPCS G0316 - Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact.
 - a. HCPCS G0316 can be listed separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services

b. It should not be reported on the same date of service as other prolonged services for evaluation and management, specifically, CPT codes 99358, 99359, 99418, 99415, 99416).

(i) G0316 should not be reported for any time unit less than 15 minutes.

D. Prolonged Nursing Facility Services

1. Reported with HCPCS G0317, Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact

a. HCPCS G0317 can be listed separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services.

(i) HCPCS G0317 should not be reported on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418.

(ii) G0317 should not be reported for any time unit less than 15 minutes.

E. Prolonged Home or Residence Services

1. HCPCS G0318, Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact.

2. HCPCS G0318 can be listed separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services.

3. HCPCS G0318 cannot be reported on the same date of service as other prolonged services for evaluation and management, (CPT codes 99358, 99359, 99417).

4. Do not report G0318 for any time unit less than 15 minutes.

F. Prolonged Office or Outpatient Visits

1. Effective January 1, 2021, CMS created a Medicare-specific code to be used as an alternative code to the CPT prolonged service codes 99358, 99359, and 99417. <MLN Matters MM12071>
2. G2212 -Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact.
3. HCPCS G2212 can be list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services
4. HCPCS G2212 should not be reported on the same date of service as CPT codes 99354, 99355, 99358, 99359, 99415, 99416.
5. Do not report G2212 for any time unit less than 15 minutes.

G. Prolonged Cognitive Assessment Services

1. Should be reported with HCPCS G2212. CMS guidance indicates that CPT codes are not to be reported for these services. <See *MLN Matters MM 12982*>

H. Visit Complexity Code – HCPCS G2211 <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.7(F)>

1. *Note: Finalized for use in 2021; however, the Consolidations Appropriations Act, 2021, suspended Medicare reimbursement until 2024. Currently the code is considered bundled service.*
2. Code Descriptor
 - a. 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.
 - b. G2211 is an add-on code, which should be listed separately in addition any to office/outpatient evaluation and management visit, at any visit level, for both new and established patients. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.7(F)>

- c. The code should not be reported with an office or outpatient E/M visit (CPT codes 99202 and 99215) reported with modifier -25. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.7(F)>

V. Concurrent Care

- A. Concurrent care is care furnished by multiple physicians in an “attending” (rather than a merely “consultative”) role during the same period of time. < See Medicare Benefit Policy Manual,
- B. Coverage Requirements < *Medicare Benefit Policy Manual*, Chapter 15 § 30(D)>
 - 1. The patient’s condition must require the services of more than one physician in an “attending” role (e.g., the patient has more than one medical condition requiring diverse specialized care), and
 - 2. The individual services by each physician must be reasonable and necessary.
- C. Same Specialty Limitation
 - 1. CMS has indicated that, while Medicare could potentially cover concurrent care by multiple physicians in the same specialty or subspecialty, the need for concurrent care by physicians in the same specialty or subspecialty should be “infrequent.” <Medicare Benefit Policy Manual, Chapter 15 § 30(D)>
- D. The One Visit Per Day Rule

In general, a physician may not bill for more than one E/M visit on the same day. <*Medicare Claims Processing Manual*, Chapter 12 § 30.6.5>

- i. The Unrelated Visit Exception
 - ii. Multiple visits involving the same patient are separately billable if the visits were for “unrelated problems” which could not be addressed during the same encounter. <*Medicare Claims Processing Manual*, Chapter 12 §§ 30.6.5, 30.6.7(B)>

Although not clear, it appears that CMS takes the position that it is not sufficient for the visits to be significant and separately identifiable, rather, the visits must be unrelated. <See Medicare Claims Processing Manual, Chapter 12 § 30.6.7(B)>

E. Physicians in the Same Group Practice

1. General Rule

- a. In general, physicians in the same group practice are treated as a single physician for E/M billing purposes. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.5>
 - (i) Presumably, this means that when two or more physicians in the same group practice see the same patient on the same day, only one E/M visit should be billed. <Medicare Claims Processing Manual, Chapter 12 § 30.6.5>
- b. The E/M level billed should reflect the combined services furnished during all visits on the same date. <Medicare Claims Processing Manual, Chapter 12 § 30.6.5>

2. Exceptions

a. The Different Specialty Exception

- (i) If two or more physicians from the same group practice see the same patient on the same day, each visit may be billed separately if the physicians are in different specialties. <*Medicare Claims Processing Manual*, Chapter 12 § 30.6.5>
- (ii) Although not entirely clear, presumably, visits on the same day with physicians from the same group practice but in different specialties are separately billable even if the visits were for the same problem.

b. Unrelated Visits

- (i) As with a single physician, multiple visits involving the same patient are separately billable if the visits were for “unrelated problems.” <*Medicare Claims Processing Manual*, Chapter 12 § 30.6.5>

VI. Evaluation and Management Services Furnished in Conjunction with an Injection

A. Significant, Separately Identifiable E/M Services are Separately Billable

1. If significant, separately identifiable E/M services are furnished on the same day as a drug administration service, both the drug administration service and the E/M service may be billed (with modifier -25 appended to the E/M code). <Medicare Claims Processing Manual, Chapter 12 § 30.6.7(D)>

a. Limitation

- (i) The E/M service may not be billed unless the service "meets a higher complexity level than CPT code 99211." <Medicare Claims Processing Manual, Chapter 12 § 30.6.7(D)>

VII. Inpatient Hospital Care

A. In General

1. "Per Day" Billing

- a. All inpatient or E/M encounters on the same day for the same patient must be billed using a single CPT code, regardless of whether or not the encounters were for related problems. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9(B)>

- (i) The E/M level should be based on all services furnished on the same day. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9(B)>

2. Multiple Physicians

a. Covering Physicians

- (i) If two physicians both see the same patient on the same day and one physician is covering for the other physician, only the "primary physician" may bill for the inpatient E/M services furnished on that day. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9(C)>

b. Visits for Different Aspects of the Patient's Care

- (i) If two physicians both furnish inpatient hospital E/M services on the same day, each physician may bill for his or services separately if:

- (a) The physicians are in different specialties, and
- (b) Each physician addresses a different diagnosis. < Medicare Claims Processing Manual, Chapter 12 § 30.6.9(C)>

B. Initial Hospital Care or Observation Care Services

1. Principal Physician of Record

- a. Only one physician may be considered the principal physician of record, i.e., the admitting physician. The principal physician of record is the one who oversees the patient's care from the other physicians/practitioners who may be providing specialty care. < Medicare Claims Processing Manual, Chapter 12 §30.6.9.1(G)>
- b. Reporting Initial Hospital or Observation Care Visits by the Principal Physician of Record
 - (i) The principal physician of record should report the AI modifier on the initial hospital care code to distinguish that s/he is the admitting physician. Reporting the AI modifier indicates Principal Physician of Record. < Medicare Claims Processing Manual, Chapter 12 §30.6.9.1(G)>

2. Initial Hospital Care Visits by Non-admitting Practitioners

- a. All non-admitting physicians and qualified non physician practitioners (where permitted) may report their initial evaluation of a hospital inpatient using the initial hospital or observation care codes (99221-99223) as long as the documentation demonstrates the work required by the code description is satisfied. Non-admitting practitioners should not report the AI modifier, because they are not considered the principal physician of record. < Medicare Claims Processing Manual, Chapter 12 §30.6.9.1(F) and (G)>

3. Hospital Admission from Another Site of Service

- a. Services Furnished on the Day of Admission
 - (i) All services furnished by the admitting physician on the date of an inpatient admission are considered to be part of the initial hospital care if the services are furnished "in conjunction with the inpatient

admission." <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(A)>

(a) This means that the admitting physician may not bill separately for any E/M services furnished in any other site of service (e.g., emergency department, physician office, or nursing facility) on the date of an inpatient admission in conjunction with the inpatient admission. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(A)>

1. The E/M level billed for the initial hospital care should be based solely on the E/M services furnished on the day of the admission and should not take into consideration E/M services furnished prior to the date of admission. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(F)>

b. Services Furnished Prior to the Day of Admission

(i) If a patient is seen in the office the day before an inpatient admission, the services furnished in the office are separately billable even if there is less than 24 hours between the office visit and the inpatient admission. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(B)>

4. Multiple Physicians Participating in an Inpatient Admission

a. Where two physicians participate in the same admission, both physicians may report the initial hospital or observation care codes. Only the "admitting physician" may report the AI modifier to distinguish that s/he is the principal physician of record. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(G)>

(i) **Caution** – presumably, the other physician may not bill separately if he or she is in the same group practice and specialty as the admitting physician. <Medicare Claims Processing Manual, Chapter 12 § 30.6.5>

5. Admission and Discharge on the Same Day

a. Where a Medicare patient is in observation or admitted for inpatient care and discharged on the same date, the following guidelines apply:

(i) Contractors pay only the initial hospital services if the length of stay is less than 8 hours. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1 (C)>

- (ii) If the length of stay is at least 8 hours but less than 24 hours, then the practitioner may report CPT codes 99234-99236 (Observation or Inpatient Care Services Including Admission and Discharge Services). <Medicare Claims Processing Manual, Chapter 12 § 30.6.8. (C)>

C. Hospital Discharge Services

1. Hospital Visits on the Date of Hospital Discharge

- a. When subsequent hospital care (i.e., hospital services – inpatient/observation) is furnished by the discharging physician on the day of discharge prior to the time of discharge, only the hospital discharge services should be billed – the subsequent hospital care is not separately billable. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.2(C)>

2. Nursing Facility Admission on the Date of Hospital Discharge

- a. If the patient is discharged from the hospital and admitted to a nursing facility on the same date by the same physician, both the hospital discharge and the nursing facility admission are billable. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.2(D)>

VIII. Observation Services

A. Initial Observation Care Services

1. Billing Limitations Applicable to Initial Observation Care

- a. A physician may not bill for initial observation care unless the physician both:
 - (i) Ordered observation services for the patient; and
 - (ii) was responsible for the patient during the observation stay. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(A)>
- b. Any other physician who furnishes E/M services to a patient while the patient is in observation must bill for his or her services using a new or established outpatient visit code as appropriate. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(A)>
- c. The physician billing for initial observation care (i.e., the physician who “placed” the patient in observation) may not bill for any other E/M

services furnished on the same date observation care was initiated.
< Medicare Claims Processing Manual, Chapter 12 § 30.6.8(A)>

2. Documentation Issues
 - a. Documentation Requirements
 - (i) A physician may not bill for observation unless the medical record contains the following documentation:
 - (a) Dated and timed physician's orders regarding the care the patient is to receive while in observation;
 - (b) Nursing notes;
 - (c) Progress notes prepared by the physician while the patient was in observation; and
 - (d) The length of time the patient was in observation. < Medicare Claims Processing Manual, Chapter 12 § 30.6.8(A) and (C)>
 - b. Limitations on the Use of Emergency Department and Clinic Documentation
 - (i) Observation services must be separately documented (as described above). Documentation prepared as a result of an emergency department or clinic encounter is not sufficient to support billing for initial observation care. < Medicare Claims Processing Manual, Chapter 12 § 30.6.8(A)>
- B. Patients Discharged from Observation on the Same Date as the Initial Observation
 1. Where a Medicare observation patient is placed in observation and discharged on the same date, the following guidelines apply:
 - a. Contractors are instructed to pay only for the initial observation if the length of stay is less than 8 hours. < Medicare Claims Processing Manual, Chapter 12 § 30.6.8 (B)>
 - b. If the length of stay is at least 8 hours but less than 24 hours, then the practitioner may report CPT codes 99234-99236 (Observation or Inpatient Care Services Including Admission and Discharge Services). < Medicare Claims Processing Manual, Chapter 12 § 30.6.8 (B)>

2. When a patient is discharged from observation on a different date from the initial observation date, the physician providing the observation discharge services should bill separately for the observation discharge services (CPT codes 99238 and 99239). <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(B)>

C. Subsequent Observation Care

1. Payment for subsequent observation care services is limited to the treating physician. Other practitioners seeing the patient in observation should use the appropriate outpatient visit code. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(B)>

D. Patient Admitted as an Inpatient from Observation

1. Inpatient Admission on the Same Date as the Placement in Observation

If the same physician who admitted a patient to observation, later on the same date admits the patient as an inpatient, only the initial hospital visits for the evaluation and management services provided on that date. (i.e., the "initial hospital care") is billable. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(D)>

E. Inpatient Admission on a Different Date

1. If a physician admits an observation patient as an inpatient on a date other than the date of the initial observation, the physician must bill a subsequent hospital inpatient or observation care code for the services provided on that date. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(D)>

IX. Emergency Department Visits

A. Site of Service Limitation

1. Emergency department services (CPT codes 99281 - 99285) should only be billed if the patient was actually seen in a hospital emergency department. It would not be appropriate to bill for emergency department services furnished in any other site of service. <Medicare Claims Processing Manual, Chapter 12 § 30.6.11(B)>
 - a. The term "emergency department" is defined as "an organized hospital-based facility for the provision of unscheduled or episodic

services to patients who present for immediate medical attention.”
 < *Medicare Claims Processing Manual*, Chapter 12 § 30.6.11(B)>

- (i) It is not clear whether CMS follows the CPT rule that a facility must be open 24 hours a day to be considered an emergency department.

B. Non-Emergency Services Furnished in the Emergency Department

- 1. CMS takes the position that where a physician provides non-emergency services in an emergency department, the services may generally still be billed as emergency department services. < *Medicare Claims Processing Manual*, Chapter 12 § 30.6.11(C)>

C. Billing of Emergency Department Services by Non-Emergency Department Physicians

1. General Rule

- a. In general, any physician furnishing services in an emergency department may bill his or her services as emergency department services. < *Medicare Claims Processing Manual*, Chapter 12 §§ 30.6.11(A), 30.6.11(C)>
 - (i) Exception – where a physician asks a patient to meet the physician in the emergency department as an alternative to the physician’s office and the patient is not registered as a patient in the emergency department, the physician should bill for his or her services as an outpatient visit rather than an emergency department service. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.11(C)>

2. Emergency Department Services Provided by the Patient’s Personal Physician at the Request of an Emergency Department Physician

- a. Where a patient is advised to go to the emergency department by a non-emergency department physician and the emergency department physician subsequently requests that the non-emergency department physician come to the hospital to evaluate the patient and advise the emergency department physician whether the patient should be admitted, the non-emergency department physician should bill as follows.
 - (i) If the non-emergency department physician admits the patient as an inpatient, the physician should bill for the appropriate level of

initial hospital care. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.11(E)>

(ii) If the patient is not admitted as an inpatient, both the emergency department physician and the non-emergency department physician should bill for the appropriate level of emergency department services. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.11(E)>

(iii) If the non-emergency department physician advises the emergency department physician by phone and does not physically see the patient, the physician may not bill for his or her participation in the patient's care. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.11(E)>

X. Consultations

A. Not Recognized by Medicare

1. Effective January 1, 2010, consultation codes are no longer recognized by Medicare Part B. Physicians and other practitioners may code e/m visits that represent where the visit occurred, and the complexity of the visit performed. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(F)>

B. Coordinating Benefits When the Primary Payer Still Recognizes Consultation Codes

1. When the primary payer still recognizes consultation codes, practitioners have two options for reporting the services to Medicare for secondary payment consideration. Practitioners billing for these services may either:
 - a. Bill the primary payer an e/m code (other than a consult) that is appropriate for the service, and then report the amount actually paid by the primary payer along with the same e/m code to Medicare for determination of whether payment is due; or
 - b. Bill the primary payer using a consultation code that is appropriate for the service and then report the amount actually paid by the primary payer, along with a non-consult e/m code that is appropriate for the service to Medicare for a determination of whether payment is due. <*MLN Matters SE 1010*>

XI. Split (or Shared) Visits

A. Definition

1. CMS defines a split (or shared) visit as an E/M visit in the facility setting that is performed in part by both a physician and an NPP who are in the same group, in accordance with applicable laws and regulations. <86 Fed Reg 65151>
2. Services Are furnished in a facility setting by a physician and an NPP in the same group, where the facility setting is defined as an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under *C.F.R.* § 410.26(b)(1).

B. New or Established Patients

1. CMS indicated in the 2022 MPFS final rule the split (or shared) visits can be provided to both new and established patients

C. Split (or shared) visits may be provided and billed for critical care services and certain nursing facility visits.

D. Billing for split (or shared) services <86 Fed. Reg. 65152>

1. The practitioner (either the physician or non-physician practitioner) who provides the substantive portion of the split (or shared) visit bills for the visit.
 - a. The substantive portion may be determined based on either:
 - (i) More than half of the total practitioner time; or
 - (ii) or medical decision making.
 - (a) If using medical decision making to determine the substantive portion, the practitioner must complete and document the medical decision making.
 - b. Originally CMS indicated the determination of the substantive portion based on the history, exam, or medical decision making was to be used of CY 2022 only.\

- c. In the 2023 Medicare Physician Fee Schedule, CMS extended this method of determination based on the medical decision making through CY 2023.
 - d. In the 2024 Medicare Physician Fee Schedule, CMS indicated that the substantive portion could be determined by time or medical decision making.
2. Split (or shared) visits are reported with the appropriate evaluation and management code and the split-shared modifier.
- a. FS - Split (or shared) evaluation and management visit

XII. Critical Care Services

A. Definition of Critical Care Services

1. For Medicare purposes, services should be considered "critical care" only if, in addition to meeting the CPT definition of critical care, they meet both of the following sets of criteria.
 - a. Clinical Condition Criterion
 - (i) There is a high probability of sudden, clinically significant, or life-threatening deterioration in the patient's condition which requires the highest level of physician preparedness to intervene urgently. <See *Medicare Claims Processing Manual*, Chapter 23 § 20.7.6.3.2(C)>
 - b. Treatment Criterion
 - (i) There are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician and withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant, or life-threatening deterioration in the patient's condition. < See *Medicare Claims Processing Manual*, Chapter 23 § 20.7.6.3.2(C)>

B. Site of Service Issues

1. Critical care services may be furnished in any site of service so long as the services furnished qualify as critical care. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12(A)>

C. Counting Critical Care Time

1. The only time that may be counted for purposes of billing for critical care services is time spent by the physician working exclusively on the critical care patient's case at the patient's bedside or elsewhere in the unit or on the same floor. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12.2>
 - a. The critical care time and the services rendered must be documented in order to bill for critical care services.
2. Concurrent Critical Care Services
 - a. Critical care services performed by physicians of different specialties may be reported for the same patient on the same day. <86 Fed Reg 65157>
 - b. Beginning CY 2022, critical care services may be furnished as a split shared visit.
 - c. Bundled services as listed in the AMA CPT manual are not separately payable

D. Coding Critical Care Services

1. Critical care services are reported with CPT codes 99291 and 99292.
 - a. CPT 99291 - Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.
 - b. CPT 99292 - Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service).
 - (i) Caution: CMS clarified 104 minutes of critical care must be provided to report CPT 99292x1 and 99292x2 <85 FR 65160>

E. Critical Care Services Furnished Concurrently by Practitioners in the Same Group and of the Same Specialty <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12.4>

