



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 Level Selection

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 times descriptors, where relevant; and

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

2. Evaluation and Management Services

- a. Level selection is based on either medical decision-making or total time of the visit.
- b. Office/Outpatient Visits
 - (i) 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.
 - (1) Example:
 - a. CPT code 99213 has an associated time range of 20-29 minutes as opposed to the associated typical time in 2020 of 30 minutes.
- c. For additional E/M visits revised in CY 2023
 - (i) Key components have been removed from the code descriptors.
 - (1) Example:
 - a. CPT code 99307 the code description states:
 - i. Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
 - b. Revised from the 2021 CPT code description that stated:
 - i. Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision

making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.

d. Hospital Inpatient and Observation Care Services

(i) Hospital inpatient and observation visits were merged into a single code set. <2023 AMA CPT Manual>

(a) CPT codes 99221-99233 are reported for inpatient or observation care services.

(1) Example:

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 exceeded.

e. Domiciliary, rest Home, custodial care and home visits were also merged into a code set.

f. Prolonged Evaluation and Management Services

(i) CMS finalized Medicare-codes for prolonged other E/M services as alternates for the newly created AMA prolonged service CPT code.

(a) 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)

(ii) The Medicare-specific codes have been created based on the location the prolonged services are provided.

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

(b) 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.
 - b. HCPCS G0317 should not be reported on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418.
 - c. G0317 should not be reported for any time unit less than 15 minutes.

(c) 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.
 - a. HCPCS G0318 can be listed separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services.
 - b. Do not report HCPCS G0318 on the same date of service as other prolonged services for evaluation and management, reported with CPT codes 99358, 99359, 99417.
 - c. Do not report G0318 for any time unit less than 15 minutes.

(d) 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.
 - a. HCPCS G2212 can be list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services
 - b. HCPCS G2212 should not be reported on the same date of service as CPT codes 99354, 99355, 99358, 99359, 99415, 99416.
 - c. Do not report G2212 for any time unit less than 15 minutes.

(e) 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*>

g. Visit Complexity Code – HCPCS G2211

Note: Finalized for use in 2021; however, the Consolidations Appropriations Act, 2021, suspended Medicare reimbursement until 2024. Currently the code is considered bundled service.

(i) 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.

- (1) G2211 is an add-on code, which should be listed separately in addition to office/outpatient evaluation and management visit, for both new and established patients.

- (2) The code should only be reported with CPT codes 99202 and 99215.

C. Concurrent Care

1. Definition

- 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*, Chapter 15 § 30(D)>

2. Coverage Requirements < *Medicare Benefit Policy Manual*, Chapter 15 § 30(D)>

- a. 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
- b. The individual services by each physician must be reasonable and necessary.

3. Same Specialty Limitation

- a. 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)>

II. Multiple E/M Encounters on the Same Day

A. The One Visit Per Day Rule

- 1. 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>
 - a. The Unrelated Visit Exception
 - (i) 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)>
 - (a) 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)>

B. 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>
 - (a) 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>

- (a) 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>

III. 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)>

IV. 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. The AI modifier should not be reported by non-admitting practitioners, 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)>

a. For example, if a physician took a comprehensive history in the office on one day and then admitted the patient to the hospital the next day, if the physician only performed a detailed history on the day of admission (because a comprehensive history had been performed the preceding day), the hospital admission would be billed as level one initial hospital care (CPT code 99221).

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 admitted to inpatient care and discharged on the same date, the following guidelines apply:
 - (i) Contractors pay only the initial hospital care code 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., an inpatient hospital visit) 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)>

V. 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 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 code 99217). <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
 - a. If the same physician who admitted a patient to observation, later on the same date admits the patient as an inpatient, the physician may not bill for either the initial observation or the observation discharge services. Rather, only the inpatient admission (i.e., the "initial hospital care") is billable. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(D)>
2. Inpatient Admission on a Different Date

- a. If a physician admits an observation patient as an inpatient on a date other than the date of the initial observation, the physician may separately bill for observation services furnished on dates prior to the date of the inpatient admission. However, the physician may not separately bill for observation-related services (including the observation discharge services) furnished on the date of the inpatient admission. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(D)>

VI. 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)>

VII. 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>

VIII. 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 § 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) the history, exam, or medical decision making.
 - (a) If using the history, exam, or medical decision making to determine the substantive portion, the practitioner must complete the component in its entirety.
 - 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. In the 2023 Medicare Physician Fee Schedule, CMS extended this method of determination through CY 2023.
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

IX. 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 criterion.
 - 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).