1. When a practitioner furnishes the initial critical care in its entirety, the practitioner reports CPT code 99291.

- a. Any additional practitioners providing critical care concurrently to the same patient on the same date will report CPT code 99292.
 2. When a practitioner begins furnishing critical care; but does not meet the required time to report CPT code 99291, another practitioner of the same specialty and group can continue to deliver critical care and the time of the of the practitioners can be aggregated to meet the time requirement to bill CPT code 99291.
 - a. Time spent furnishing critical care past the requirements for CPT code 99291 can only be reported by a practitioner (same specialty/group) when an additional 30 minutes of critical care is provided on the same date.
- F. Critical Care and Other E/M Services Provided on the Same Day
1. Practitioners may bill E/M services provided on the same day as critical care services when the documentation supports the medical necessity <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12.6>
 - a. The practitioner must document the following:
 - (a) The E/M visit was provided prior to the critical care service at a time when the patient did not require critical care,
 - (b) The visit was medically necessary, and
 - (c) The services are separate and distinct,
 1. No duplicative elements from the critical care service provided later in the day. <86 Fed Reg 65161>
 - (ii) Reporting/Coding
 - (a) Practitioners must report modifier -25 on the claim for the initial E/M service when reporting these critical care services.
 2. Critical Care Services Furnished During the Global Surgical Period
 - a. Pre-operative and Post-operative Critical care are included in the surgical package of many procedures with a 10 or 90 day global period; however, critical care unrelated to a procedure with a global surgical period may be separately reported and reimbursed when the following requirements are met:

- (i) The service must meet the definition of critical care and require the full attention of the physician or the qualified healthcare professional;
 - (ii) The critical care provided is above and beyond the procedure performed; and
- b. Unrelated to the specific anatomic injury or the general surgical procedure performed. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12.7>

G. Critical Care Documentation Requirements

1. Each practitioner must document the total critical care time they provided.
2. Documentation should indicate that the services furnished to the patient, including any concurrent care, were medically reasonable and necessary.
3. The role of each practitioner provided concurrent care should be clearly identified in the medical record.
4. If critical care is provided as a split (or shared) service, the documentation must indicate the following:
 - a. Critical care services were provided by both practitioner and the care they each provided;
 - b. The record must be signed and dated by the billing provider; and
 - c. Total time of each practitioner must be documented. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12.8>

XIII. Nursing Facility Visits

A. Federally Required Monitoring Visits

1. Medicare covers physician services necessary to satisfy federal requirements for the monitoring of nursing facility residents. However, Medicare policy does not cover additional E/M visits furnished solely to meet state law requirements for a facility admission or other additional visits "to satisfy facility or other administrative purposes," unless there

was a medical reason for the visit. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(B)>

a. Frequency limits on “monitoring” visits

(i) Although not clear, CMS appears to take the position that nursing facility monitoring visits may not be billed more frequently than once every 30 days for the first 90 days after admission and every 60 days thereafter. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(B)>

(a) However, these limits do not prohibit physicians from billing for more frequent visits if the visits are otherwise medically necessary (i.e., the visits are for some medical reason other than routine monitoring). <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(B)>

B. Nursing Facility Visits by Non-Physician Practitioners

1. Federally Required Monitoring Visits

a. Skilled Nursing Facility (SNF) Residents

(i) The “initial visit” for a SNF resident must be furnished by a physician. <Medicare Claims Processing Manual, Chapter 12 § 30.6.13(A)>

(ii) Initial visits performed by the admitting physician should be identified with the AI modifier. Other physicians evaluating the patient for specialty care should report the Initial Nursing Facility Care Codes without the AI modifier. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(C)>

(a) Visits after the “initial visit” may be performed by a non-physician practitioner so long as the non-physician practitioner is permitted to furnish the service under applicable state law and the other Medicare requirements applicable to non-physician practitioners are met. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(C)>

1. Medically necessary e/m visits provided by NPPs in the SNF may be considered for reimbursement under the subsequent nursing facility care codes (99307-99310) even if the visits are provided prior to the physician’s initial visit. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(C)>

b. Nursing Facility (NF) Visits

- (i) The initial visit by a non-physician practitioner is covered so long as the non-physician practitioner is not an employee of the nursing facility, the non-physician practitioner is permitted to furnish the service under applicable state law and the other Medicare requirements applicable to non-physician practitioners are met. <See *Medicare Claims Processing Manual*, Chapter 12 §§ 30.6.13(A), 30.6.13(C)>
- (ii) Other visits by a non-physician practitioner are covered so long as the non-physician is permitted to furnish the service under applicable state law and the other Medicare requirements applicable to non-physician practitioners are met. < See *Medicare Claims Processing Manual*, Chapter 12 §§ 30.6.13(A), 30.6.13(C)>

C. Place of Service Code Issues

- 1. The following place of service codes should be used to bill for E/M services furnished to SNF/NF residents: < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(A)>
 - a. SNF Residents in a Covered Part A Stay
 - (i) POS 31 - SNF
 - b. Other SNF Residents
 - (i) POS 32 - NF
 - c. NF Residents
 - (i) POS 32 – NF

XIV. Care Plan Oversight Services

A. Scope of Services

- 1. Care plan oversight is the physician supervision of a patient under the care of a home health agency or hospice that requires complex and multidisciplinary care modalities involving:
 - a. Regular physician development and/or revision of care plans,

- b. Review of subsequent reports of patient status,
- c. Review of laboratory results and other studies,
- d. Communication with other healthcare professionals not in the same practice,
- e. Integration of new information into the care plan, and
- f. Adjustments to therapy. <See *Medicare Benefit Policy Manual*, Chapter 15 § 30 (G)>

B. Coverage Limitations

1. Care plan oversight services are subject to numerous limitations on coverage as set forth in the Medicare Benefit Policy Manual, Chapter 15 § 30(G).

C. Documentation Requirements

1. A physician who furnishes care plan oversight services must document:
 - a. The date the services were furnished,
 - b. The length of time spent furnishing the services, and
 - c. The nature of the services furnished. <See *Medicare Benefits Policy*, Chapter 15 § 30(G)>

D. Coding and Billing Requirements

1. Coding Issues
 - a. The CPT codes for care plan oversight services are not billable to Medicare. Care plan oversight services furnished for Medicare beneficiaries must be billed using one of the following HCPCS codes: <See *Medicare Claims Processing Manual*, Chapter 12 § 100.1.4>
 - (i) G0179 – Physician recertification services for Medicare covered services of a home health agency.
 - (ii) G0180 – Physician certification services for Medicare covered services of a home health agency.

(iii)G0181 – Physician supervision of a patient receiving Medicare covered home health services provided by a home health agency, 30 minutes or more.

(a) Carriers will allow non-physician practitioners to report G0181 for home health care plan oversight even though they are not allowed to certify a patient for home health or sign the plan of care. < See *Medicare Claims Processing Manual*, Chapter 12 § 180.1(B)>

(iv)G0182 – Physician supervision of a patient receiving services under a Medicare approved hospice, 30 minutes or more.

(a) Carriers will allow non-physician practitioners to report G0182, along with modifier GV for hospice care plan oversight services. < See *Medicare Claims Processing Manual*, Chapter 12 § 180.1(B)>>

2. General Billing Requirements

a. Care plan oversight services must be billed on a separate claim (i.e., no other services may be billed on the same claim as the care plan oversight services). <Medicare Claims Processing Manual, Chapter 12 § 180.1(A)>

b. Care plan oversight services must be billed after the end of the month in which the services were furnished. <Medicare Claims Processing Manual, Chapter 12 § 180.1(A)>

c. Only one unit of care plan oversight services is billable per month. <Medicare Claims Processing Manual, Chapter 12 § 180.1(A)>

d. Claims submitted for care plan oversight services must include the Medicare provider number of the home health agency or hospice that provided Medicare covered services to the beneficiary during the time the care plan oversight services were furnished. <Medicare Claims Processing Manual, Chapter 12 § 180.1(C)>

(i) **Alert:** This requirement was rescinded due to the lack of data field for this information on the HIPAA Standard ASC X12N 837. It is waived temporarily while a new version of the electronic standard format is being developed. <Medicare Claims Processing Manual, Chapter 12 § 180.1 (C)>

- e. An E/M service must have been furnished to the beneficiary within six months immediately preceding the first CPO service. <Medicare Benefit Policy Manual, Chapter 15 § 30.G.6>
3. Additional Billing Requirements Applicable to Care Plan Oversight Services Furnished in Connection with Certification of a Home Health Plan of Care
- a. A physician may not bill for care plan oversight services furnished in connection with home health certification (G0180) or recertification (G0179) unless the same physician signed the home health or hospice plan of care. <Medicare Benefit Policy Manual, Chapter 15 § 30.G>
 - b. Care plan oversight services furnished in connection with home health certification (G0180) may only be billed if the patient has not received Medicare-covered home health services during the preceding 60-day period. <Medicare Claims Processing Manual, Chapter 12 § 180.1(B)>
 - c. Care plan oversight services furnished in connection with home health recertification (G0179) may only be billed when the patient has received home health services for at least 60 days or one certification period. <Medicare Claims Processing Manual, Chapter 12 § 180.1(B)>
 - (i) In general, G0179 may be billed only once every 60 days. <Medicare Claims Processing Manual, Chapter 12 § 180.1(B)>
 - (a) Exception – G0179 may be billed more than once every 60 days if, prior to expiration of an existing recertification period, the patient began a new episode of care that required a new plan of care. <Medicare Claims Processing Manual, Chapter 12 § 180.1(B)>

XV. Care Management Services

Medicare Recognizes the Following Categories of Care Management Services

- *General Care Management (GCM) which includes Chronic Care Management (CCM), Principal Care Management (PCM), Behavioral Health Integration (BHI), Principal Illness Navigation (PIN), Community Health Integration (CHI), Remote Physiological Monitoring (RPM), and Remote Therapeutic Monitoring (RTM – Reported with G0511)*
- *Transition Care Management (TCM) – billed with 99495 or 99496*
- *Psychiatric Collaborative Care Model (CoCM) – billed with G0512*

A. General Care Management Services

1. Care and support services provided by clinical staff under the direction of a physician or NPP to a patient residing at home, domiciliary, rest home or assisted living facility.
2. Services 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. See the CPT Manual for the complete list of care management activities.
 - a. If the physician or other qualified health care professional (e.g., nurse practitioner or physician assistant) supplies the time, that time may also count toward the 20 minutes.
3. Patients must have two or more chronic continuous or episodic health conditions that place the patient at significant risk and are expected to last at least 12 months or until death.
4. Services may be reported on a monthly basis by a single physician/NPP.

5. Reporting is dependent on whether the care management service is provided by clinical staff versus the physician or qualified health care professional. Time may or may not be face-to-face with the patient.
 - a. Clinical staff time on the same day of an e/m is not counted toward the care management service.
 6. Billing practices must provide 24/7 access to physicians, NPPs, or clinical staff to address urgent needs, provide continuity of care, and utilize an electronic health record system so that providers have timely access to clinical information. See the CPT Manual for the complete list of practice requirements.
 7. Care management services may not be reported by the surgeon when performed during the post-op period.
 8. Many services are included in care management and are therefore not separately reported such as care plan oversight services (99339, 99340, 99374-99380), medical team conferences (99366, 99367, 99368), transitional care management services (99495, 99496), etc. See the CPT Manual for the complete list.
 9. CPT categorizes care management services as either Chronic Care Management or Complex Chronic Care Management.
- B. Chronic Care Management Services
1. Non-complex Chronic Care Management (CPT 99490, 99491, and 99439)
 - a. CPT Code 99491 - CCM services provided personally by a physician or other qualified health care professional for at least 30 minutes.
 - b. CPT code 99490 - non-complex CCM is a 20-minute timed service provided by clinical staff to coordinate care across providers and support patient accountability.
 - c. At least 20 minutes of clinical staff time must be spent in care management activities for the month.
 - d. Medicare recognizes this service. Reimbursement is similar to an established patient level 2 office visit.
 - e. Can be performed under general supervision <CMS Chronic Care Management Fact Sheet, May 2015>

- f. Practitioner must inform eligible patients of the availability of and obtain consent for the CCM service before furnishing or billing the service. In some instances, there are certified electronic health record implications for this consent. Verify if you must meet these requirements before billing <CMS Chronic Care Management Fact Sheet, May 2015>
- g. CPT code 99439 - each additional 20 minutes of clinical staff time spent providing non-complex CCM directed by a physician or other qualified health care professional. Add-on code to be reported in conjunction with CPT code 99490.
 - (i) Add-on code to be reported in conjunction with CPT code 99480.

C. Complex Chronic Care Management Services (99487-99489)

- 1. Complex chronic care management service (99487), must meet the following required elements:
 - a. Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
 - (i) Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
 - (ii) Establishment or substantial revision of a comprehensive care plan with moderate or high complexity medical decision making
 - (iii) 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
 - (iv) CPT 99489 - Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
- 2. Complex Chronic Care Management should not be reported when the care plan is unchanged or requires only minimal change (e.g., medication is changed or an adjustment in a treatment modality is ordered).

D. Principal Care Management (PCM) Services (G2064-G2065)

1. Beginning January 1, 2020, Medicare created PCM codes for comprehensive care management for a single high-risk disease.
 - a. Appropriate when the beneficiary only has a single high-risk disease or when the beneficiary has multiple chronic conditions, but the practitioner is providing comprehensive care for a single condition.
 - b. Management of a single condition may be more common with specialists.
 - c. The distinguishing feature in the codes is dependent on who is doing the comprehensive care management:
 - (i) G2064 - Comprehensive care management services for a single high-risk disease at least 30 minutes of **physician or other qualified health care professional** time per calendar month
 - (ii) G2065 Comprehensive care management services for a single high-risk disease at least 30 minutes of **clinical staff** time per calendar month...
2. Both codes require 30 minutes of time during the calendar month.
3. CMS intends to monitor these new codes for the unintended consequence of fragmented care or inappropriate care that overlaps into duplicative services.

E. Chronic Pain Management

1. For CY 2023 CMS finalized two HCPCS codes for chronic pain management services performed by physicians or other qualified healthcare professionals. <MLN Matters MM12982>
 - a. HCPCS G3002 - Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health

treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month.

(i) To report G3002, 30 minutes must be met or exceeded.

- b. HCPCS G3003 - Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for G3002).

(i) To report HCPCS G3003, 15 minutes must be met or exceeded.

XVI. Health Equity Services

A. Principal Illness Navigation (PIN) Services and Principal Illness Navigation-Peer Support (PIN-PS) Services

1. Four time-based HCPCS codes for the purpose of assisting patients with their navigation of high-risk serious illnesses, expected to last three months.
 - a. CMS will pay for certified or trained auxiliary personnel, as part of the treatment plan, under the direction of the billing practitioner.
 - (i) Examples of auxiliary staff:
 1. Patient navigator or certified peer specialists
 - (ii) Auxiliary staff must be trained to provide all included elements of PIN services and authorized to perform under state law.
2. PIN services are incident-to-services; therefore, can only be reported in a non-facility setting.
3. Informed consent is required.

- a. Consent may be written or verbal but must be documented in the patient's medical record.
4. PIN services require an initiating visit
 - a. When provided by a medical provider:
 - (i) The initiating visit can be an office visit, or Annual Wellness Visit
 - (a) The visit cannot be a low-level visit (CPT 99211) and must be performed by the physician or the NPP.
 - b. When provided by a clinical psychologist:
 - (i) The initiating visit can be one of the following:
 - (ii) 90791 – Psychiatric diagnostic evaluation,
 - (iii) 96156, 96158, or 96159 – Health behavior assessments; or
 - (iv) 96164, 96165, 96167 and 96168 – Health behavior interventions
5. PIN services may be provided under contract with the practitioner if incident-to requirements are met.
 - a. However, the third party must have clinical integration with the practice.
6. Principal Illness Navigation-Peer Support (PIN-PS)
 - a. Intended more for patients with high-risk behavioral health condition.
 - b. Different service elements that fit the scope of practice of peer support specialists.
7. Coding PIN Services
 - a. G0023: Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:

- Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition
 - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that aren't separately billed)
 - Facilitating patient-driven goal setting and establishing an action plan
 - Providing tailored support as needed to accomplish the practitioner's treatment plan
- Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
- Practitioner, home- and community-based care communication
 - Coordinating receipt of needed services from health care practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable)
 - Communicating with practitioners, home-, and community-based service providers hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
 - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities
 - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
- Health education - helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making
- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition

- Health care access/health system navigation
- Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them
- Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable

-Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals

- Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals

- Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals

- b. G0024: Principal illness navigation services, additional 30 minutes per calendar month (List separately in addition to G0023)

8. Coding Principal Illness Navigation – Peer Support (PIN-PS)

- a. G0140 - Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month
- b. G0146 - Principal illness navigation - peer support, additional 30 minutes per calendar month (list separately in addition to G0140)

9. Billing and Payment of PIN Services

- a. The billing practitioner can't furnish PIN services more than once per practitioner per month for any single serious high-risk condition.
- b. PIN and PIN-PS services may not be billed concurrently.

B. Care Giver Training Services

1. Effective January 1, 2024, CMS will provide coverage and payment for care giver training when provided by physicians and/or other qualified health care professionals.
2. CMS defines caregiver in the 2024 MPFS Final Rule as:
 - a. "An adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation" and "a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition" <88 Fed. Reg. 78917>
3. Services must be reasonable and necessary
 - a. Training must be relevant to the person-centered treatment plan for the patient.
 - b. The volume and frequency of training should be based on treatment plan, patient diagnosis, or change in condition, or caregiver.
4. Two sets of codes were created:
 - a. Behavior management/modification for patients with mental or physical health diagnoses
 - (i) CPT 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
 - (ii) CPT 96203 – each additional 15 minutes
 - b. Patient functional performance in the home/community, related to activities of daily living (ADLs)

- c. Caregiver training services provided under a therapy plan of care established by a physical therapist, occupational therapist, or a speech-language pathologist <88 *Fed. Reg.* 78915>
 - (i) CPT 97550 - 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
 - (ii) CPT 97551 - each additional 15 minutes
 - (iii) CPT 97552 - Group 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 with multiple sets of caregivers
- d. Caregiver training services are considered "sometimes therapy" codes <88 *Fed. Reg.*78920>

C. Social Determinants of Health Risk Assessments

1. Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. <Office of Disease Prevention and Health Promotions>
2. CMS refers to the Health People 2030's definition of SDOH, in the 2024 MPFS Final Rule:
 - a. Healthy People 2030 define the broad groups of SDOH as: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context, which include factors like housing, food and nutrition access, and transportation needs. <88 *Fed. Reg.*78932>
3. CMS stresses the service is an assessment, it is not intended to be a screening.

- a. Should be linked to a known or suspected SDOH need that interferes with the practitioner's diagnosis or treatment <88 *Fed. Reg.* 78934>

4. Coding SDOH Assessments

- a. G0136 - Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes, not more than every six months

5. Appropriate Reporting

- a. May be provided with:
 - (i) An evaluation and management (E/M) visit, which can include hospital discharge or transitional care management services
 - (ii) Behavioral health office visits, such as psychiatric diagnostic evaluation and health behavior assessment and intervention
 - (iii) The Annual Wellness Visit (AWV)

6. Documentation

- a. CMS indicates that SDOH needs identified during the assessment needs to be documented in the medical record
- b. Not requiring the SDOH Z-codes for documentation but are encouraging their reporting to improve data. <88 *Fed. Reg.* 78936>

D. Community Health Integration (CHI) Services, Effective January 1, 2024

- 1. CHI services address unmet social determinants of health (SDOH) needs that affect both the diagnosis and treatment of a patient's medical conditions.
 - a. CHI services include:
 - (i) Person centered training;
 - (ii) Health system navigation;
 - (iii) Facilitating access to community-based resources;

- (iv) Practitioner, home, and community-based care coordination; or
 - (v) Patient self-advocacy promotion
2. CHI services are initiated when a practitioner identifies an unmet SDOH that significantly impacts diagnosis and treatment of the patient's condition during an initiating visit.
 3. CHI services can be provided by auxiliary personnel, including community health workers (CHW). <See *MLN 9201074*>
 - a. The services of the community health workers and auxiliary personnel are paid incidental to the services of the health care practitioner who bills Medicare.
 - (a) Note: There is no Medicare benefit for directly paying community mental health workers or auxiliary personnel
 4. Requirements for Community Health Integration (CHI) Services
 - a. The patient must be seen prior to furnishing and billing (CHI) services. < See *MLN Booklet, Health Equity Services in the 2024 Physician Fee Schedule Final Rule*>
 - (i) The initiating visit must be performed by clinical staff. The following qualify as an initiating visit:
 - (a) Evaluation and Management (E/M) visit; or
 1. This visit may be the face-to-face visit provided as part of the Transitional Care Management (TCM) services.
 2. The E/M visit cannot be a low-level E/M (i.e. 99211 – level I E/M).
 - (b) An annual wellness visit (AVW)
 1. During the initiating visit, the practitioner establishes the treatment plan, addresses how addressing the unmet SDOH aids in the treatment plan, and establishes the CHI services as incidental to the practitioner's services.

- a. All must be documented in the medical record.

(ii) Consent

- (a) Prior to furnishing CHI services, advanced patient consent must be obtained.
 1. Consent need only be obtained once unless there is a change in the furnishing/billing practitioner.
 2. Consent may be written or verbal; but, must be documented in the patient's medical record.
 3. Consent must include an explanation of beneficiary cost sharing, frequency of CHI services.
 - a. Only one practitioner can bill for CHI services per month;

(iii) Auxiliary Staff and Supervision

- (a) CHI services provided by auxiliary personnel, incident to the physician's service, are provided under general supervision.
- (b) Auxiliary personnel must meet applicable state requirements and licensure.
 1. For states silent on requirements and licensure, auxiliary personnel must be certified and trained in the following competencies:
 - a. Patient and family communication,
 - b. Interpersonal and relationship-building skills,
 - c. Patient and family capacity building,
 - d. Service Coordination and systems navigation,

- e. Patient advocacy, facilitation, individual and community assessment,
- f. Professionalism and ethical conduct, and
- g. Appropriate knowledge base, including community resources. < See *MLN Booklet, Health Equity Services in the 2024 Physician Fee Schedule Final Rule*>

5. Billing CHI services

- a. Only one physician may bill for CHI services per month
- b. CHI services may be billed for the same period as other care management services. However, CHI services may only be billed during the same period (month) if:
 - (a) Time and effort are not counted more than once;
 - (b) All billing requirements for other care management services are met; and
 - (c) The services performed are medically necessary.
- c. Documentation of Community Health Integration (CHI) Services
 - (i) The following must be documented in the patient's medical record:
 - (a) The amount of time the auxiliary personnel spent with the patient and the nature of activities; and
 - (b) Any unmet social needs that CHI services are addressing.
 - (ii) Documenting ICD-10 Z-codes can count as the appropriate documentation.

d. Coding CHI Services

- (i) G0019- Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month

Note: For complete code description see MLN 9201074, January 2024 behind the outline.

- (ii) G0022 - Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019)

XVII. Transitional Care Management (TCM) Services (99495-99496)

1. Used for new or established patients whose medical problems require moderate or high complexity medical decision during transition from an inpatient hospital setting (includes acute care, rehab, long-term acute care hospital), partial hospital, observation status or SNF/NF to a community setting (home, domiciliary, rest home or assisted living).
2. TCM starts on the date of discharge and continues for the next 29 days.
3. An interactive contact with the patient or caregiver, as appropriate, must occur within two business days of discharge.
 - a. Contact may be face-to-face, telephonic, or by electronic means.
4. TCM entails one face-to-face visit in combination with non-face-to-face services. Medication reconciliation and management must occur no later than the date of the face-to-face visit.
 - a. Face-to-Face Visit Rules
 - (i) The first face-to-face visit is included in the TCM. Other e/m services provided subsequently may be separately reported.
 - (ii) The visit must occur within 14 days of discharge if the medical decision making is of moderate complexity. Use code 99495.

(iii) The visit must occur within 7 days of discharge if the medical decision making is of high complexity. Use code 99496.

(a) If the medical decision making is of high complexity, but the visit does not occur until day 8 post-discharge, use code 99495.

5. Only one individual may report TCM services and only once per patient within 30 days of discharge.
6. The same provider may report hospital or observation discharge services (99238-99239, or 99217) and TCM.
7. TCM services provided in the postoperative period by the surgeon are considered bundled and not separately reported.
8. Documentation Requirements for TCM
 - a. Documentation in the medical record must at a minimum indicate:
 - (i) Date the beneficiary was discharged;
 - (ii) Date the interactive contact with the beneficiary and/or caregiver was made;
 - (iii) Date that the face-to-face visit occurred; and
 - (iv) The complexity of medical decision making (moderate or high).
9. For additional details on Medicare requirements for TCM, see the TCM fact sheet: <https://www.cms.gov/files/document/mln908628-transitional-care-management-services.pdf>

XVIII. Psychiatric Collaborative Care and Behavioral Integration Services (99492, 99493, 99494)

1. Billed by treating physician/Primary Care Provider (PCP)
2. The consulting psychiatrist and the care manager are then paid by the PCP through a contract, employment, or other arrangement.
3. All bulleted items must be performed to report the service

B. Example 99492

- (i) Tracking patient follow-up and progress using the registry, with appropriate documentation;
- (ii) Participation in weekly caseload consultation with the psychiatric consultant;
- (iii) Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
- (iv) Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- (v) Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- (vi) Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment. <CMS FAQs Behavioral Integration Services>

XIX. Advance Care Planning (99497-99498)

1. Advance care planning is making decisions about the care patients would want to receive in the event they become unable to speak for themselves.
2. These are time-based codes which may or may not involve completing relevant legal forms.
3. Other e/m services may be reported with advance care planning when performed at the same time.
 - (i) Exception: Advance care planning cannot be reported with critical care or intensive care services.
4. When advance care planning services are provided during the Annual Wellness Visit (AWV -- G0438 or G0439), the deductible and co-pay will be waived. <MLN Matters Article MM9271>
5. It is necessary to report modifier 33 (preventive service) on the advance care planning code(s). <MLN Matters Article MM9271>

XX. Dental and Oral Health Issues

- A. In the 2023 Medicare Physician Fee Schedule Final Rule, CMS clarified its interpretation of the current statute regarding dental services.
1. Under current law, Medicare is prohibited from making payments for "...services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth." <Social Security Act §1862(a)(12)>
 - a. Exceptions to the prohibition:
 - (i) Can apply "in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."
- B. CMS clarified Medicare's current policy which indicates, medically necessary dental services under both Parts A and B if they are "incident to and as an integral part" a covered procedure.
- C. The clarification of the statute, the 2023 Medicare Physician Fee Schedule Final Rule, codifies the following:
1. Dental services can continue to be made based on the interpretation that these services "are inextricably linked to, and substantially related and integral to the clinical success of, an otherwise covered medical service," including:
 - a. Dental or oral examination as part of a comprehensive workup prior to a renal organ transplant surgery;
 - b. Reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor;
 - c. Wiring or immobilization of teeth in connection with the reduction of a jaw fracture;
 - d. Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and

- e. dental splints only when used in conjunction with medically necessary treatment of a medical condition.
2. The Final Rule also finalizes a policy that Medicare can pay for ancillary services that contribute to the success of dental services (e.g., X-rays, anesthesia administration, and operating room use).
 3. Payment can now be made for dental services under Medicare Parts A and B for:
 - a. CY 2023 - dental or oral examinations, including necessary treatment, performed as part of a comprehensive workup prior to any organ transplant surgery or prior to cardiac valve replacement or valvuloplasty procedures.
 - b. CY 2024 - dental or oral examination performed as part of a comprehensive workup in either the inpatient or outpatient setting prior to or at the same time as Medicare-covered treatments for head and neck cancer.

Version 04/25/2024
Check for Updates

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev. 12461; Issued: 01-18-24)

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(Rev. 1, 10-01-03)

B3-4820-4824

Physicians bill for management of immunosuppressive therapy using the office or subsequent hospital visit codes that describe the services furnished. If the physician who is managing the immunotherapy is also the transplant surgeon, he or she bills these visits with modifier “-24” indicating that the visit during the global period is not related to the original procedure if the physician also performed the transplant surgery and submits documentation that shows that the visit is for immunosuppressive therapy.

30.6.4 - Evaluation and Management (E/M) Services Furnished Incident to Physician’s Service by Nonphysician Practitioners

(Rev. 1, 10-01-03)

When evaluation and management services are furnished incident to a physician’s service by a nonphysician practitioner, the physician may bill the CPT code that describes the evaluation and management service furnished.

When evaluation and management services are furnished incident to a physician’s service by a nonphysician employee of the physician, not as part of a physician service, the physician bills code 99211 for the service.

A physician is not precluded from billing under the “incident to” provision for services provided by employees whose services cannot be paid for directly under the Medicare program. Employees of the physician may provide services incident to the physician’s service, but the physician alone is permitted to bill Medicare.

Services provided by employees as “incident to” are covered when they meet all the requirements for incident to and are medically necessary for the individual needs of the patient.

30.6.5 - Physicians in Group Practice

(Rev. 1, 10-01-03)

Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level.

Physicians in the same group practice but who are in different specialties may bill and be paid without regard to their membership in the same group.

30.6.6 - Payment for Evaluation and Management Services Provided During Global Period of Surgery

(Rev. 954, Issued: 05-19-06, Effective: 06-01-06, Implementation: 08-20-06)

A. CPT Modifier “-24” - Unrelated Evaluation and Management Service by Same Physician During Postoperative Period

A/B MACs (B) pay for an evaluation and management service other than inpatient hospital care before discharge from the hospital following surgery (CPT codes 99221-99238) if it was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with CPT modifier “-24,” and accompanied by

documentation that supports that the service is not related to the postoperative care of the procedure. They do not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred unless the doctor is also treating another medical condition that is unrelated to the surgery. All care provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment.



B. CPT Modifier “-25” - Significant Evaluation and Management Service by Same Physician on Date of Global Procedure

Medicare requires that Current Procedural Terminology (CPT) modifier -25 should only be used on claims for evaluation and management (E/M) services, and only when these services are provided by the same physician (or same qualified nonphysician practitioner) to the same patient on the same day as another procedure or other service. A/B MACs (B) pay for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier -25 is added to the E/M code on the claim.

Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified nonphysician practitioner in the patient’s medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.

If the physician bills the service with the CPT modifier “-25,” A/B MACs (B) pay for the service in addition to the global fee without any other requirement for documentation unless one of the following conditions is met:

- When inpatient dialysis services are billed (CPT codes 90935, 90945, 90947, and 93937), the physician must document that the service was unrelated to the dialysis and could not be performed during the dialysis procedure;
- When preoperative critical care codes are being billed on the date of the procedure, the diagnosis must support that the service is unrelated to the performance of the procedure; or
- When an A/B MAC (B) has conducted a specific medical review process and determined, after reviewing the data, that an individual or a group has high use of modifier “-25” compared to other physicians, has done a case-by-case review of the records to verify that the use of modifier was inappropriate, and has educated the individual or group, the A/B MAC (B) may impose prepayment screens or documentation requirements for that provider or group. When a A/B MAC (B) has completed a review and determined that a high usage rate of modifier “-57,” the A/B MAC (B) must complete a case-by-case review of the records. Based upon this review, the A/B MAC (B) will educate providers regarding the appropriate use of modifier “-57.” If high usage rates continue, the A/B MAC (B) may impose prepayment screens or documentation requirements for that provider or group.

A/B MACs (B) may not permit the use of CPT modifier “-25” to generate payment for multiple evaluation and management services on the same day by the same physician, notwithstanding the CPT definition of the modifier.

C. CPT Modifier “-57” - Decision for Surgery Made Within Global Surgical Period

A/B MACs (B) pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier “-57” to indicate that the service resulted in the decision to perform the procedure. A/B MACs (B) may not pay for an evaluation and management service billed with the CPT modifier “-57” if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.



30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99202 - 99215) **7 - 48**

(Rev. 12461; Issued:01-18-24; Effective:01-01-24 Implementation: 02-19-24)

A. Definition of New Patient for Selection of E/M Visit Code

Interpret the phrase “new patient” to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

B. Office/Outpatient E/M Visits Provided on Same Day for Unrelated Problems

As for all other E/M services except where specifically noted, the Medicare Administrative Contractors (MACs) may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office, off campus-outpatient hospital, or on campus-outpatient hospital setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

C. Office/Outpatient or Emergency Department E/M Visit on Day of Admission to Nursing Facility

MACs may not pay a physician for an emergency department visit or an office visit **and** a comprehensive nursing facility assessment on the same day. Bundle E/M visits on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician (see section on Nursing Facility Services below).

D. Drug Administration Services and E/M Visits Billed on Same Day of Service

MACs must advise physicians that CPT code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code (effective January 1, 2004). This drug administration policy was expanded in the Physician Fee Schedule Final Rule, November 15, 2004, to also include a therapeutic or diagnostic injection code (effective January 1, 2005). Therefore, when a medically necessary, significant and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of these drug administration services, the appropriate E/M CPT code should be reported with modifier -25. Documentation should support the level of E/M service billed. For an E/M service provided on the same day, a different diagnosis is not required.

E. Prolonged Office/Outpatient E/M Visits

When the practitioner selects office/outpatient E/M visit level using time, the practitioner reports prolonged office/outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office/outpatient E/M services). See Prolonged Services section for additional information.

F. Add-On Code for Office/Outpatient E/M Visit Complexity



Beginning January 1, 2021, Medicare established HCPCS add-on code G2211 describing visit complexity inherent to office/outpatient E/M visits 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. 7-49

HCPCS code 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)).

The Consolidated Appropriations Act, 2021 delayed PFS payment for this code until January 1, CY 2024 or later. *Effective January 1, 2024, Medicare is changing the status of HCPCS code G2211 to make it separately payable by assigning it an "active" status indicator.*

- HCPCS code G2211 includes services that enable practitioners to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single, high-risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. This includes furnishing services to patients on an ongoing basis that result in care that is personalized to the patient. The services result in a comprehensive, longitudinal, and continuous relationship with the patient and involve delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape. *The "continuing focal point for all needed health care services" and "part of ongoing care related to a patient's single, serious condition or a complex condition" describe relationships between the patient and the practitioner.*

- Reporting is not restricted based on specialty. HCPCS code G2211 may be reported with any visit level. *HCPCS code G2211 may not be reported with an O/O E/M visit reported with Modifier -25. See 30.6.19 – Office/Outpatient Evaluation and Management (O/O E/M) Complexity Add-on Payment (Code G2211).*

- *Example 1: A patient has a primary care practitioner that is the continuing focal point for all health care services, and the patient sees this practitioner to be evaluated for sinus congestion. The inherent complexity that this code (G2211) captures is not in the clinical condition itself—sinus congestion—but rather the cognitive load of the continued responsibility of being the focal point for all needed services for this patient. There is previously unrecognized but important cognitive effort of utilizing the longitudinal relationship itself in the diagnosis and treatment plan and weighing the factors that affect a longitudinal doctor patient relationship. In this example, the primary care practitioner could recommend conservative treatment or prescription of antibiotics. If the practitioner recommends conservative treatment and no new prescriptions, some patients may think that the doctor is not taking the patient's concerns seriously and it could erode the trust placed in that practitioner. In turn, an eroded primary care practitioner/ patient relationship may make it less likely that the patient would follow that practitioner's advice on a needed vaccination at the next visit. The primary care practitioner must decide—what course of action and choice of words in the visit itself, would lead to the best health outcome in this single visit, while simultaneously building up an effective, trusting longitudinal relationship with this patient for all of their primary health care needs. Weighing these various factors, even for a seemingly simple condition like sinus congestion, makes the entire interaction inherently complex, and it is this complexity in the relationship between the doctor and patient that this code captures.*

- *Example 2: a patient with HIV has an office visit with their infectious disease physician, who is part of ongoing care. The patient with HIV admits to the infectious disease physician that there have been several missed doses of HIV medication in the last month. The infectious*

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disease physician has to weigh their response during the visit—the intonation in their voice, the choice of words—to not only communicate clearly that it is important to not miss doses of HIV medication, but also to create a sense of safety for the patient in sharing information like this in the future. If the interaction goes poorly, it could erode the sense of trust built up over time, and the patient may be less likely to share their medication adherence shortcomings in the future. If the patient isn't forthright about their medication adherence, it may lead to the infectious disease physician switching HIV medicines to another with greater side effects, even when there was no issue with the original medication. It is because the infectious disease physician is part of ongoing care, and has to weigh these types of factors, that the E/M visit becomes inherently more complex and the practitioner bills this code (G2211). Even though the infectious disease doctor may not be the focal point for all services, such as in the previous example, HIV is a single, serious condition, and/or a complex condition, and so as long as the relationship between the infectious disease physician and patient is ongoing, this E/M visit could be billed with the add-on.

The most important information used to determine whether or not the add-on code could be billed is the relationship between the practitioner and the patient. If the practitioner is the focal point for all needed services, such as a primary care practitioner, the HCPCS G2211 add-on code could be billed. Or, if the practitioner is part of ongoing care for a single, serious condition or a complex condition, e.g., sickle cell disease, then the add-on code could be billed. The add-on code captures the inherent complexity of the visit that is derived from the longitudinal nature of the practitioner and patient relationship.

G. Medical Review When Practitioners Use Time to Select Visit Level

 Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit.

30.6.8 - Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services) (Rev. 11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

A. Who May Bill Observation Care Codes

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

A/B MACs (B) pay for initial observation care billed by only the physician who ordered hospital outpatient observation services and was responsible for the patient during his/her observation care. A physician who does not have inpatient admitting privileges but who is authorized to furnish hospital outpatient observation services may bill these codes.

For a physician to bill observation care codes, there must be a medical observation record for the patient which contains dated and timed physician's orders regarding the observation

services the patient is to receive, nursing notes, and progress notes prepared by the physician while the patient received observation services. This record must be in addition to any record prepared as a result of an emergency department or outpatient clinic encounter. **7-51**

Payment for an initial observation care code is for all the care rendered by the ordering physician on the date the patient's observation services began. All other physicians who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

For example, if an internist orders observation services and asks another physician to additionally evaluate the patient, only the internist may bill the initial and subsequent observation care codes. The other physician who evaluates the patient must bill the new or established office or other outpatient visit codes as appropriate.