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, doesn't 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 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>

X. 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

XI. 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)>

XII. Care Management Services

- A. 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.
 - 1. 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.
 - 2. Patients must have two or more chronic continuous or episodic health conditions that place the patient at significant risk which are expected to last at least 12 months or until death.
 - 3. Services may be reported on a monthly basis by a single physician/NPP.

4. 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.
5. 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.
6. Care management services may not be reported by the surgeon when performed during the post-op period.
7. 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.
8. 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.
- h. More information available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>
- 2. Complex Chronic Care Management Services (99487-99489)
 - a. Complex chronic care management service (99847), must meet the following required elements:
 - (i) Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
 - (ii) Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
 - (iii) Establishment or substantial revision of a comprehensive care plan with moderate or high complexity medical decision making
 - (iv) 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
 - (v) 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)
- 3. 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).

C. 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
 - (j) G2065 Comprehensive care management services for a single high-risk disease at least 30 minutes of **clinical staff** time per calendar month...
 - a. Both codes require 30 minutes of time during the calendar month.
 - b. CMS intends to monitor these new codes for the unintended consequence of fragmented care or inappropriate care that overlaps into duplicative services.

D. 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.

E. 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. The 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 the medical decision making (moderate or high).
- 9. For additional details on Medicare requirements for TCM, see the TCM fact sheet: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf>
- F. 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
 - a. 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>

G. General Behavioral Health Integration Services Provided by Clinical Psychologists (CP) or Clinical Social Workers (CSW)

1. CMS created and finalized a new HCPCS code for CY 2023 to account for the monthly care integration for mental health services provided by a CP or a CSW when serving as a focal point of care integration <MLN Matters MM12982>
2. HCPCS Code G0323 - Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. (these services include the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric

consultation; and continuity of care with a designated member of the care team).

H. 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>
 - (i) It is necessary to report modifier 33 (preventive service) on the advance care planning code(s). <MLN Matters Article MM9271>

XIII. 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 02/15/2023
Check for Updates

April 24, 1998 Letter from the Health Care Financing Administration to the
American Medical Association (CCH ¶ 46,327)

Percy Wooton, M.D.
President, American Medical Association

Dear Dr. Wooton:

I am writing to you about the Documentation Guidelines for Evaluation and Management Services (E/M), because I continue to hear physicians express concerns about them. I thought it would be helpful to provide you with the Health Care Financing Administration's (HCFA's) views on the Guidelines, the process for improving *** the increased emphasis on accurate billing and proper documentation. Understandably, physicians are reacting to flaws in the Documentation Guidelines that we are committed to fix. Also, many physicians fear they will be unjustifiably targeted for fraud and abuse investigations as a result of simple coding errors. I want to do what I can to allay those fears.

As stewards of the Medicare program, HCFA must be sure the payments we make on behalf of our beneficiaries are for medically necessary and appropriate services, and that the services have been accurately reported. Our FY 1997 CFO Audit, which was released April 24, indicates that while we are making progress in reducing inappropriate payments, we still have much work to do, particularly in the area of ensuring that documentation for physician claims is adequate. Inadequate or no documentation is the principal cause of the improper payments identified in the CFO audit report.

HCFA needs to be confident that Medicare carriers are reviewing medical records in a consistent manner. Physicians need assurances that they are billing appropriately and have adequate documentation in the event of an audit. A workable version of the Documentation Guidelines is an essential tool for both physicians and our carriers. Further, improving program integrity serves the interest of Medicare, its beneficiaries, and its providers, including physicians.

I have heard that physicians believe the 1997 Documentation Guidelines that the American Medical Association (AMA) and HCFA developed together are too complex and burdensome. The most troubling concern is that some physicians believe the new Guidelines will divert too much physician time and attention from patient care to paperwork. I believe we can and must work together to improve the Guidelines so they do not impose requirements in excess of those associated with clinically appropriate medical record-keeping practices.