For information regarding hospital billing of observation services, see Chapter 4, §290.

B. Physician Billing for Observation Care Following Initiation of Observation Services

Starting in CY 2023, hospital inpatient and observation care by practitioners will be billed using the same CPT codes, CPT codes 99221 through 99223, 99231 through 99233, and 99238 and 99239. (CPT 99234 through 99236 are already used for billing hospital inpatient or observation care (including admission or discharge.) Although observation care codes (CPT codes 99218 through 99220 and 99224 through 99226) are being deleted, practitioners will still be able to furnish and bill for observation services using the revised Hospital Inpatient or Observation Care Services code set. Where noted, the term "observation care code" applies to Hospital Inpatient or Observation Care Services codes (CPT codes 99221-99223, 99231-99239.)

The time counted toward the Hospital Inpatient or Observation Care codes is "per day." "Per day," also referred to as "date of encounter," means the "calendar date." When using MDM or time for code selection, a continuous service that spans the transition of 2 calendar dates is a single service and is reported on one date, which is the date the encounter begins. If the service is continuous, before and through midnight, all the time may be applied to the reported date of the service (that is, the calendar date the encounter began).

A billing practitioner shall bill only one of the hospital inpatient or observation care codes for an initial visit, a subsequent visit, or inpatient or observation care (including admission and discharge), as appropriate, once per calendar date. The practitioner selects a code that reflects all of the practitioner's services provided during the date of the service. The definitions of "initial visit" and "subsequent visit" for the purposes of billing observation care using the Hospital Inpatient or Observation Care Services codes can be found in section 30.6.9.E. Note also, that in some cases, practitioners may bill a prolonged code in addition to the Hospital Inpatient or Observation Care Services base code; refer to section 30.6.9.F.)

Observation care codes are billed by the treating practitioner. All other practitioners who furnish consultations or additional evaluations or services while the patient is receiving hospital outpatient observation services must bill the appropriate outpatient service codes.

For additional guidance for billing observation care using the Hospital Inpatient or Observation Care Services code set, CPT codes 99221-99223, 99231-99239, refer to sections 30.6.9.1 and 30.6.9.2, where specified.

For additional guidance for billing prolonged Hospital Inpatient or Observation Care, refer to section 30.6.9.15.

The physician shall satisfy the E/M documentation guidelines for furnishing observation care or inpatient hospital care. In addition to meeting the documentation requirements for medically appropriate history and/or examination, and medical decision making, documentation in the medical record shall include:

- Documentation stating the stay for observation care or inpatient hospital care involves 8 hours, but less than 24 hours;
- Documentation identifying the billing physician was present and personally performed the services; and
- Documentation identifying the order for observation services, progress notes, and discharge notes were written by the billing physician.

In the rare circumstance when a patient receives observation services for more than 2 calendar dates, the physician shall bill observation services furnished on day(s) other than the initial or discharge date using subsequent observation care codes.

D. Admission to Inpatient Status Following Observation Care

For the purposes of reporting an initial hospital inpatient or observation care service, a transition from observation status to inpatient status does not constitute a new stay.

If the same physician who ordered hospital outpatient observation services also admits the patient to inpatient status before the end of the date on which the patient began receiving hospital outpatient observation services, pay only an initial hospital visit for the evaluation and management services provided on that date. Medicare payment for the initial hospital visit includes all services provided to the patient on the date of admission by that physician, regardless of the site of service. The physician may not bill an initial or subsequent observation care code for services on the date that he or she admits the patient to inpatient status. If the patient is admitted to inpatient status from hospital outpatient observation care subsequent to the date of initiation of observation services, the physician must bill a subsequent hospital inpatient or observation care code for the services provided on that date. The physician may not bill the hospital inpatient or observation discharge management code (CPT codes 99238-99239) or an outpatient/office visit for the care provided while the patient received hospital outpatient observation services on the date of admission to inpatient status. Note that in some cases, practitioners may bill a prolonged code in addition to the Hospital Inpatient or Observation Care Services base code; time spent by the same practitioner on the same day for the same patient in multiple settings (or for a patient who transitions between outpatient and inpatient status) may be counted toward the Hospital Inpatient or Observation Care Services base code and, if applicable, a prolonged code. Refer to section 30.6.9.F.)

E. Hospital Observation Services During Global Surgical Period

The global surgical fee includes payment for hospital observation care services unless the criteria for use of CPT modifiers “-24,” “-25,” or “-57” are met. A/B MACs (B) must pay for these services in addition to the global surgical fee only if both of the following requirements are met:

- The hospital observation service meets the criteria needed to justify billing it with CPT modifiers “-24,” “-25,” or “-57” (decision for major surgery); and

- The hospital observation service furnished by the surgeon meets all of the criteria for the hospital observation code billed.

Examples of the decision for surgery during a hospital observation period are:

- An emergency department physician orders hospital outpatient observation services for a patient with a head injury. A neurosurgeon is called in to evaluate the need for surgery while the patient is receiving observation services and decides that the patient requires surgery. The surgeon would bill a new or established office or other outpatient visit code as appropriate with the “-57” modifier to indicate that the decision for surgery was made during the evaluation. The surgeon must bill the office or other outpatient visit code because the patient receiving hospital outpatient observation services is not an inpatient of the hospital. Only the physician who ordered hospital outpatient observation services may bill for observation care.
- A neurosurgeon orders hospital outpatient observation services for a patient with a head injury. During the observation period, the surgeon makes the decision for surgery. The surgeon would bill the appropriate level of hospital observation code with the “-57” modifier to indicate that the decision for surgery was made while the surgeon was providing hospital observation care.

Examples of hospital observation services during the postoperative period of a surgery are:

- A surgeon orders hospital outpatient observation services for a patient with abdominal pain from a kidney stone on the 80th day following a TURP (performed by that surgeon). The surgeon decides that the patient does not require surgery. The surgeon would bill the observation code with CPT modifier “-24” and documentation to support that the observation services are unrelated to the surgery.
- A surgeon orders hospital outpatient observation services for a patient with abdominal pain on the 80th day following a TURP (performed by that surgeon). While the patient is receiving hospital outpatient observation services, the surgeon decides that the patient requires kidney surgery. The surgeon would bill the observation code with HCPCS modifier “-57” to indicate that the decision for surgery was made while the patient was receiving hospital outpatient observation services. The subsequent surgical procedure would be reported with modifier “-79.”
- A surgeon orders hospital outpatient observation services for a patient with abdominal pain on the 20th day following a resection of the colon (performed by that surgeon). The surgeon determines that the patient requires no further colon surgery and discharges the patient. The surgeon may not bill for the observation services furnished during the global period because they were related to the previous surgery.

An example of a billable hospital observation service on the same day as a procedure is when a physician repairs a laceration of the scalp in the emergency department for a patient with a head injury and then subsequently orders hospital outpatient observation services for that patient. The physician would bill the observation code with a CPT modifier 25 and the procedure code.

30.6.9 - Payment for Inpatient Hospital Visits - General

(Rev. 11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

Starting in CY 2023, hospital inpatient and observation care by practitioners will be billed using the same CPT codes, CPT codes 99221 through 99223, 99231 through 99233, and 99238 and 99239. (CPT 99234 through 99236 are already used for billing hospital inpatient or observation care (including admission or discharge.) Where they appear, references such as “hospital care,” “hospital E/M” or “hospital inpatient care services” in this section apply to



A. Hospital Visit and Critical Care on Same Day

Hospital evaluation and management (E/M) visits may be billed the same day as critical care services in certain circumstances discussed in section 30.6.12. Documentation must support the claims as indicated in that section.

During critical care management of a patient those services that do not meet the level of critical care shall be reported using an inpatient hospital care service with CPT Subsequent Hospital Care using a code from CPT code range 99231 - 99233.

Both Initial Hospital Care (CPT codes 99221 - 99223) and Subsequent Hospital Care codes are “per diem” services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.



B. Two Hospital Visits Same Day

The time counted toward the Hospital Inpatient or Observation Care codes is “per day.” “Per day,” also referred to as “date of encounter,” means the “calendar date.” When using MDM or time for code selection, a continuous service that spans the transition of 2 calendar dates is a single service and is reported on one date, which is the date the encounter begins. If the service is continuous, before and through midnight, all the time may be applied to the reported date of the service (that is, the calendar date the encounter began).

A billing practitioner shall bill only one of the hospital inpatient or observation care codes for an initial visit, a subsequent visit, or inpatient or observation care (including admission and discharge), as appropriate, once per calendar date. The practitioner selects a code that reflects all of the practitioner’s services provided during the date of the service. The definitions of “initial visit” and “subsequent visit” for the purposes of billing observation care using the Hospital Inpatient or Observation Care Services codes can be found in section 30.6.9.E.

A/B MACs (B) pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not.

Note that in some cases, practitioners may bill a prolonged code in addition to the Hospital Inpatient or Observation Care Services base code; time spent by the same practitioner on the same day for the same patient in multiple settings (or for a patient who transitions between outpatient and inpatient status) may be counted toward the Hospital Inpatient or Observation Care Services base code and, if applicable, a prolonged code. Refer to section 30.6.9.F.)

C. Hospital Visits Same Day But by Different Physicians

In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, A/B MACs (B) do not pay physician B for the second visit. The hospital visit descriptors include the phrase “per day” meaning care for the day.

If the physicians are each responsible for a different aspect of the patient’s care, pay both visits if the physicians are in different specialties and the visits are billed with different diagnoses. There are circumstances where concurrent care may be billed by physicians of the same specialty.

D. Visits to Patients in Swing Beds

If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, the nursing facility codes apply. **7-55**

E. Definition of Initial and Subsequent Visit

An initial service is one that occurs when the patient has not received any professional services from the physician or NPP or another physician or NPP of the same specialty who belongs to the same group practice during the stay.

A subsequent service is one that occurs when the patient has received any professional services from the physician or NPP or another physician or NPP of the same specialty who belongs to the same group practice during the stay.

F. Prolonged Hospital Inpatient or Observation Care Services

Beginning January 1, 2023, prolonged services are reported for certain hospital inpatient or observation care visits using G0316. Prolonged services can be reported when time is used to select visit level, and the total practitioner time for the highest-level visit is exceeded by 15 or more minutes for services that are medically reasonable and necessary. See Prolonged Services section below for detailed reporting instructions.

30.6.9.1 - Payment for Initial Hospital Inpatient or Observation Care Services and Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services) (Rev. 11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

A. Initial Hospital Inpatient or Observation Care From Emergency Department

A/B MACs (B) pay for an initial hospital inpatient or observation care service if a practitioner sees a patient in the emergency department and decides to admit the person to the hospital or place the patient in observation care. They do not pay for both E/M services. Also, they do not pay for an emergency department visit by the same practitioner on the same date of service. When the patient is admitted to the hospital via another site of service (e.g., hospital emergency department, physician's office, nursing facility), all services provided by the practitioner in conjunction with that admission are considered part of the initial hospital inpatient or observation care when performed on the same date as the admission.

B. Initial Hospital Inpatient or Observation Care on Day Following Visit

A/B MACs (B) pay both visits if a patient is seen in the office on one date and admitted to the hospital as an inpatient or receives observation care on the next date, even if fewer than 24 hours has elapsed between the visit and the admission for hospital inpatient or placement in observation care.

C. Initial Hospital Inpatient or Observation Care and Discharge on Same Day

Both hospital inpatient and observation care coding should be billed as follows:

When the patient is admitted to inpatient hospital care or is in observation care for less than 8 hours on the same date, then Initial Hospital Inpatient or Observation Care, from CPT code range 99221 - 99223, shall be reported by the physician. The Hospital Inpatient or Observation Discharge Day Management service, CPT codes 99238 or 99239, shall not be reported for this scenario.

When a patient is admitted to inpatient hospital care or is in observation care and then discharged on a different calendar date, the physician shall report an Initial Hospital Inpatient or Observation Care from CPT code range 99221 - 99223 and a Hospital Inpatient or Observation Discharge Day Management service, CPT code 99238 or 99239.

When a patient has been admitted to inpatient hospital care or is in observation care for a minimum of 8 hours but less than 24 hours and discharged on the same calendar date, Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services), from CPT code range 99234 - 99236, shall be reported.



The following table summarizes the above, based on hospital length of stay and discharge date:

Hospital Length of Stay	Discharged On	Code(s) to Bill
< 8 hours	Same calendar date as admission or start of observation	Initial hospital services only*
8 or more hours	Same calendar date as admission or start of observation	Same-day admission/discharge*
< 8 hours	Different calendar date than admission or start of observation	Initial hospital services only*
8 or more hours	Different calendar date than admission or start of observation	Initial hospital services* + discharge day management

*Plus prolonged inpatient/observation services, if applicable.

D. Documentation Requirements for Billing Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services)

The physician shall satisfy the E/M documentation guidelines for admission to and discharge from inpatient observation or hospital care. In addition to meeting the documentation requirements for medically appropriate history and/or examination, and medical decision making documentation in the medical record shall include:

- Documentation stating the stay for hospital treatment or observation care status involves 8 hours but less than 24 hours;
- Documentation identifying the billing physician was present and personally performed the services; and
- Documentation identifying the admission and discharge notes were written by the billing physician.

E. Physician Services Involving Transfer From One Hospital to Another; Transfer Within Facility to Prospective Payment System (PPS) Exempt Unit of Hospital; Transfer From One Facility to Another Separate Entity Under Same Ownership and/or Part of Same Complex; or Transfer From One Department to Another Within Single Facility

Physicians may bill both the hospital discharge management code and an initial hospital care code when the discharge and admission do not occur on the same day if the transfer is between:

- Different hospitals;

- Different facilities under common ownership which do not have merged records; or
- Between the acute care hospital and a PPS exempt unit within the same hospital when there are no merged records.

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In all other transfer circumstances, the physician should bill only the appropriate level of subsequent hospital care for the date of transfer.

F. Initial Hospital Care Service Requirements

Per the CPT code descriptors for Initial Hospital Inpatient or Observation Care Services, a medically appropriate history and/or examination will be required, but will no longer be used to select visit level. Practitioners working in hospitals should continue to be aware of the documentation needed to meet requirements for other payment systems or Conditions of Participation, in addition to the documentation required to bill Hospital Inpatient or Observation Care codes under the PFS.

Physicians who provide an initial visit to a patient during inpatient hospital care that meets the code descriptor requirements shall report an initial hospital care code (99221-99223). The principal physician of record shall append modifier “-AI” (Principal Physician of Record) to the claim for the initial hospital care code. This modifier will identify the physician who oversees the patient’s care from all other physicians who may be furnishing specialty care.

Physicians may bill initial hospital care service codes (99221-99223), for services that were reported with CPT consultation codes (99241 - 99255) prior to January 1, 2010, when the furnished service and documentation meet the Initial Hospital Inpatient or Observation Care code descriptor requirements. Physicians must meet all the requirements of the initial hospital care codes, to report CPT code 99221, which are greater than the requirements for consultation codes 99251 and 99252.

Reporting CPT code 99499 (Unlisted evaluation and management service) should be limited to cases where there is no other specific E/M code payable by Medicare that describes that service. Reporting CPT code 99499 requires submission of medical records and A/B MAC (B) manual medical review of the service prior to payment. A/B MACs (B) shall expect reporting under these circumstances to be unusual.

G. Initial Hospital Care Visits by Two Different M.D.s or D.O.s When They Are Involved in Same Admission

In the inpatient hospital setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 - 99223) or nursing facility care codes (99304 - 99306). A/B MACs (B) consider only one M.D. or D.O. to be the principal physician of record (sometimes referred to as the admitting physician.) 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. Only 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.

30.6.9.2 - Subsequent Hospital Inpatient or Observation Care Visit and Hospital Inpatient or Observation Discharge Day Management (Codes 99231 - 99239)

(Rev. 11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)



(Refer to §§40-40.4 on global surgery)

The Medicare physician fee schedule payment amount for surgical procedures includes all services (e.g., evaluation and management visits) that are part of the global surgery payment; therefore, A/B MACs (B) shall not pay more than that amount when a bill is fragmented for staged procedures.

B. Hospital Inpatient or Observation Discharge Day Management Service

Hospital Inpatient or Observation Discharge Day Management Services, CPT code 99238 or 99239 is a face-to-face evaluation and management (E/M) service between the attending physician and the patient. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified nonphysician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital inpatient or observation discharge day management service is payable per patient per hospital stay.

Only the attending physician of record reports the discharge day management service. Physicians or qualified nonphysician practitioners, other than the attending physician, who have been managing concurrent health care problems not primarily managed by the attending physician, and who are not acting on behalf of the attending physician, shall use Subsequent Hospital Care (CPT code range 99231 - 99233) for a final inpatient hospital visit; practitioners furnishing additional observation care services bill the appropriate office/outpatient code, per section 30.6.8.B.

C. Subsequent Hospital Inpatient or Observation Visit and Discharge Management on Same Day

Pay only the hospital inpatient or observation discharge management code on the day of discharge (unless it is also the day of admission, in which case, refer to §30.6.9.1 C for the policy on Hospital Inpatient or Observation Care Services (Including Admission and Discharge Services CPT Codes 99234 - 99236). A/B MACs (B) do not pay both a subsequent hospital inpatient or observation care visit in addition to hospital inpatient or observation discharge day management service on the same day by the same physician. Instruct physicians that they may not bill for both a hospital inpatient or observation care visit and hospital inpatient or observation discharge management for the same date of service.

D. Hospital Inpatient or Observation Discharge Management (CPT Codes 99238 and 99239) and Nursing Facility Admission Code When Patient Is Discharged From Hospital and Admitted to Nursing Facility on Same Day

A/B MACs (B) pay the hospital inpatient or 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.

If a surgeon is admitting the patient to the nursing facility due to a condition that is not as a result of the surgery during the postoperative period of a service with the global surgical period, he/she bills for the nursing facility admission and care with a modifier “-24” and provides documentation that the service is unrelated to the surgery (e.g., return of an elderly patient to the nursing facility in which he/she has resided for five years following discharge from the hospital for cholecystectomy).

A/B MACs (B) do not pay for a nursing facility admission by a surgeon in the postoperative period of a procedure with a global surgical period if the patient’s admission to the nursing

facility is to receive post operative care related to the surgery (e.g., admission to a nursing facility to receive physical therapy following a hip replacement). Payment for the nursing facility admission and subsequent nursing facility services are included in the global fee and cannot be paid separately. **7-59**

E. Hospital Inpatient or Observation Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital Inpatient or Observation Discharge Day Management Service, CPT code 99238 or 99239. The date of the pronouncement shall reflect the calendar date of service on the day it was performed even if the paperwork is delayed to a subsequent date.

30.6.10 - Consultation Services

(Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

Consultation Services versus Other Evaluation and Management (E/M) Visits

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 and that identify the complexity of the visit performed.

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. Subsequent hospital care codes could potentially meet the component work and medical necessity requirements to be reported for an E/M service that could be described by CPT consultation code 99251 or 99252. A/B MACs (B) shall not find fault in cases where the medical record appropriately demonstrates that the work and medical necessity requirements are met for reporting a subsequent hospital care code (under the level selected), even though the reported code is for the provider's first E/M service to the inpatient during the hospital stay. Unlisted evaluation and management service (code 99499) shall only be reported for consultation services when an E/M service that could be described by codes 99251 or 99252 is furnished, and there is no other specific E/M code payable by Medicare that describes that service. Reporting code 99499 requires submission of medical records and A/B MAC (B) manual medical review of the service prior to payment. CMS expects reporting under these circumstances to be unusual. 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.

In the CAH setting, those CAHs that use method II shall bill the appropriate new or established visit code for those physician and non-physician practitioners who have reassigned their billing rights, depending on the relationship status between the physician and patient.

In the office or other outpatient setting where an evaluation is performed, physicians and qualified nonphysician practitioners shall use the CPT codes (99201 - 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician. All physicians and qualified nonphysician practitioners shall follow the E/M documentation guidelines for all E/M services. These rules are applicable for Medicare secondary payer claims as well as for claims in which Medicare is the primary payer.

30.6.11 - Emergency Department Visits (Codes 99281 - 99288)

(Rev. 1875, Issued: 12-14-09, Effective: 01-01-10, Implementation: 01-04-10)

Any physician seeing a patient registered in the emergency department may use emergency department visit codes (for services matching the code description). It is not required that the physician be assigned to the emergency department.

B. Use of Emergency Department Codes In Office

Emergency department coding is not appropriate if the site of service is an office or outpatient setting or any sight of service other than an emergency department. The emergency department codes should only be used if the patient is seen in the emergency department and the services described by the HCPCS code definition are provided. The emergency department is defined as an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.

C. Use of Emergency Department Codes to Bill Nonemergency Services

Services in the emergency department may not be emergencies. However the codes (99281 - 99288) are payable if the described services are provided.

However, if the physician asks the patient to meet him or her in the emergency department as an alternative to the physician's office and the patient is not registered as a patient in the emergency department, the physician should bill the appropriate office/outpatient visit codes. Normally a lower level emergency department code would be reported for a nonemergency condition.

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

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

E. Physician Billing for Emergency Department Services Provided to Patient by Both Patient's Personal Physician and Emergency Department Physician

If a physician advises his/her own patient to go to an emergency department (ED) of a hospital for care and the physician subsequently is asked by the ED physician to come to the hospital to evaluate the patient and to advise the ED physician as to whether the patient should be admitted to the hospital or be sent home, the physicians should bill as follows:

- If the patient is admitted to the hospital by the patient's personal physician, then the patient's regular physician should bill only the appropriate level of the initial hospital care (codes 99221 - 99223) because all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The ED physician who saw the patient in the emergency department should bill the appropriate level of the ED codes.
- If the ED physician, based on the advice of the patient's personal physician who came to the emergency department to see the patient, sends the patient home, then the ED physician should bill the appropriate level of emergency department service. The patient's personal physician should also bill the level of emergency department code that describes the service he or she provided in the emergency department. If the patient's personal physician does not come to the hospital to see the patient, but only

F. Emergency Department Physician Requests Another Physician to See the Patient in Emergency Department or Office/Outpatient Setting

If the emergency department physician requests that another physician evaluate a given patient, the other physician should bill an emergency department visit code. If the patient is admitted to the hospital by the second physician performing the evaluation, he or she should bill an initial hospital care code and not an emergency department visit code.

30.6.12 - Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

30.6.12.1 – Definition

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

For payment under the Medicare Physician Fee Schedule (PFS), Medicare adopts the definition of critical care services in the CPT Codebook, and the CPT listing of bundled services, unless otherwise specified. This includes the CPT prefatory language stating that critical care is the direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening deterioration of the patient's condition. It involves high complexity decision-making to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

Bundled services that are included by CPT in critical care services and therefore not separately payable include interpretation of cardiac output measurements, chest X rays, pulse oximetry, blood gases and collection and interpretation of physiologic data (for example, ECGs, blood pressures, hematologic data), gastric intubation, temporary transcutaneous pacing, ventilator management, and vascular access procedures. As a result, these codes are not separately billable by a practitioner during the time-period when the practitioner is providing critical care for a given patient. Time spent performing separately reportable procedures or services should be reported separately and should not be included in the time reported as critical care time.

Because critical care services are delivered by a physician(s) or QHP(s), critical care may be reported by physicians and other practitioners who are qualified by education, training, licensure/regulation (when applicable), facility privileging (when applicable), and the applicable Medicare benefit category to perform critical care services and independently report them, referred to in this manual section as physicians and non-physician practitioners (NPPs).

As specified in CPT prefatory language, critical care may be furnished on multiple days, and is typically furnished in a critical care area, which can include an intensive care unit or emergency care facility. Critical care requires the full attention of the physician or NPP and therefore, for any given time period spent providing critical care services, the practitioner cannot provide services to any other patient during the same period of time.

30.6.12.2 - Critical Care by a Single Physician or NPP

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

For payment of critical care by a single physician or NPP, we are adopting CPT's reporting rules. When a single physician or NPP furnishes 30 -74 minutes of critical care services to a patient on a given date, the physician or NPP will report CPT code 99291. CPT code 99291 will be used only once per date even if the time spent by the practitioner is not continuous on



CPT codes 99291 and 99292 will be used to report the total duration of time spent by the physician or NPP providing critical care services to a critically ill or critically injured patient, even if the time spent by the practitioner on that date is not continuous. Non-continuous time for medically necessary critical care services may be aggregated.

Regarding critical care services crossing midnight, CPT guidance defines how a service is to be billed when the service extends across calendar dates. For continuous services that extend beyond midnight, the physician or NPP will report the total units of time provided continuously. Any disruption in the service, however, creates a new initial service. We are adopting this rule for critical care being furnished by a single physician or NPP when the critical care crosses midnight.



30.6.12.3 - Critical Care Visits Furnished Concurrently by Different Specialties

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

Concurrent care is when more than one physician renders services that are more extensive than consultative services during a period of time. The reasonable and necessary services of each physician furnishing concurrent care is covered when each plays an active role in the patient's treatment. In the context of critical care services, a critically ill patient may have more than one medical condition requiring diverse, specialized medical services and requiring more than one practitioner, each having a different specialty, playing an active role in the patient's treatment.

Medicare policy allows critical care visits furnished as concurrent care (or concurrently) to the same patient on the same date by more than one practitioner in more than one specialty (for example, an internist and a surgeon, allergist and a cardiologist, neurosurgeon and NPP), regardless of group affiliation, if the service meets the definition of critical care and is not duplicative of other services. Additionally, these critical care visits need to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.



30.6.12.4 - Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-Up Care)

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

Physician(s) or NPP(s) in the same specialty and in the same group may provide concurrent follow-up care, such as a critical care visit subsequent to another practitioner's critical care visit. This may be as part of continuous staff coverage or follow-up care to critical care services furnished earlier in the day on the same calendar date.

In the situation where a practitioner furnishes the initial critical care service in its entirety and reports CPT code 99291, any additional practitioner(s) in the same specialty and the same group furnishing care concurrently to the same patient on the same date report their time using the code for subsequent time intervals (CPT code 99292). CPT code 99291 will not be reported more than once for the same patient on the same date by these practitioners. This policy recognizes that multiple practitioners in the same specialty and the same group can maintain continuity of care by providing follow-up care for the same patient on a single date.

When one practitioner begins furnishing the initial critical care service, but does not meet the time required to report CPT code 99291, another practitioner in the same specialty and group can continue to deliver critical care to the same patient on the same date. The total time spent by the practitioners is aggregated to meet the time requirement to bill CPT code 99291. Once the cumulative required critical care service time is met to report CPT code 99291, CPT code

99292 can only be reported by a practitioner in the same specialty and group when an additional 30 minutes of critical care services have been furnished to the same patient on the same date (74 minutes + 30 minutes = 104 total minutes). **7-63**

The aggregated time spent on critical care visits must be medically necessary and each visit must meet the definition of critical care in order to add the times for purposes of meeting the time requirement to bill CPT code 99291.

For purposes of payment under the Physician Fee Schedule, Medicare classifies NPPs in a specialty that is not the same as a physician with whom the NPP is working, so the policies above would not apply to the situation where an NPP provides the follow-up care to a physician, or vice versa. Instead, see the section below regarding split (or shared) critical care services.

30.6.12.5 - Split (or Shared) Critical Care Visits

(Rev. 11828; Issued: 02-02-23; Effective: 01-01-23; Implementation: 03-03-23)

Critical care visits may be furnished as split (or shared) visits, defined in section 30.6.18. The rules described in section 30.6.18 for other types of split (or shared) visits apply (except for the listing of qualifying activities for determining the substantive portion, discussed below), and service time is counted for CPT code 99292 in the same way as for prolonged E/M services. Specifically, the billing practitioner bills the initial service (CPT 99291) and any add-on codes(s) for additional time (CPT 99292). Also, the substantive portion for critical care services is defined as more than half of the total time spent by the physician and NPP beginning January 1, 2022. In the context of critical care, split (or shared) visits occur when the total critical care service time furnished by a physician and NPP in the same group on a given calendar date to a patient is summed, and the practitioner who furnishes the substantive portion of the cumulative critical care time reports the critical care service(s).

As stated earlier, when critical care services are furnished as a split (or shared) visit, the substantive portion is defined as more than half the cumulative total time in qualifying activities that are included in CPT codes 99291 and 99292. Since, unlike other types of E/M visits, critical care services can include additional activities that are bundled into the critical care visits code(s), there is a unique listing of qualifying activities for split (or shared) critical care. These qualifying activities are described in the prefatory language for critical care services in the CPT Codebook.

To bill split (or shared) critical care services, the billing practitioner first reports CPT code 99291 and, if 104 or more cumulative total minutes are spent providing critical care, the billing practitioner reports one or more units of CPT code 99292. Modifier -FS (split or shared E/M visit) must be appended to the critical care CPT code(s) on the claim.

The same documentation rules apply for split (or shared) critical care visits as for other types of split (or shared) E/M visits. Consistent with all split (or shared) visits, when two or more practitioners spend time jointly meeting with or discussing the patient as part of a critical care service, the time can be counted only once for purposes of reporting the split (or shared) critical care visit.

30.6.12.6 - Critical Care and Other Same-Day Evaluation and Management (E/M) Visits

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

Our general policy, as described in section 30.6.5, states that physicians in the same group who are in the same specialty must bill and be paid for services under the PFS as though they were a single physician. If more than one E/M visit is provided on the same date to the same patient by the same physician, or by more than one physician in the same specialty in the same group,

only one E/M service may be reported, unless the E/M services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level. This general policy is intended to ensure that multiple E/M visits for a patient on a single day are medically necessary and not duplicative. 7 - 64

However, in situations where a patient receives another E/M visit on the same calendar date as critical care services, both may be billed (regardless of practitioner specialty or group affiliation) as long as the medical record documentation supports: 1) that the other E/M visit was provided prior to the critical care services at a time when the patient did not require critical care, 2) that the services were medically necessary, and 3) that the services were separate and distinct, with no duplicative elements from the critical care services provided later in the day. Practitioners must use modifier -25 (same-day significant, separately identifiable evaluation and management service) on the claim when reporting these critical care services.

30.6.12.7 - Critical Care Visits and Global Surgery

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

Critical care visits are sometimes needed during the global period of a procedure, whether preoperatively, on the same day, or during the post-operative period. In some cases, preoperative and postoperative critical care visits are included in procedure codes that have a global surgical period.

In those cases where a critical care visit is unrelated to the procedure with a global surgical period, critical care visits may be paid separately in addition to the procedure. Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (for example, trauma, burn cases). When the critical care service is unrelated to the procedure, append the modifier -FT ((unrelated evaluation and management (E/M) visit on the same day as another E/M visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated.)) to the critical care CPT code(s).

If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), modifiers -54 (surgical care only) and -55 (postoperative management only) must also be reported to indicate the transfer of care. The surgeon will report modifier -54. The intensivist accepting the transfer of care will report both modifier -55 and modifier -FT. As usual, medical record documentation must support the claims.

30.6.12.8 - Medical Record Documentation

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

Critical care is a time-based service, and therefore, practitioners must document in the medical record the total time (not necessarily start and stop times) that critical care services are furnished by each reporting practitioner. Documentation needs to indicate that the services furnished to the patient, including any concurrent care by the practitioners, are medically reasonable and necessary for the diagnosis and/or treatment of illness and/or injury or to improve the functioning of a malformed body member.

To support coverage and payment determinations regarding concurrent care, services must be sufficiently documented to allow a medical reviewer to determine the role each practitioner played in the patient's care (that is, the condition or conditions for which the practitioner treated the patient).

When critical care services are reported the same date as another E/M visit, the medical record documentation must support: 1) that the other E/M visit was provided prior to the critical care services at a time when the patient did not require critical care, 2) that the services were medically necessary, and 3) that the services were separate and distinct, with no duplicative elements from the critical care services provided later on that date.

When critical care services are furnished in conjunction with a global procedure, the medical record documentation must support that the critical care was unrelated to the procedure, as discussed above.

To support coverage and payment determinations regarding split (or shared) critical care services, the documentation requirements for all split (or shared) E/M visits apply to critical care visits also (see section 30.6.18).

30.6.13 - Nursing Facility Services

(Rev. 11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

Definition of Initial and Subsequent Visits

An initial service is one that occurs when the patient has not received any professional services from the physician or other NPP of the same specialty who belongs to the same group practice during the stay. A subsequent service is one that occurs when the patient has received any professional services from the physician or NPP of the same specialty who belongs to the same group practice during the stay.

A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

The distinction made between the delegation of physician visits and tasks in a skilled nursing facility (SNF) and in a nursing facility (NF) is based on the Medicare Statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs. For further information refer to the Medicare Learning Network article SE0418 at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo>

The federally mandated visits in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4) and (f)). The principal physician of record must append the modifier “-AI”, (Principal Physician of Record), to the initial nursing facility care code. This modifier will identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care. All other physicians or qualified NPPs who perform an initial evaluation in the NF or SNF may bill the initial nursing facility care code. The initial federally mandated visit is defined in S&C-04-08 (see <http://www.cms.gov/site-search/search-results.html?q=S%26C-04-08>) as the initial comprehensive visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, a visit must occur no later than 30 days after admission.

Further, per the Long Term Care regulations at 42 CFR 483.40 (c) (4) and (e) (2), in a SNF the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C-04-08 the physician may not delegate the initial federally mandated comprehensive visit in a SNF.

The only exception, as to who performs the initial visit, relates to the NF setting. In the NF setting, a qualified NPP (i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS)), who is not employed by the facility, may perform the initial visit when the State law permits. The evaluation and management (E/M) visit shall be within the 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. A qualified NPP may perform medically necessary E/M visits prior to and after the initial visit if all the requirements for collaboration, general physician supervision, licensure, and billing are met.

The CPT Nursing Facility Services codes shall be used with place of service (POS) 31 (SNF) if the patient is in a Part A SNF stay. They shall be used with POS 32 (nursing facility) if the patient does not have Part A SNF benefits or if the patient is in a NF or in a non-covered SNF stay (e.g., there was no preceding 3-day hospital stay). The CPT Nursing Facility code definition also includes POS 54 (Intermediate Care Facility/Individuals with Intellectual Disabilities) and POS 56 (Psychiatric Residential Treatment Center). For further guidance on POS codes and associated CPT codes refer to §30.6.14.

Effective January 1, 2006, the Initial Nursing Facility Care codes 99301- 99303 are deleted.

Beginning January 1, 2006, the new CPT codes, Initial Nursing Facility Care, per day, (99304 - 99306) shall be used to report the initial federally mandated visit. Only a physician may report these codes for an initial federally mandated visit performed in a SNF or NF (with the exception of the qualified NPP in the NF setting who is not employed by the facility and when State law permits, as explained above).

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.

A physician who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment. An NPP who is employed by the SNF or NF may perform and bill Medicare Part B directly for those services where it is permitted as discussed above. The employer of the PA shall always report the visits performed by the PA. A physician, NP or CNS has the option to bill Medicare directly or to reassign payment for his/her professional service to the facility.

As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.

For Office/Outpatient or Emergency Department E/M Visit on Day of Admission to Nursing Facility see section 30.6.7.C above.

A given practitioner cannot bill an initial NF visit and another E/M visit (such as an O/O visit or ED visit) on the same date of service, for the same patient. However, the time the practitioner spends furnishing a visit in another setting can be counted toward reporting prolonged NF services, if requirements for reporting prolonged NF services are met.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial federally mandated visit in both the SNF and NF. 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. A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting--Place of Service Code 32

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial federally mandated visit by the physician or qualified NPP where permitted, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

Effective January 1, 2006, the Subsequent Nursing Facility Care, per day, codes 99311- 99313 are deleted.

Beginning January 1, 2006, the new CPT codes, Subsequent Nursing Facility Care, per day, (99307 - 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.

A/B MACs (B) shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service. The Nursing Facility Services codes represent a “per day” service.

The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The physician/qualified NPP shall bill only one E/M visit.

Beginning January 1, 2023, the CPT code, Other Nursing Facility Service (99318), has been deleted and is no longer used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. Effective for dates of service on and after 1-1-2023, for Medicare Part B payment policy, the regular code set for Nursing Facility Services shall be used.

Qualified NPPs, whether employed or not by the SNF, may perform alternating federally mandated physician visits, at the option of the physician, after the initial federally mandated visit by the physician in a SNF.

Qualified NPPs in the NF setting, who are not employed by the NF and who are working in collaboration with a physician, may perform federally mandated physician visits, at the option of the State.

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Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes. E/M visits, prior to and after the initial federally mandated physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.

C. Visits by Qualified Nonphysician Practitioners

All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs. General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. 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. A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

SNF Setting--Place of Service Code 31

Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting--Place of Service Code 32

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

D. Medically Complex Care

Payment is made for E/M visits to patients in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are reasonable and medically necessary and documented in the medical record. Physicians and qualified NPPs shall report initial nursing facility care codes for their first visit with the patient. The principal physician of record must append the modifier "-AI" (Principal Physician of Record), to the initial nursing facility care code when billed to identify the physician who oversees the patient's care from other physicians who may be furnishing specialty care. Follow-up visits shall be billed as subsequent nursing facility care visits.

E. Incident to Services

Where a physician establishes an office in a SNF/NF, the “incident to” services and requirements are confined to this discrete part of the facility designated as his/her office. “Incident to” E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B. Thus, visits performed outside the designated “office” area in the SNF/NF would be subject to the coverage and payment rules applicable to the SNF/NF setting and shall not be reported using the CPT codes for office or other outpatient visits or use place of service code 11. **7 - 69**

F. Prolonged NF Services

Beginning January 1, 2023, prolonged NF services are reported using Medicare-specific coding (HCPCS code G0317). Prolonged Services can be reported when time is used to select visit level, and the total time for the highest-level visit is exceeded by 15 or more minutes for services that are reasonable and medically necessary. See Prolonged Services section below for detailed reporting instructions on prolonged NF visits. Prolonged services are not reportable in conjunction with codes for NF discharge day management.

G. Multiple Visits

The complexity level of an E/M visit and the CPT code billed must be a covered and medically necessary visit for each patient (refer to §§1862 (a)(1)(A) of the Act). Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits. The E/M visit (Nursing Facility Services) represents a “per day” service per patient as defined by the CPT code. The medical record must be personally documented by the physician or qualified NPP who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient.