I understand that the written comments you received in mid-March contained a number of thoughtful suggestions. I have asked Robert A. Berenson, M.D., the new director of HCFA's Center for Health Plans and Providers, to participate in your "fly in" meeting today. We look forward to discussions about implementation issues, as well as the content of the Guidelines themselves.

In December 1997, HCFA agreed to your request that carriers use both the 1995 and 1997 versions of the Documentation Guidelines to evaluate claims until July 1, 1998. When we set that July 1 date, neither the AMA nor HCFA fully understood the magnitude of the problems with the 1997 Guidelines. I think it is unrealistic to expect that the revisions can be completed by that date and it is clear that an additional period is needed for testing the Guidelines as well as for education of physicians and carriers.



Therefore, I am directing carriers to continue to use both the 1995 and 1997 Guidelines, whichever is more advantageous to the physician, until the revisions have been completed and there has been an adequate period of time for testing and education. Since there is still uncertainty about how quickly that work can be done, I think it is premature to set an implementation date now. Dr. Berenson and his staff will report to me in the early fall on the status of the revision efforts and the projected schedule for testing, refinement, and physician education. I anticipate using that information to set a final date for implementation of the revised Guidelines that will allow ample time for completion of the pre-implementation activities.

We believe the final product will be strengthened by the broad physician participation in the revision process. Working together, we can make the Guidelines easier to understand and we can sharpen the focus so that only documentation directly related to the care provided is required.

Let me turn to the broader issue of the emphasis on fraud and abuse, particularly the provisions in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regarding sanctions for coding errors. Civil monetary penalties may now be assessed for coding that the person knows, or should know, will result in greater payments than appropriate. However, the statute is very clear that there must be a pattern or practice of such behavior.

I want to assure you that physicians will not be punished for honest mistakes and we will not make referrals to the Office of the Inspector General for occasional errors. To be certain there is no misunderstanding about this, I have asked my staff to issue an instruction to the carriers reminding them of our long standing policy that referrals are to be made to the Office of the Inspector General for possible sanctions only after the carrier determines the situation was not caused by error and there is evidence of intentional improper billing practices. We have to believe there is some level of fraudulent intent before we make any referrals. Sanctions are intended for physicians who act in "deliberate ignorance" or with "reckless disregard" of the truth or falsity of information. For criminal penalties, the standard is that the provider had "knowing and willful" intent to defraud the government.

We are at a critical juncture in the development of the Documentation Guidelines. I am confident that by working together we can develop revised Documentation Guidelines that will meet our needs to assure that Medicare payments are appropriate without imposing undue burden on physicians. I hope your meeting is a productive one that will move us closer to that goal.

Sincerely,

Nancy-Ann Min DeParle, HCFA Administrator

Medicare Benefit Policy Manual

Chapter 15 – Covered Medical and Other Health Services

Table of Contents (Rev. 11771, 12-30-22) (Rev. 11769, 12-30-22)

Transmittals for Chapter 15

- 10 - Supplementary Medical Insurance (SMI) Provisions
- 20 - When Part B Expenses Are Incurred
 - 20.1 - Physician Expense for Surgery, Childbirth, and Treatment for Infertility
 - 20.2 - Physician Expense for Allergy Treatment
 - 20.3 - Artificial Limbs, Braces, and Other Custom Made Items Ordered But Not Furnished
- 30 - Physician Services
 - 30.1 - Provider-Based Physician Services
 - 30.2 - Teaching Physician Services
 - 30.3 - Interns and Residents
 - 30.4 - Optometrist's Services
 - 30.5 - Chiropractor's Services
 - 30.6 - Indian Health Service (IHS) Physician and Nonphysician Services
 - 30.6.1 - Payment for Medicare Part B Services Furnished by Certain IHS Hospitals and Clinics
- 40 - Effect of Beneficiary Agreements Not to Use Medicare Coverage
 - 40.1 - Private Contracts Between Beneficiaries and Physicians/Practitioners
 - 40.2 - General Rules of Private Contracts
 - 40.3 - Effective Date of the Opt-Out Provision
 - 40.4 - Definition of Physician/Practitioner
 - 40.5 - When a Physician or Practitioner Opts Out of Medicare
 - 40.6 - When Payment May be Made to a Beneficiary for Service of an Opt-Out Physician/Practitioner
 - 40.7 - Definition of a Private Contract
 - 40.8 - Requirements of a Private Contract
 - 40.9 - Requirements of the Opt-Out Affidavit
 - 40.10 - Failure to Properly Opt Out
 - 40.11 - Failure to Maintain Opt-Out