H. Split (or Shared) SNF/NF E/M Visit

SNF E/M visits may be billed as split (or shared) visits if they meet the rules for split (or shared) visit billing, discussed in our other manual sections, except for SNF E/M visits that are required to be performed in their entirety by a physician. NF visits do not meet the definition of split (or shared) services, and therefore, are not billable as such. See section 30.6.18 for additional information.

I. SNF/NF Discharge Day Management Service

Medicare Part B payment policy requires a face-to-face visit with the patient provided by the physician or the qualified NPP to meet the SNF/NF discharge day management service as defined by the CPT code. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date. The CPT codes 99315 - 99316 shall be reported for this visit. 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.

30.6.14 - Home or Residence Services (Codes 99341- 99350)

(Rev. 11732, Issued: 12-08-22, Effective: 01-01-23, Implementation: 01-03-23)

Physician Visits to Patients Residing in Various Places of Service

Prior to January 1, 2023, the American Medical Association’s Current Procedural Terminology (CPT) used new patient codes 99324 - 99328 and established patient codes 99334 - 99337 for Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services, to report

evaluation and management (E/M) services to residents residing in a facility which provides room, board, and other personal assistance services, generally on a long-term basis. These CPT codes were used to report E/M services in facilities assigned places of service (POS) codes 13 (Assisted Living Facility), 14 (Group Home), 33 (Custodial Care Facility) and 55 (Residential Substance Abuse Treatment Facility). Assisted living facilities may also be known as adult living facilities. The CPT codes 99324 - 99337 for Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services are deleted beginning January 1, 2023. 7-70

Beginning January 1, 2023, the CPT is merging the two E/M visit families currently titled “Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services” and “Home Services.” The new family will be titled “Home or Residence Services. The codes in this family (CPT codes 99341 – 99350) will be used to report E/M services furnished to a patient residing in their home, in an assisted living facility, in a group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), in a custodial care facility, or in a residential substance abuse treatment facility. There are no changes to the included care settings from each respective family, rather the current care settings for each of the current families are being included within the new, merged family. For services in an intermediate care facility for individuals with intellectual disabilities and services provided in a psychiatric residential treatment center, see Nursing Facility Services in Section 30.6.13.

Physicians and qualified nonphysician practitioners (NPPs) furnishing E/M services to residents in a living arrangement described by one of the POS listed above must use the level of service code in the CPT code range 99341 - 99350 to report the service they provide.

Beginning in 2006, reasonable and medically necessary prolonged services may be reported with the appropriate companion E/M codes when a physician or qualified NPP, provides a prolonged service that is beyond the usual E/M visit service for a Home or Residence Service. All the requirements for prolonged services at §30.6.15 must be met.

Beginning in 2006, E/M services provided to patients residing in a Skilled Nursing Facility (SNF) or a Nursing Facility (NF) must be reported using the appropriate CPT level of service code within the range identified for Initial Nursing Facility Care (CPT codes 99304 - 99306) and Subsequent Nursing Facility Care (CPT codes 99307 - 99310). Use CPT codes 99315 - 99316 for SNF/NF discharge services. The Home or Residence Services codes should not be used for these places of service.

The CPT SNF/NF code definition includes intermediate care facilities (ICFs) and long term care facilities (LTCFs). These codes are limited to the specific 2-digit POS 31 (SNF), 32 (Nursing Facility), 54 (Intermediate Care Facility/Individuals with Intellectual Disabilities) and 56 (Psychiatric Residential Treatment Center).

The CPT nursing facility codes should be used with POS 31 (SNF) if the patient is in a Part A SNF stay and POS 32 (nursing facility) if the patient does not have Part A SNF benefits. There is no longer a different payment amount for a Part A or Part B benefit period in these POS settings.

30.6.14.1 - Home or Residence Services (Codes 99341 - 99350) When Performed in Place of Service 12 (Home)

(Rev. 11732, Issued: 12-08-22, Effective: 01-01-23, Implementation: 01-03-23)

A. Requirement for Physician Presence in Place of Service 12 (Home)

A home visit using codes 99341-99350 with POS 12 cannot be billed by a physician unless the physician was actually present in the beneficiary’s home. Section 10.1.1 in Chapter 1 of this manual provides additional information on billing with POS 12.

B. Homebound Status

Under the home health benefit the beneficiary must be confined to the home for services covered. For home services provided by a physician using 99341-99350 with POS 12, the beneficiary does not need to be confined to the home.

C. Fee Schedule Payment for Services to Homebound Patients under General Supervision

Payment may be made in some medically underserved areas where there is a lack of medical personnel and home health services for injections, EKGs, and venipunctures that are performed for homebound patients under general physician supervision by nurses and paramedical employees of physicians or physician-directed clinics. Section 60.4 in Chapter 15 of the Medicare Benefit Policy Manual (Pub. 100-02) provides additional information on the provision of services to homebound Medicare patients.

30.6.15 - Prolonged Services, Standby Services, and Evaluation and Management Service for Power Mobility Devices (PMDs) (G0372) (Rev. 11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

30.6.15.1 - Prolonged Services – General Rules

(Rev. 11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

Prolonged E/M services may be reported for certain E/M visit families, when the total visit time spent by the practitioner exceeds a certain time threshold. Prolonged E/M services are reported using Medicare-specific coding.

See section 30.6.18 for rules regarding billing of E/M visits that are split (or shared) and involve prolonged service time.

30.6.15.2 Prolonged Office/Outpatient E/M Visits

(Rev. 11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

When the practitioner selects visit level using time, the practitioner may report prolonged office/outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office/outpatient E/M services). The following table provides reporting examples.

HCPCS Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes.	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

HCPCS code G2212 (Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services). (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)).

Qualifying activities are listed in the CPT Codebook's E/M Service Guidelines (Guidelines for Selecting Level of Service Based on Time). These activities may be counted when time is used to select visit level, when performed and medically reasonable and necessary. 7-72

30.6.15.3 Prolonged Other E/M Visits

(Rev. 11842; Issued; 02-09-23 Effective:01-01-23; Implementation: 05-09-23)

Beginning January 1, 2023, prolonged Other E/M visit services are reported as discussed in this section. Other E/M visits include inpatient/observation visits, nursing facility visits, home/residence visits, and cognitive impairment assessment and care planning. Prolonged Other E/M services may be reported with the highest visit level, for timed visits, when the total visit time spent by the practitioner exceeds a certain time threshold.

Prolonged services are not reported in conjunction with emergency department visits or critical care services.

Prolonged services are created to provide payment for additional practitioner time that is not already accounted for in the valuation of the primary service. Accordingly, practitioner time spent in qualifying activities can be counted when performed on any date within the surveyed timeframe for the visit, and when the total time (in the physician time file) is exceeded by 15 or more minutes. We show this in the following table.

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	90 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	65 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	110 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	n/a	n/a	n/a
Emergency Department Visits	n/a	n/a	n/a
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
Home/Residence Visit New Pt (99345)	G0318	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after
Consults	n/a	n/a	n/a

* Time must be used to select visit level. Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe and includes time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we do not assign a frequency limitation.

Qualifying activities are listed in the CPT Codebook's E/M Service Guidelines (Guidelines for Selecting Level of Service Based on Time). These activities may be counted when time is used to select visit level, when performed and medically reasonable and necessary. **7 - 73**

30.6.15.4 - Power Mobility Devices (PMDs) (Code G0372) **(Rev. 748, Issued: 11-04-05; Effective/Implementation Dates: 10-25-05)**

Section 302(a)(2)(E)(iv) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) sets forth revised conditions for Medicare payment of Power Mobility Devices (PMDs). This section of the MMA states that payment for motorized or power wheelchairs may not be made unless a physician (as defined in §1861(r)(1) of the Act), a physician assistant, nurse practitioner, or a clinical nurse specialist (as those terms are defined in §1861(aa)(5)) has conducted a face-to-face examination of the beneficiary and written a prescription for the PMD.

Payment for the history and physical examination will be made through the appropriate evaluation and management (E&M) code corresponding to the history and physical examination of the patient. Due to the MMA requirement that the physician or treating practitioner create a written prescription and a regulatory requirement that the physician or treating practitioner prepare pertinent parts of the medical record for submission to the durable medical equipment supplier, code G0372 (physician service required to establish and document the need for a power mobility device) has been established to recognize additional physician services and resources required to establish and document the need for the PMD.

The G code indicates that all of the information necessary to document the PMD prescription is included in the medical record, and the prescription and supporting documentation is delivered to the PMD supplier within 30 days after the face-to-face examination.

Effective October 25, 2005, G0372 will be used to recognize additional physician services and resources required to establish and document the need for the PMD and will be added to the Medicare physician fee schedule.

30.6.17 – Physician Management Associated with Superficial Radiation Treatment **(Rev.4339, Issued: 07-25-19, Effective: 01-01-19, Implementation: 08-27-19)**

Evaluation and management codes for levels I through III (99211, 99212, and 99213) may be billed with modifier 25 when performed for the purpose of reporting physician work associated with radiation therapy planning, radiation treatment device construction, and radiation treatment management when performed on the same date of service as superficial radiation treatment delivery. See chapter 13, section 70.2, of this manual for information regarding services bundled into treatment management codes.

30.6.18 - Split (or Shared) Visits **(Rev. 11842; Issued: 02-09-23 Effective:01-01-23; Implementation: 05-09-23)**

A. Definition of Split (or Shared) Visit

A split (or shared) visit is an evaluation and management (E/M) visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner (NPP) who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if furnished independently by only one of them. Payment is made to the practitioner who performs the substantive portion of the visit.

Facility setting means an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under regulations. **7-74**

B. Definition of Substantive Portion

(1) More Than Half of the Total Time

Beginning January 1, 2024, substantive portion means more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

During the transitional year from January 1, 2023 through December 31, 2023, except for critical care visits, the substantive portion can be one of the three key E/M visit components (a medically appropriate history or exam, or medical decision-making (MDM)), or more than half of the total time spent by the physician and NPP performing the split (or shared) visit. In other words, for calendar year 2023, the practitioner who spends more than half of the total time, or performs the medically appropriate history or exam described in the code descriptor, or MDM can be considered to have performed the substantive portion and can bill for the split (or shared) E/M visit. When one of the three key components is used as the substantive portion in 2023, the practitioner who bills the visit must perform that component in its entirety in order to bill. For example, if history is used as the substantive portion, the billing practitioner must perform the history as described in the code descriptor in order to bill. If physical exam is used as the substantive portion, the billing practitioner must perform the exam as described in the code descriptor in order to bill. If MDM is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner must perform all portions or aspects of MDM that are required to select the visit level billed.

For critical care visits, starting for services furnished in CY 2022, the substantive portion will be more than half of the total time. A unique listing of qualifying activities for purposes of determining the substantive portion of critical care visits applies (see below).

We summarize these policies in the following table.

Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2022-2023 Definition of Substantive Portion	2024 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/SNF*	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

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

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

(2) Distinct Time

In accordance with the CPT E/M Guidelines, only distinct time can be counted. When the practitioners jointly meet with or discuss the patient, only the time of one of the practitioners can be counted.

Example: If the NPP first spent 10 minutes with the patient and the physician then spent another 15 minutes, their individual time spent would be summed to equal a total of 25

minutes. The physician would bill for this visit, since they spent more than half of the total time (15 of 25 total minutes). If, in the same situation, the physician and NPP met together for five additional minutes (beyond the 25 minutes) to discuss the patient's treatment plan, that overlapping time could only be counted once for purposes of establishing total time and who provided the substantive portion of the visit. The total time would be 30 minutes, and the physician would bill for the visit, since they spent more than half of the total time (20 of 30 total minutes).

(3) Qualifying Time

Drawing on the CPT E/M Guidelines, except for critical care visits, the following listing of activities can be counted toward total time for purposes of determining the substantive portion, when performed and whether or not the activities involve direct patient contact:

- Preparing to see the patient (for example, review of tests).
- Obtaining and/or reviewing separately obtained history.
- Performing a medically appropriate examination and/or evaluation.
- Counseling and educating the patient/family/caregiver.
- Ordering medications, tests, or procedures.
- Referring and communicating with other health care professionals (when not separately reported).
- Documenting clinical information in the electronic or other health record.
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver.
- Care coordination (not separately reported).

Practitioners cannot count time spent on the following:

- The performance of other services that are reported separately.
- Travel.
- Teaching that is general and not limited to discussion that is required for the management of a specific patient.

See section 30.6.12 for a listing of qualifying activities for purposes of determining the substantive portion of critical care services.

For all split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit. The substantive portion can be entirely with or without direct patient contact, and is determined by the proportion of total time, not whether the time involves patient contact.

(4) Application to Prolonged Services

For 2022 and 2023 transitional years, the billing practitioner reports the codes for the primary service and the prolonged services, regardless of the amount of time the billing practitioner spent.

Starting in 2024, since the substantive portion is more than half of the practitioners' total time, the physician or practitioner who spent more than half the total time (the substantive portion starting in 2024) will bill for the primary E/M visit and the prolonged service code(s) when the service is furnished as a split (or shared) visit, if all other requirements to bill for split (or shared) services are met. The physician and NPP will add their time together, and whomever furnished more than half of the total time, including prolonged time, (that is, the substantive portion) will report both the primary service code and the prolonged services add-on code(s), assuming the time threshold for reporting prolonged services is met (see Prolonged Services

- During the transitional calendar years 2022-2023, when practitioners use a key component as the substantive portion, Emergency department and critical care visits are not reported as prolonged services.

We summarize these policies in the following table.

Reporting Prolonged Services for Split (or Shared) Visits

E/M Visit Code Family	2022-2023		2024
	If Substantive Portion is a Key Component...	If Substantive Portion is Time...	Substantive Portion Must Be Time
Other Outpatient*	Combined time of both practitioners must meet the threshold for reporting prolonged services	Combined time of both practitioners must meet the threshold for reporting prolonged services	Combined time of both practitioners must meet the threshold for reporting prolonged services
Inpatient/Observation/Hospital/SNF*	Combined time of both practitioners must meet the threshold for reporting prolonged services	Combined time of both practitioners must meet the threshold for reporting prolonged services	Combined time of both practitioners must meet the threshold for reporting prolonged services
Emergency Department	N/A	N/A	N/A
Critical Care	N/A	N/A	N/A

Acronyms: E/M (Evaluation and Management); SNF (Skilled Nursing Facility)

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

C. New and Established Patients, and Initial and Subsequent Visits

Split (or shared) visits may be billed for new and established patients, as well as for initial and subsequent visits, that otherwise meet the requirements for split (or shared) visit payment.

D. Settings of Care

Split (or shared) visits are furnished only in the facility setting, meaning institutional settings in which payment for services and supplies furnished incident to a physician or practitioner’s professional services is prohibited under our regulations at 42 CFR § 410.26.

Accordingly, split (or shared) visits are billable for E/M visits furnished in hospital and skilled nursing facility (SNF) settings. Visits in these settings that are required by our regulations to be performed in their entirety by a physician are not billable as split (or shared) services. For example, our Conditions of Participation require certain SNF visits to be performed directly and solely by a physician; accordingly, those SNF visits cannot be billed as a split (or shared) visit (see Section 30.6.13).

E. Medical Record Documentation

Documentation in the medical record must identify the physician and NPP who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.

F. Claim Identification

Modifier -FS (Split or Shared E/M Visit) must be reported on claims for split (or shared) visits, to identify that the service was a split (or shared) visit.

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The modifier identified by CPT for purposes of reporting partial services (modifier -52 (reduced services)) cannot be used to report partial E/M visits, including any partial services furnished as split (or shared) visits. Medicare does not pay for partial E/M visits.

30.6.19 – Office/Outpatient Evaluation and Management (O/O E/M) Complexity Add-on Payment (Code G2211)

(Rev. 12370; Issued: 11-21-23; Effective: 01-01-24; Implementation: 01-02-24)

Starting on January 1, 2024 O/O E/M visit complexity add-on code, G2211 to describe intensity and complexity inherent to O/O E/M visits not accounted for in the valuation of the primary service codes is unbundled and separately payable as an additional payment to the payment for O/O E/M visit primary service codes (99202-99205, 99211-99215).

The full descriptor, refined in the calendar year (CY) 2021 PFS final rule, is code 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)). (See the CY 2021 Medicare Physician Fee Schedule final rule in the Federal Register (85 FR 84571)).

The A/B MACs (A & B) shall not pay code G2211 on the same date of service as an office/outpatient evaluation and management visit (codes 99202-99205, 99211-99215) reported with Modifier 25, to the same beneficiary by the same practitioner or nonphysician practitioner.

40 - Surgeons and Global Surgery

(Rev. 1, 10-01-03)

B3-4820

A national definition of a global surgical package has been established to ensure that payment is made consistently for the same services across all A/B MAC (B) jurisdictions, thus preventing Medicare payments for services that are more or less comprehensive than intended. The national global surgery policy became effective for surgeries performed on and after January 1, 1992.

The instructions that follow describe the components of a global surgical package and payment rules for minor surgeries, endoscopies and global surgical packages that are split between two or more physicians. In addition, billing, mandatory edits, claims review, adjudication, and postpayment instructions are included.

In addition to the global policy, uniform payment policies and claims processing requirements have been established for other surgical issues, including bilateral and multiple surgeries, co-surgeons, and team surgeries.

40.1 - Definition of a Global Surgical Package

(Rev. 11287; Issued:03-02-22; Effective:01-01-22; Implementation: 02-22-22)

B3-4821, B3-15900.2



Chronic Care Management Services



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What's Changed?

- Beginning 2022, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can bill Chronic Care Management (CCM) and Transitional Care Management (TCM) services for the same patient during the same time period (page 9)
- In 2021 we added 5 codes to report staff-provided Principal Care Management (PCM) services under physician supervision (pages 10–11)
- Beginning 2022 we replaced G2058 with 99439 (page 11)

You'll find substantive content updates in dark red font.

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CMS recognizes Chronic Care Management (CCM) is a critical primary care service that contributes to better patient health and care.

This booklet provides background on payable CCM service codes, names eligible billing practitioners and patients, and details the Medicare Physician Fee Schedule (PFS) billing requirements.

In 2014, we started paying for CCM services furnished to patients with multiple [chronic conditions](#) under the PFS. The [Medicare Physician Fee Schedule Look-Up Tool](#) has code-specific payment information by geographic location.

Note: “You” refers to practitioners.

As the billing practitioner, you no longer need to offer face-to-face CCM services to Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) patients because CCM describes non-face-to-face services.

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

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the [CMS Office of Minority Health](#):

- [Health Equity Technical Assistance Program](#)
- [Disparities Impact Statement](#)

Chronic Care Management Service Elements: Highlights

CCM services are extensive, including:

- Structured recording of patient health information
- Keeping comprehensive electronic care plans
- Managing care transitions and other care management services
- Coordinating and sharing patient health information promptly within and outside the practice

CCM service elements apply to complex and non-complex CCM unless otherwise specified. See [Chronic Care Management Service Summary](#) section for more information.

You'll typically furnish CCM services outside face-to-face patient visits and focus on advanced primary care characteristics like:

- Continuous patient relationship with chosen care team member
- Supporting patients with chronic diseases in achieving health goals
- 24/7 patient access to care and health information
- Patient receiving preventive care
- Patient and caregiver engagement
- Prompt sharing and using patient health information

Chronic Care Management Service Practitioners

These physicians and Non-Physician Practitioners (NPPs) may bill CCM services:

- Certified Nurse Midwives (CNMs)
- Clinical Nurse Specialists (CNSs)
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)

Note: Primary care practitioners most often bill CCM services, but some specialty practitioners may furnish and bill them as well. CCM services aren't within the scope of practice of limited-license physicians and practitioners like clinical psychologists, podiatrists, or dentists, but CCM practitioners may refer or consult with these practitioners to coordinate and manage care.

CPT code 99491 — Time only the billing practitioner spends. Clinical staff time doesn't count toward the required reporting time threshold code.

CPT codes 99487, 99489, and 99490 — Time spent directly by clinical staff. Time spent by the billing practitioner may also count toward the time threshold if not used to report 99491.

For CCM services the billing practitioner doesn't personally furnish, the clinical staff furnish them under direction of the billing practitioner on an incident to basis (as an integral part of services furnished by the billing practitioner), subject to applicable state law, licensure, and scope of practice. Clinical staff are employees or working under contract with the billing practitioner and we directly pay that practitioner for CCM services.



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Supervision

- We assign CCM codes describing clinical staff activities (CPT 99487, 99489, and 99490) as general supervision under the Medicare PFS
- General supervision means when the billing practitioner doesn't personally furnish the service, it's done under their overall direction and control
- We don't require the physician's physical presence while service is furnished

Patient Eligibility

- Eligible CCM patients will have multiple (2 or more) chronic conditions expected to last at least 12 months or until the patient's death and or that place them at significant risk of death, acute exacerbation and or decompensation, or functional decline
- These services aren't typically **face-to-face** and allow eligible practitioners to bill at least 20 minutes or more of care coordination services per month
- Billing practitioners may consider identifying patients who require CCM services using criteria suggested in CPT guidance (like number of illnesses, number of medications, repeat admissions, or emergency department visits) or the typical patient profile in the CPT prefatory language
- CCM services can also help reduce geographic and racial or ethnic health care disparities

Examples of chronic conditions include, but aren't limited to:

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



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Initiating Visit

- Before CCM services can start, we require an initiating visit for new patients or patients who the billing practitioner hasn't seen within 1 year
- Initiating visit can occur during comprehensive face-to-face Evaluation and Management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE)
- If practitioner doesn't discuss CCM during an E/M visit, AWV, or IPPE, it can't count as the initiating visit
- Face-to-face initiating visit isn't part of CCM and can be separately billed

Although patient cost sharing applies to the CCM service, some patients have [Supplemental Insurance \(Medigap\)](#) to help cover CCM cost sharing. Also, CCM may help avoid the need for more costly services in the future by proactively managing patient health, rather than only treating severe or acute disease and illness.

Practitioners who personally furnish extensive assessment and care planning outside the usual effort described by the initiating visit and CCM codes may also bill:

- **HCPCS code G0506** — Comprehensive assessment of and care planning by the physician or other qualified health care practitioner for patients requiring CCM services (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service)
 - Billing practitioners can bill G0506 only once, as part of initiating visit

Patient Consent

Get the patient's written or verbal consent for CCM services before you bill for them. This helps ensure patients are engaged and aware of their cost sharing responsibilities. This also helps prevent duplicate practitioner billing. You must also inform the patient of these items and document it in their medical record:

- Availability of CCM services
- Possible cost sharing responsibilities
- Only 1 practitioner can furnish and bill CCM services during a calendar month
- Patient's right to stop CCM services at any time (effective the end of calendar month)

Patients need to provide informed consent only once unless they switch to a different CCM practitioner.

Recording Patient Health Information

Record the patient's demographics, problems, medications, and medication allergies using certified Electronic Health Record (EHR) technology. This means a version of certified EHR that's acceptable under the EHR Incentive Programs as of December 31 of the Calendar Year (CY) preceding each Medicare PFS payment year. [Promoting Interoperability](#) has more information.

Comprehensive Care Plan

- Person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and inventory of resources and supports
 - Comprehensive care plan for all health issues with focus on managing chronic conditions
- Provide patients and or caregivers with copy of the care plan
- Make electronic care plan available and shared promptly both within and outside the billing practice with individuals involved in patient's care
- Several organizations make [care planning tools](#) and [resources](#) publicly available

Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but isn't limited to:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers
- Requirements for periodic review
- When applicable, revision of the care plan

Access to Care & Care Continuity

- Provide 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified practitioners or clinical staff, including providing patients or caregivers with a way to contact health care practitioners in the practice to discuss urgent needs no matter the time of day or day of week
- Provide continuity of care with a designated practitioner or member of the care team with whom the patient can get successive routine appointments
- Provide patients and caregivers enhanced opportunities to communicate with their practitioners about their care by phone and through secure messaging, secure web, or other asynchronous non-face-to-face consultation methods (like email or secure electronic patient portal)

Comprehensive Care Management

- Assess the patient's medical, functional, and psychosocial needs
- Make sure the patient receives timely recommended preventive services
- Review medications and any potential interactions
- Oversee the patient's medication self-management
- Coordinate care with home- and community-based clinical service providers

Manage Care Transitions

- Manage care transitions between and among health care providers and settings, including referrals to other clinicians, or follow-up after an emergency department visit or after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Create and exchange or share continuity of care document(s) promptly with other practitioners

Concurrent Billing

- You can't report complex CCM and non-complex CCM for the same patient in a calendar month
 - Don't report 99491 in the same calendar month as 99487, 99489, or 99490
- You can't bill CCM during the same service period by the same practitioner as HCPCS codes G0181 or G0182 (home health care supervision, hospice care supervision) or CPT codes 90951–90970 (certain ESRD services)
- You can report CCM codes 99487, 99489, 99490 and 99491 by the same practitioner for services furnished during the 30-day TCM service period (CPT 99495, 99496)
- You can't report complex CCM and prolonged [Evaluation and Management \(E/M\)](#) services in the same calendar month
- Consult CPT instructions for other codes you can't bill concurrently with CCM
 - Other practitioner billing restrictions may apply if you're taking part in a CMS-sponsored model or demonstration program
- You can't count time toward the CCM service code for any other billed code
- **Beginning CY 2022, RHCs and FQHCs can bill CCM and TCM services for the same patient during the same time period**

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Principal Care Management

- Beginning CY 2020, we introduced Principal Care Management (PCM) services to furnish CCM for patients with a single chronic condition or with multiple chronic conditions but focused on a **single** high-risk condition
- PCM services may be expected to last 6 months–1 year or until patient’s death
 - PCM services require 30 minutes before billing
- CCM codes require patients have 2 or more chronic conditions expected to last 12 months or until their death
 - CCM services require 20 minutes before billing

Chronic Care Management & Principal Care Management Codes

In 2021, we added 5 new CPT codes describing PCM services furnished by clinical staff under the supervision of a NPP.

Table 1. Applicable CPT Codes

CPT Code	Descriptor
99424	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99425	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

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Table 1. Applicable CPT Codes (cont.)

CPT Code	Descriptor
99426	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month
99427	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month (List separately in addition to code for primary procedure)
99437	Chronic care management services, provided personally by a physician or other qualified health care professional, 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; 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)
99439*	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

*Beginning 2022 we replaced G2058 with 99439.

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Table 1. Applicable CPT Codes (cont.)

CPT Code	Descriptor
99487	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of comprehensive care plan, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99489	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or significant revision of comprehensive care plan, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99491	Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of physician or other qualified healthcare professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored

Chronic Care Management & Medicare Demonstrations

CCM service codes include care coordination and care management payment for a patient with multiple chronic conditions within Original Medicare. We won't duplicate payments for the same or similar services for patients with chronic conditions already paid under the various demonstration initiatives. Get more information on potentially duplicated billing by consulting the CMS staff responsible for [demonstration initiatives](#).

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Chronic Care Management Service Summary

Initiating Visit

- Face-to-face E/M visit, AWW, or IPPE for new patients or patients who the billing practitioner hasn't seen within 1 year before CCM services start.



Structured Recording of Patient Health Information Using Certified EHR Technology

- Record the patient's demographics, problems, medications, and medication allergies using certified EHR technology. A full EHR list of problems, medications, and medication allergies must inform the care plan, care coordination, and ongoing clinical care.



24/7 Access & Continuity of Care

- Provide 24/7 access to physicians or other qualified practitioners or clinical staff, including providing patients or caregivers with a way to contact health care practitioners in the practice to discuss urgent needs no matter the time of day or day of week.
- Provide continuity of care with a designated practitioner or member of the care team with whom the patient can get successive routine appointments.



Comprehensive Care Management

- Assess the patient's medical, functional, and psychosocial needs.
- Make sure the patient receives timely recommended preventive services.
- Oversee the patient's medication self-management.



Comprehensive Care Plan

- Create, revise, and or monitor (per code descriptors) a person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, environmental (re)assessment, and inventory of resources and supports.
 - Comprehensive care plan for all health issues with focus on managing chronic conditions.
- Provide patients and or caregivers with copy of the care plan.
- Electronically capture care plan information and make it available promptly both within and outside billing practice with individuals involved in the patient's care, as appropriate.



Manage Care Transitions

- Manage care transitions between and among health care providers and settings, including referrals to other clinicians, or follow-up after an emergency department visit or after discharges from hospitals, skilled nursing facilities, or other health care facilities.
- Create and exchange or share continuity of care document(s) promptly with other practitioners.



Home- and Community-Based Care Coordination

- Coordinate care with home- and community-based clinical service practitioners.
- Communicate with home- and community-based practitioners about the patient's psychosocial needs and functional decline and document it in the patient's medical record.



Enhanced Communication Opportunities

- Provide patients and caregivers enhanced opportunities to communicate with their practitioners about their care by phone and through secure messaging, secure web, or other asynchronous non-face-to-face consultation methods (like email or secure electronic patient portal).



Patient Consent

- Inform patient that:
 - CCM services are available
 - They may have cost sharing responsibilities
 - Only 1 practitioner can furnish and bill CCM services during a calendar month
 - They can stop the CCM services at any time (effective the end of calendar month)
- Document in patient's medical record that you explained the required information and whether they accepted or declined services.



Medical Decision-Making

- Complex CCM services require and include moderate to high complexity medical decision-making (by the physician or other billing provider).



Resources

- [CCM Materials for FQHCs](#)
- [CCM Materials for RHCs](#)
- [CCM Materials for Hospital Outpatient Departments](#)
- [CCM Materials for Physicians](#)
- [Chronic Conditions Data Warehouse](#)
- [Connected Care: CCM](#)
- [Find Your Medicare Administrative Contractor \(MAC's\) Website](#)
- [Health Disparities & CCM](#)

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Health Equity Services in the 2024 Physician Fee Schedule Final Rule

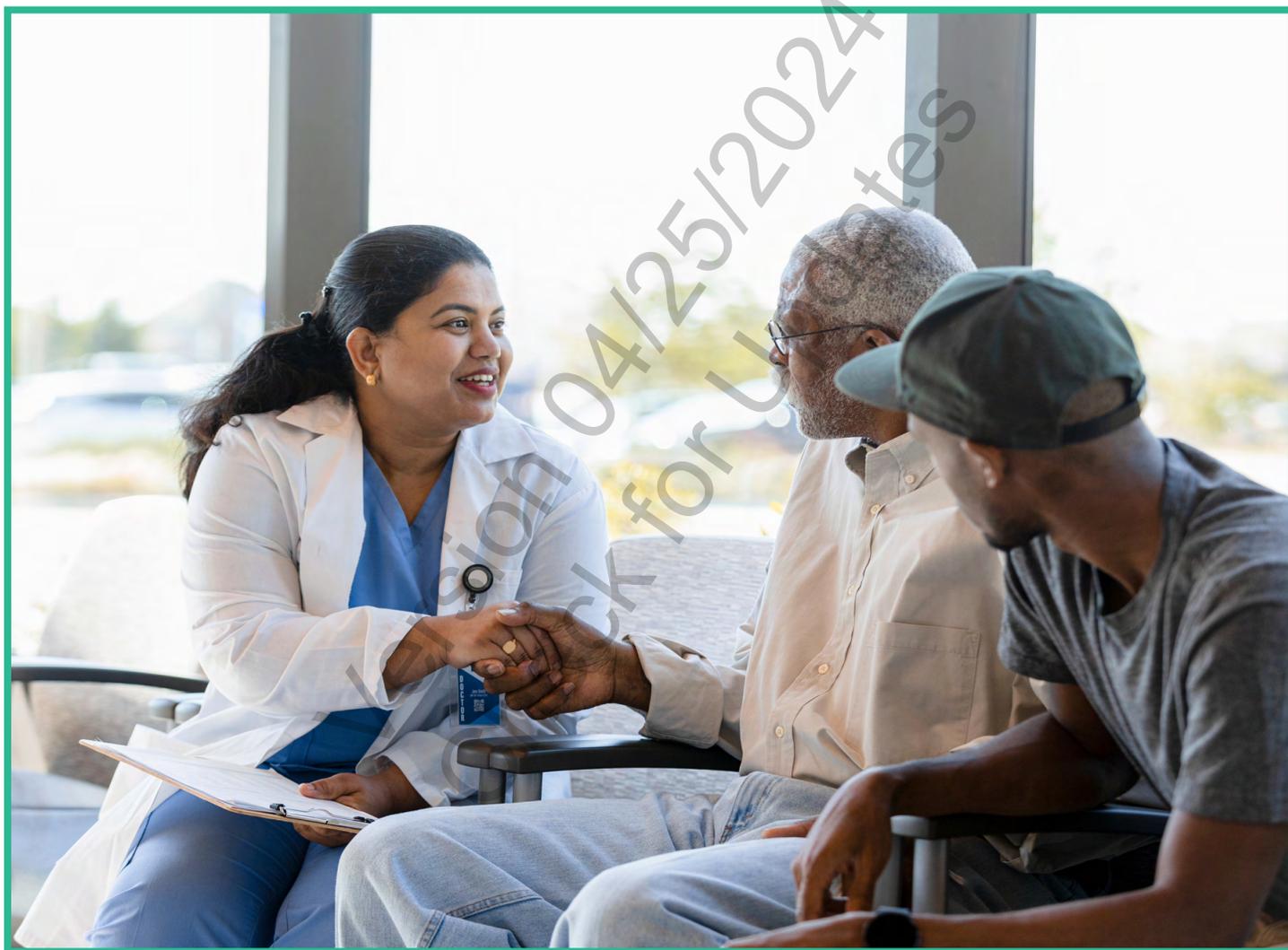


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We define health equity as “the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes.”

Our [framework for health equity](#) lists 5 priorities for reducing disparities in health. Each priority reflects a key area in which people from underserved and disadvantaged communities ask us to take action to advance health equity. The 5 health equity priorities are:

1. Expand the collection, reporting, and analysis of standardized data
2. Assess causes of disparities within our programs and address inequities in policies and operations to close gaps
3. Build capacity of health care organizations and the workforce to reduce health and health care disparities
4. Advance language access, health literacy, and the provision of culturally tailored services
5. Increase all forms of accessibility to health care services and coverage

The [2024 Physician Fee Schedule \(PFS\) Final Rule](#) has 4 services to help further address these priorities. These are:

Caregiver Training Services (CTS)

We created new coding to make payment when practitioners train and involve 1 or more caregivers to help patients carry out a treatment plan for certain diseases or illnesses, like dementia. For caregiver training services, we define a “caregiver” as “an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation” and “a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition.”

Together we can advance health equity and help eliminate health disparities in rural communities, territories, Tribal nations, and geographically isolated communities. Find these resources and more from the [CMS Office of Minority Health](#):

- [Rural Health](#)
- [CMS Framework for Rural, Tribal, and Geographically Isolated Areas](#)
- [Data Stratified by Geography \(Rural/Urban\)](#)
- [Health Equity Technical Assistance Program](#)



We'll pay for CTS when a physician or a non-physician practitioner (NPP) provides this training. NPPs include:

- Nurse practitioners
- Clinical nurse specialists (CNSs)
- Certified nurse-midwives (CNMs)
- Physician assistants (PAs)
- Clinical psychologists
- Therapists, including physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs)

We'll pay for CTS for patients under an individualized treatment plan or therapy plan of care, without the patient present. Use these CPT codes for CTS starting January 1, 2024:

- **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
- **96203:** 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); each additional 15 minutes (List separately in addition to code for primary service)
- **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
- **97551:** 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; each additional 15 minutes (List separately in addition to code for primary service) (Use 97551 in conjunction with 97550)
- **97552:** Group 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 with multiple sets of caregivers

To bill for CTS, you should select the appropriate group codes, like CPT codes 96202, 96203, or 97552 or individual codes like CPT codes 97550 or 97551, based on the number of patients represented by caregivers receiving training. If multiple caregivers for the same patient are trained in a group, you won't bill individually for each caregiver. Where more than 1 patient's caregivers are trained at the same time, you must bill under the group code for each patient represented, regardless of the number of caregivers. The patient's or representative's consent is required for the caregiver to get CTS, and you must document this in the patient's medical record.

Social Determinants of Health Risk (SDOH) Assessment

We finalized a new stand-alone G code, G0136, to pay for administering an SDOH risk assessment, no more than once every 6 months:

G0136: Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every 6 months.

You may provide this service with:

- An evaluation and management (E/M) visit, which can include hospital discharge or transitional care management services
- Behavioral health office visits, such as psychiatric diagnostic evaluation and health behavior assessment and intervention
- The Annual Wellness Visit (AWV)

SDOH risk assessments that you furnish as part of an E/M or behavioral health visit isn't a screening. It may be medically reasonable and necessary as part of a comprehensive social history, when you have reason to believe there are unmet SDOH needs that are interfering with the practitioner's diagnosis and treatment of a condition or illness or will influence choice of treatment plan or plan of care. In these circumstances, patient cost sharing will apply, just as it does for any medical service. The risk assessment wouldn't usually be administered in advance of the visit.

Example: A patient who hasn't been seen recently requests an appointment at a specific time or on a specific date due to limited availability of transportation to or from the visit, or requests a refill of refrigerated medication that went bad when the electricity was terminated at their home. If the patient hasn't gotten an SDOH risk assessment in the past 6 months, you could have the patient fill out an SDOH risk assessment 7–10 days in advance of an appointment as part of intake to ensure that you have enough information to appropriately treat them. You may also furnish SDOH risk assessments as an optional element of the AWV, in which case it's a preventive service and cost sharing won't apply.

SDOH risk assessment refers to a review of the individual's SDOH needs or identified social risk factors influencing the diagnosis and treatment of medical conditions. Use a standardized, evidence-based SDOH risk assessment tool to assess for:

- Housing insecurity
- Food insecurity
- Transportation needs
- Utility difficulty

You may choose a tool or ask additional questions that also include other areas if prevalent or culturally important to your patient population. Some tools you may consider that are standardized and evidence-based include the [CMS Accountable Health Communities Tool](#), [Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences \(PRAPARE\)](#), and [instruments identified](#) for Medicare Advantage Special Needs Population Health Risk Assessment.

Note: G0136 is also added to telehealth services on a permanent basis.