Where a supplier breaches an agreement to make a prosthesis, brace, or other custom-made device for a Medicare beneficiary, e.g., an unexcused failure to provide the article within the time specified in the contract, payment may not be made for any work or material expended on the item. Whether a particular supplier has lived up to its agreement, of course, depends on the facts in the individual case.

30 - Physician Services

(Rev. 10639; Issued: 03-12-2021; Effective: 01-01-2021; Implementation: 04-12-2021)

A. General

Physician services are the professional services performed by a physician or physicians for a patient including diagnosis, therapy, surgery, consultation, and care plan oversight.

The physician must render the service for the service to be covered. (See Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §70, for definition of physician.) A service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.

For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of a verbal description) is a covered service.

Professional services of the physician are covered if provided within the United States, and may be performed in a home, office, institution, or at the scene of an accident. A patient's home, for this purpose, is anywhere the patient makes his or her residence, e.g., home for the aged, a nursing home, a relative's home.

B. Consultations



As of January 1, 2010, CMS no longer recognizes consultation codes for Medicare payment, except for inpatient telehealth consultation HCPCS G-codes. Instead, physicians and qualified nonphysician practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code. For further detail regarding reporting services that would otherwise be described by the CPT consultation codes (99241-99245 and 99251-99255), see Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.6. For detailed instructions regarding reporting telehealth consultation services and other telehealth services, see Pub. 100-04, chapter 12, section 190.3.

C. Patient-Initiated Second Opinions

Patient-initiated second opinions that relate to the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy) are covered under Medicare. In the event that the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered. Second and third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient, and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion. In some cases, the results of tests done by the first physician may be available to the second physician.



D. Concurrent Care

Concurrent care exists where more than one physician renders services more extensive than consultative services during a period of time. The reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services.

In order to determine whether concurrent physicians' services are reasonable and necessary, the A/B MAC (B) must decide the following:

1. Whether the patient's condition warrants the services of more than one physician on an attending (rather than consultative) basis, and
2. Whether the individual services provided by each physician are reasonable and necessary.

In resolving the first question, the A/B MAC (B) should consider the specialties of the physicians as well as the patient's diagnosis, as concurrent care is usually (although not always) initiated because of the existence of more than one medical condition requiring diverse specialized medical or surgical services. The specialties of the physicians are an indication of the necessity for concurrent services, but the patient's condition and the inherent reasonableness and necessity of the services, as determined by the A/B MAC (B)'s medical staff in accordance with locality norms, must also be considered. For example, although cardiology is a sub-specialty of internal medicine, the treatment of both diabetes and of a serious heart condition might require the concurrent services of two physicians, each practicing in internal medicine but specializing in different sub-specialties.

While it would not be highly unusual for concurrent care performed by physicians in different specialties (e.g., a surgeon and an internist) or by physicians in different subspecialties of the same specialty (e.g., an allergist and a cardiologist) to be found medically necessary, the need for such care by physicians in the same specialty or subspecialty (e.g., two internists or two cardiologists) would occur infrequently since in most cases both physicians would possess the skills and knowledge necessary to treat the

patient. However, circumstances could arise which would necessitate such care. For example, a patient may require the services of two physicians in the same specialty or sub-specialty when one physician has further limited his or her practice to some unusual aspect of that specialty, e.g., tropical medicine. Similarly, concurrent services provided by a family physician and an internist may or may not be found to be reasonable and necessary, depending on the circumstances of the specific case. If it is determined that the services of one of the physicians are not warranted by the patient's condition, payment may be made only for the other physician's (or physicians') services.

Once it is determined that the patient requires the active services of more than one physician, the individual services must be examined for medical necessity, just as where a single physician provides the care. For example, even if it is determined that the patient requires the concurrent services of both a cardiologist and a surgeon, payment may not be made for any services rendered by either physician which, for that condition, exceed normal frequency or duration unless there are special circumstances requiring the additional care.

The A/B MAC (B) must also assure that the services of one physician do not duplicate those provided by another, e.g., where the family physician visits during the post-operative period primarily as a courtesy to the patient.

Hospital admission services performed by two physicians for the same beneficiary on the same day could represent reasonable and necessary services, provided, as stated above, that the patient's condition necessitates treatment by both physicians. The level of difficulty of the service provided may vary between the physicians, depending on the severity of the complaint each one is treating and that physician's prior contact with the patient. For example, the admission services performed by a physician who has been treating a patient over a period of time for a chronic condition would not be as involved as the services performed by a physician who has had no prior contact with the patient and who has been called in to diagnose and treat a major acute condition.

A/B MACs (B) should have sufficient means for identifying concurrent care situations. A correct coverage determination can be made on a concurrent care case only where the claim is sufficiently documented for the A/B MAC (B) to determine the role each physician played in the patient's care (i.e., the condition or conditions for which the physician treated the patient). If, in any case, the role of each physician involved is not clear, the A/B MAC (B) should request clarification.

E. Completion of Claims Forms

Separate charges for the services of a physician in completing a Form CMS-1500, a statement in lieu of a Form CMS-1500, or an itemized bill are not covered. Payment for completion of the Form CMS-1500 claim form is considered included in the fee schedule amount.

F. Care Plan Oversight Services



Care plan oversight is supervision of patients under care of home health agencies or hospices that require 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 with other health professionals not employed in the same practice who are involved in the patient's care, integration of new information into the care plan, and/or adjustment of medical therapy.

Such services are covered for home health and hospice patients, but are not covered for patients of skilled nursing facilities (SNFs), nursing home facilities, or hospitals.

These services are covered only if all the following requirements are met:

1. The beneficiary must require complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient's plan of care;
2. The care plan oversight (CPO) services should be furnished during the period in which the beneficiary was receiving Medicare covered HHA or hospice services;
3. The physician who bills CPO must be the same physician who signed the home health or hospice plan of care;
4. The physician furnished at least 30 minutes of care plan oversight within the calendar month for which payment is claimed. Time spent by a physician's nurse or the time spent consulting with one's nurse is not countable toward the 30-minute threshold. Low-intensity services included as part of other evaluation and management services are not included as part of the 30 minutes required for coverage;
5. The work included in hospital discharge day management (codes 99238-99239) and discharge from observation (code 99217) is not countable toward the 30 minutes per month required for work on the same day as discharge but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital;
6. The physician provided a covered physician service that required a face-to-face encounter with the beneficiary within the 6 months immediately preceding the first care plan oversight service. Only evaluation and management services are

acceptable prerequisite face-to-face encounters for CPO. EKG, lab, and surgical services are not sufficient face-to-face services for CPO;

7. The care plan oversight billed by the physician was not routine post-operative care provided in the global surgical period of a surgical procedure billed by the physician;
8. If the beneficiary is receiving home health agency services, the physician did not have a significant financial or contractual interest in the home health agency. A physician who is an employee of a hospice, including a volunteer medical director, should not bill CPO services. Payment for the services of a physician employed by the hospice is included in the payment to the hospice;
9. The physician who bills the care plan oversight services is the physician who furnished them;
10. Services provided incident to a physician's service do not qualify as CPO and do not count toward the 30-minute requirement;
11. The physician is not billing for the Medicare end stage renal disease (ESRD) capitation payment for the same beneficiary during the same month; and
12. The physician billing for CPO must document in the patient's record the services furnished and the date and length of time associated with those services.



G. Medical Record Documentation for Part B Services

This medical record documentation requirement applies to Part B professional services that are paid under the Medicare physician fee schedule. Accordingly, for Part B covered services, the certified nurse-midwife, nurse practitioner, physician assistant, clinical nurse specialist, and any individual who is authorized under Medicare law to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date), rather than re-document notes in a patient's medical record made by physicians, residents, nurses, and students (including students in therapy or other clinical disciplines), or other members of the medical team, including as applicable, notes documenting the physician or nonphysician practitioner's presence and participation in the service.