Community Health Integration (CHI)

We created 2 new service codes describing CHI services that auxiliary personnel, including community health workers (CHWs), may perform incidental to the professional services of a physician or other billing practitioner, under general supervision. The billing practitioner initiates CHI services during an initiating visit where the practitioner identifies unmet SDOH needs that significantly limit their ability to diagnose or treat the patient. The same practitioner bills for the subsequent CHI services provided by the auxiliary personnel. Initiating visits are personally performed by the practitioner, and include:

- An E/M visit
 - Can't be a low-level (level 1) E/M visit performed by clinical staff
 - Can be the E/M visit provided as part of Transitional Care Management (TCM) services
- An Annual Wellness Visit (AWV)

You must see a patient for a CHI initiating visit prior to furnishing and billing CHI services. We created CHI service codes for auxiliary personnel, including community health workers, to provide tailored support and system navigation to help address unmet social needs that significantly limit a practitioner's ability to carry out a medically necessary treatment plan. CHI services include items like:

- Person-centered planning
- Health system navigation
- Facilitating access to community-based resources
- Practitioner, home and community-based care coordination
- Patient self-advocacy promotion

You may provide CHI services following an initiating visit where you identify unmet SDOH needs that significantly limit your ability to diagnose or treat the patient. During this visit you'll establish the treatment plan, specify how addressing the unmet SDOH needs would help accomplish that plan, and establish the CHI services as incidental to your professional services. Auxiliary personnel can perform the subsequent CHI services.

Since there isn't a Medicare benefit for paying community health workers and other auxiliary personnel directly, we'll pay their services as incidental to the services of the health care practitioner who directly bills Medicare. See [42 CFR 410.26](#) and [42 CFR 410.27](#) for more information. The auxiliary personnel may be external to, and under contract with, the practitioner or their practice, such as through a community-based organization (CBO) that employs CHWs or other auxiliary personnel, if they meet all "incident to" requirements and conditions for payment of CHI services.

Auxiliary personnel must meet applicable state requirements, including licensure. In states with no applicable requirements, auxiliary personnel must be certified and trained in the following competencies:

- Patient and family communication
- Interpersonal and relationship-building skills
- Patient and family capacity building
- Service coordination and systems navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Development of an appropriate knowledge base, including of local community-based resources

You or the auxiliary personnel under supervision must get advance patient consent before furnishing CHI services. Consent can be written or verbal, so long as you document it in the patient's medical record. As part of consent, you must explain to the patient that cost sharing applies and that only 1 practitioner may furnish and bill the services in each month. You don't need to get consent again unless the practitioner furnishing and billing CHI changes.

Only 1 practitioner can bill for CHI services per month. This helps ensure a single point of contact for addressing social needs that may span other health care needs. It helps to avoid a fragmented approach and duplicative services.

We currently make separate payment under the PFS for a number of [care management and other services](#) that may include aspects of CHI services. Those care management services focus heavily on clinical, rather than social, aspects of care. You can furnish CHI services in addition to other care management services if you:

- Don't count time and effort more than once
- Meet requirements to bill the other care management services
- Perform services that are medically reasonable and necessary

You must document the patient's unmet social needs that CHI services are addressing in the medical record. Documenting ICD-10 Z-codes can count as the appropriate documentation. You can bill CHI services monthly as medically reasonable and necessary, billing for the first 60 minutes of CHI services (G0019) and then each additional 30 minutes thereafter (G0022). Also document the amount of time spent with the patient and the nature of the activities.

You don't necessarily need to perform these services in-person. We expect you to perform them using a combination of in-person and virtual via audio-video or via two-way audio since evidence shows that there should be some in-person interaction.

The new G codes for CHI:

- **G0019** – Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that significantly limit the ability to diagnose or treat problem(s) addressed in an initiating visit:
 - Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating visit
 - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that aren't separately billed)
 - Facilitating patient-driven goal-setting and establishing an action plan
 - Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan
 - Practitioner, home-, and community-based care coordination
 - Coordinating receipt of needed services from health care practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable)
 - Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
 - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities
 - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s)
 - Health education – helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of SDOH need(s), and educating the patient on how to best participate in medical decision-making
 - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment
 - Health care access/health system navigation
 - Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them

- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals
 - Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals
 - Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
- **G0022** – Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019)

Note: Certain types of E/M visits, such as inpatient and observation visits, emergency department (ED) visits, and skilled nursing facility (SNF) visits, wouldn't serve as CHI initiating visits because the practitioners providing the E/M visit wouldn't typically be the one providing continuing care to the patient, including providing necessary CHI services in the subsequent months.

Principal Illness Navigation (PIN)

We created 4 new service codes describing PIN services that auxiliary personnel, including care navigators or peer support specialists, may perform incidental to the professional services of a physician or other billing practitioner, under general supervision. Two codes describe PIN services, and 2 codes describe Principal Illness Navigation-Peer Support (PIN-PS) services, which are intended more for patients with high-risk behavioral health conditions and have slightly different service elements that better describe the scope of practice of peer support specialists. In general, where we describe aspects of PIN, it also applies to PIN-PS unless otherwise specified.

The billing practitioner initiates PIN services during an initiating visit addressing a serious high-risk condition, illness, or disease, with these characteristics:

- 1 serious, high-risk condition and for PIN-PS, a serious, high-risk *behavioral health* condition expected to last at least 3 months that places the patient at significant risk of:
 - Hospitalization
 - Nursing home placement
 - Acute exacerbation or decompensation
 - Functional decline or death
- A condition that requires development, monitoring, or revision of a disease-specific care plan, and may require frequent adjustment in the medication or treatment regimen, or substantial assistance from a caregiver



Examples of a serious, high-risk condition, illness, or disease include:

- Cancer
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Dementia
- HIV/AIDS
- Severe mental illness
- Substance use disorder

A health care practitioner initiates PIN services during an initiating visit where they identify the medical necessity of PIN services and establish an appropriate treatment plan. The same practitioner bills for the subsequent PIN services that auxiliary personnel provide. The billing practitioner personally performs initiating visits including:

- E/M visit, other than a low-level E/M visit done by clinical staff
- A Medicare AVW provided by a practitioner who meets the requirements to furnish subsequent PIN services
- CPT code 90791 (Psychiatric diagnostic evaluation) or the Health Behavior Assessment and Intervention (HBAI) services that CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168 describe

You must see a patient for a PIN initiating visit before furnishing and billing PIN services. We created PIN services for auxiliary personnel like patient navigators and peer support specialists to provide navigation in the treatment of a serious, high-risk condition or illness. These services help guide the patient through their course of care, including addressing any unmet social needs that significantly limit the practitioner's ability to diagnose or treat the condition. PIN services include items like:

- Health system navigation
- Person-centered planning
- Identifying or referring patient and caregiver or family, if applicable, to supportive services
- Practitioner, home, and community-based care coordination or communication
- Patient self-advocacy promotion
- Community-based resources access facilitation

The billing practitioner or auxiliary personnel may provide PIN services following an initiating visit where the billing practitioner addresses the serious, high-risk condition. During this initiating visit, the billing practitioner will establish the treatment plan, specify how PIN services are reasonable and necessary to help accomplish that plan, and establish the PIN services as incidental to their professional services. Auxiliary personnel can perform the subsequent PIN services.

Since there isn't a Medicare benefit for paying navigators and peer support specialists directly, we'll pay for their services as incidental to the services of the health care practitioner who directly bills Medicare. The auxiliary personnel may be external to, and under contract with, the practitioner or their practice, such as

through a CBO that employs navigators, peer support specialists or other auxiliary personnel, if they meet all “incident to” requirements and conditions for payment of PIN services.

Auxiliary personnel must meet applicable state requirements, including licensure. In states with no applicable requirements, auxiliary personnel providing PIN services must be trained or certified in the competencies of:

- Patient and family communication
- Interpersonal and relationship-building
- Patient and family capacity building
- Service coordination and systems navigation
- Patient advocacy, facilitation, individual and community assessment
- Professionalism and ethical conduct
- Developing an appropriate knowledge base, including specific certification or training on the serious, high-risk condition, illness, or disease being addressed



For PIN-PS services (HCPCS codes G0140 and G0146), if no applicable state requirements exist, the training must be consistent with the National Model Standards for Peer Support Certification published by Substance Abuse Mental Health Services Administration (SAMHSA). This is the most universally recognized standard for peer support specialists in the country and was developed and is maintained by SAMHSA, who has an expertise in this area.

The billing practitioner or the auxiliary personnel under supervision must get advance patient consent before providing PIN services, and annually thereafter. Consent can be written or verbal, so long as you document it in the patient’s medical record. Explain to the patient that cost sharing will apply.

The billing practitioner can’t furnish PIN services more than once per practitioner per month for any single serious high-risk condition. This avoids duplication of PIN service elements when utilizing the same navigator or billing practitioner. Don’t bill PIN and PIN-PS services concurrently for the same serious, high-risk condition.

We currently make separate payment under the PFS for a number of [care management and other services](#) that may include aspects of navigation services. Those care management services focus heavily on clinical, rather than social, aspects of care. You can furnish PIN services in addition to other care management services if you:

- Don’t count time and effort more than once
- Meet requirements to bill the other care management services
- Perform services that are medically reasonable and necessary

In the medical record, document the amount of time the auxiliary personnel spent with the patient and the nature of the activities. Document any unmet social needs that PIN services are addressing. Documenting ICD-10 Z-codes can count as the appropriate documentation.

The billing practitioner or auxiliary personnel don't necessarily need to perform these services in-person. We expect that many service elements will involve direct patient contact, especially for PIN-PS services, and may be most impactful when provided in-person.

We finalized the following PIN service codes:

- **G0023:** Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator; 60 minutes per calendar month, in the following activities:
 - Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition
 - Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors and including unmet SDOH needs (that aren't separately billed)
 - Facilitating patient-driven goal setting and establishing an action plan
 - Providing tailored support as needed to accomplish the practitioner's treatment plan
 - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
 - Practitioner, home- and community-based care communication
 - Coordinating receipt of needed services from health care practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable)
 - Communicating with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors
 - Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities
 - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
 - Health education - helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making
 - Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition
 - Health care access/health system navigation
 - Helping the patient access health care, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them
 - Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable

- Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals
 - Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals
 - Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
- **G0024:** Principal illness navigation services, additional 30 minutes per calendar month (List separately in addition to G0023)
 - **G0140:** Principal illness navigation - peer support by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a certified peer specialist; 60 minutes per calendar month, in the following activities:
 - Person-centered interview, performed to better understand the individual context of the serious, high-risk condition
 - Conducting a person-centered interview to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors, and including unmet SDOH needs (that aren't billed separately)
 - Facilitating patient-driven goal setting and establishing an action plan
 - Providing tailored support as needed to accomplish the person-centered goals in the practitioner's treatment plan
 - Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services
 - Practitioner, home, and community-based care communication
 - Assisting the patient in communicating with their practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, goals, preferences, and desired outcomes, including cultural and linguistic factors
 - Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s)
 - Health education
 - Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making



- Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition
- Developing and proposing strategies to help meet person-centered treatment goals and supporting the patient in using chosen strategies to reach person-centered treatment goals
- Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet person-centered diagnosis and treatment goals
- Leveraging knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals
- **G0146:** Principal illness navigation - peer support, additional 30 minutes per calendar month (List separately in addition to G0140)

Note: Certain types of E/M visits, like inpatient and observation visits, ED visits, and SNF visits wouldn't serve as PIN initiating visits because the practitioner providing the E/M visit wouldn't typically provide continuing care to the patient, including providing necessary PIN services in subsequent months.

Resources:

- [Caregiver Training Services in 2024 PFS final rule](#)
- [CMS Health Equity](#)
- [Community Health Integration in 2024 PFS final rule](#)
- [Health Equity Fact Sheet](#)
- [Principal Illness Navigation in 2024 PFS final rule](#)
- [SDOH Risk Assessment in 2024 PFS final rule](#)

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Transitional Care Management Services



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Version 04/25/2024
Check for Updates

What's Changed?

Note: No substantive content updates.

Version 04/25/2024
Check for Updates

Medicare may cover transitional care services during the **30-day period** that begins when a physician discharges a Medicare patient from an inpatient stay and continues for the next 29 days. These services help eligible patients transition back to a community setting after a stay at certain facility types.

In this booklet, **you** refers to physicians or health care professionals providing TCM services.

Transitional Care Management Services Requirements

Required patient transitional care management (TCM) services include:

- Supporting a patient's transition to a community setting
- Health care professionals who accept patients at the time of post-facility discharge, **without a service gap**
- Health care professionals taking responsibility for a patient's care
- Moderate or high complexity medical decision making for patients with medical or psychosocial problems

The 30-day TCM period begins the day the patient is discharged from 1 of these inpatient or partial hospitalization settings and continues for the next 29 days:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Inpatient rehabilitation facility
- Long-term care hospital
- Skilled nursing facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

After an inpatient discharge, the patient must return to their community setting. These could include a:

- Home
- Domiciliary (like a group home or boarding house)
- Nursing facility
- Assisted living facility

Who Can Provide TCM Services?

TCM services include both face-to-face visits and non-face-to-face services. These health care practitioners can provide services associated with face-to-face TCM services and can supervise auxiliary personnel (including clinical staff):

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

CNMs, CNSs, NPs, and PAs may provide non-face-to-face TCM services “incident to” services of a physician and other CNMs, CNSs, NPs, and PAs.

Supervision

TCM codes are care management codes. Auxiliary personnel may assign them for TCM non-face-to-face services under the general supervision of the physician or NPP subject to applicable state law, scope of practice, and the Medicare Physician Fee Schedule incident to rules and regulations.

CNMs, CNSs, NPs, and PAs may also provide the non-face-to-face TCM services incident to the physician’s services.



TCM Components

When a patient discharges from an approved inpatient setting, you must provide at least these TCM components during the 30-day service period:

Interactive Contact

- You (or clinical staff under your direction) must contact the patient or their caregiver by phone, email, or face-to-face within 2 business days after the patient's discharge from the inpatient or partial hospitalization setting
 - "Clinical staff" means someone who's supervised by a physician or other qualified health care professional and is allowed by law, regulation, and facility policy to perform or assist in a specialized professional service, but doesn't individually report that professional service
- The interactive contact must be performed by clinical staff who can address patient status and needs beyond scheduling follow-up care
- You may report the service if you make 2 or more unsuccessful separate contact attempts in a timely manner (and if you meet the other service requirements, including a timely face-to-face visit)
- Document your attempts in the patient's medical record
- Continue trying to contact the patient until you're successful
- If the face-to-face visit isn't within the required timeframe, you can't bill TCM services (see the [face-to-face](#) section)

Non-Face-to-Face Services

- You and your clinical staff (as appropriate) must provide patients medically reasonable and necessary non-face-to-face services within the 30-day TCM service period
- Clinical staff under your direction may provide certain non-face-to-face services

Physician or NPP Non-Face-to-Face Services

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

- Review discharge information (for example, discharge summary or continuity-of-care documents)
- Review the patient's need for, or follow up on, diagnostic tests and treatments
- Interact with other health care professionals who may assume or reassume care of the patient's system-specific problems
- Educate the patient, family, guardian, or caregiver
- Establish or re-establish referrals and arrange needed community resources
- Help schedule required community providers and services follow-up

Auxiliary Personnel Under Physician or NPP General Supervision Non-Face-to-Face Services

Auxiliary personnel may provide these non-face-to-face TCM services under general supervision:

- Communicate with the patient
- Communicate with agencies and community service providers the patient uses
- Educate the patient, family, guardian, or caregiver to support self-management, independent living, and activities of daily living
- Assess and support treatment adherence, including medication management
- Identify available community and health resources
- Help the patient and family access needed care and services



Face-to-Face Visit

You must provide 1 face-to-face visit within the timeframes described by these 2 CPT codes:

- **99495** — Transitional care management services with the following required elements:
Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge At least moderate level of medical decision making during the service period Face-to-face visit, within 14 calendar days of discharge
- **99496** — Transitional care management services with the following required elements:
Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge High level of medical decision making during the service period Face-to-face visit, within 7 calendar days of discharge

Don't report the TCM face-to-face visit separately.

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Telehealth Services

You can provide CPT codes 99495 and 99496 through telehealth. We pay for a limited number of Part B services that you provide to an eligible patient using a telecommunications system. [Telehealth Services](#) fact sheet has more information.

Medication Reconciliation & Management

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

TCM Concurrent Billing

You can bill certain other care management services concurrently with TCM services, when medically reasonable and necessary and if time and effort are not counted more than once. See Table 1 for commonly used codes.

Table 1. HCPCS Codes You Can Bill Concurrently

HCPCS Code	Descriptor
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90956	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month

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Table 1. HCPCS Codes You Can Bill Concurrently (cont.)

HCPCS Code	Descriptor
90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age

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Table 1. HCPCS Codes You Can Bill Concurrently (cont.)

HCPCS Code	Descriptor
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
93792	Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

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Table 1. HCPCS Codes You Can Bill Concurrently (cont.)

HCPCS Code	Descriptor
99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99491	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; 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)

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Table 1. HCPCS Codes You Can Bill Concurrently (cont.)

HCPCS Code	Descriptor
G0181	Physician or allowed practitioner supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans
G0182	Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

Medical Decision Making

Patients who get TCM must need moderate medical decision making (if you're billing CPT code 99495) or high-level medical decision making (if you're billing CPT code 99496). The levels of medical decision making are defined in the [CPT E/M Guidelines](#). Medical decision making refers to establishing diagnoses, assessing the status of a condition, and selecting a management option, and is defined by 3 elements:

- **Problems:** The number and complexity of problems that are addressed during the encounter
- **Data:** The amount and complexity of data to be reviewed and analyzed, like medical records, diagnostic tests, and other information
- **Risk:** The risk of complications and morbidity or mortality of patient management

Billing TCM Services

TCM services billing tips:

- Only 1 physician or NPP may report TCM services.
- Report services once per patient during the TCM period.
- The same health care professional may discharge the patient from the hospital, report hospital or observation discharge services, and bill TCM services. The required face-to-face visit **can't** take place on the same day you report discharge day management services.
- Report reasonable and necessary E/M services (except required face-to-face visit) to manage the patient's clinical issues separately.

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- You **can't** bill TCM services within a post-operative global surgery period (we don't pay for TCM services if any of the 30-day TCM period falls within a global surgery period for a procedure code billed by the same practitioner).
- At a minimum, document this information in the patient's medical record:
 - Patient discharge date
 - Patient or caregiver first interactive contact date
 - Face-to-face visit date
 - Medical decision making (moderate or high)

Advance Health Equity

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

- [Building an Organizational Response to Health Disparities](#) — Resources and concepts for improving equity and responding to disparities. Topics include data collection, data analysis, culture of equity, quality improvement, and interventions
- [Guide to Reducing Disparities in Readmissions](#) — Overview and case studies of key care coordination and readmission issues and strategies for racially and ethnically diverse Medicare patients

Resources

- [2013 Medicare Physician Fee Schedule Final Rule](#)
- [Care Management](#)
- [Evaluation & Management Visits](#)
- [Federally Qualified Health Center](#)
- [Information for Rural Health Clinics](#)
- [Rural Health Information Hub: Transitional Care Management](#)
- [Telehealth](#)

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