For documentation requirements specific to E/M services furnished by physicians and certain nonphysician practitioners, see Chapter 12, section 30.6 of the Medicare Claims Processing Manual, publication 100-04.

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents (Rev. 11732, 12-08-22)

Transmittals for Chapter 12

10 - General

20 - Medicare Physicians Fee Schedule (MPFS)

- 20.1 - Method for Computing Fee Schedule Amount
- 20.2 - Relative Value Units (RVUs)
- 20.3 - Bundled Services/Supplies
- 20.4 - Summary of Adjustments to Fee Schedule Computations
 - 20.4.1 - Participating Versus Nonparticipating Differential
 - 20.4.2 - Site of Service Payment Differential
 - 20.4.3 - Assistant at Surgery Services
 - 20.4.4 - Supplies
 - 20.4.5 - Allowable Adjustments
 - 20.4.6 - Payment Due to Unusual Circumstances (Modifiers “-22” and “-52”)
 - 20.4.7 - Technical Component Payment Reduction for X-Rays and Other Imaging Services
- 20.5 - No Adjustments in Fee Schedule Amounts
- 20.6 - Update Factor for Fee Schedule Services
- 20.7 - Comparability of Payment Provision of Delegation of Authority by CMS to Railroad Retirement Board
- 20.8 - Payment for Teleradiology Physician Services Purchased by Indian Health Services (IHS) Providers and Physicians

30 - Correct Coding Policy

- 30.1 - Digestive System (Codes 40000 - 49999)
- 30.2 - Urinary and Male Genital Systems (Codes 50010 - 55899)
- 30.3 - Audiology Services
- 30.4 - Cardiovascular System (Codes 92950-93799)
- 30.5 - Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions
- 30.6 - Evaluation and Management Service Codes - General (Codes 99201 - 99499)
 - 30.6.1 - Selection of Level of Evaluation and Management Service
 - 30.6.1.1 - Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)

The physician may report the infusion code for “each additional hour” only if the infusion interval is greater than 30 minutes beyond the 1 hour increment. For example if the patient receives an infusion of a single drug that lasts 1 hour and 45 minutes, the physician would report the “initial” code up to 1 hour and the add-on code for the additional 45 minutes. **7-44**

Several chemotherapy administration and nonchemotherapy injection and infusion service codes have the following parenthetical descriptor included as a part of the CPT code, “List separately in addition to code for primary procedure.” Each of these codes has a physician fee schedule indicator of “ZZZ” meaning this service is allowed if billed with another chemotherapy administration or nonchemotherapy injection and infusion service code.

Do not interpret this parenthetical descriptor to mean that the add-on code can be billed only if it is listed with another drug administration primary code. For example, code 90761 will be ordinarily billed with code 90760. However, there may be instances when only the add-on code, 90761, is billed because an “initial” code from another section in the drug administration codes, instead of 90760, is billed as the primary code.

Pay for code 96523, “Irrigation of implanted venous access device for drug delivery systems,” if it is the only service provided that day. If there is a visit or other chemotherapy administration or nonchemotherapy injection or infusion service provided on the same day, payment for 96523 is included in the payment for the other service.

F. Chemotherapy Administration (or Nonchemotherapy Injection and Infusion) and Evaluation and Management Services Furnished on the Same Day

For services furnished on or after January 1, 2004, do not allow payment for CPT code 99211, with or without modifier 25, if it is billed with a nonchemotherapy drug infusion code or a chemotherapy administration code. Apply this policy to code 99211 when it is billed with a diagnostic or therapeutic injection code on or after January 1, 2005.

Physicians providing a chemotherapy administration service or a nonchemotherapy drug infusion service and evaluation and management services, other than CPT code 99211, on the same day must bill in accordance with §30.6.6 using modifier 25. The A/B MACs (B) pay for evaluation and management services provided on the same day as the chemotherapy administration services or a nonchemotherapy injection or infusion service if the evaluation and management service meets the requirements of section §30.6.6 even though the underlying codes do not have global periods. If a chemotherapy service and a significant separately identifiable evaluation and management service are provided on the same day, a different diagnosis is not required.

In 2005, the Medicare physician fee schedule status database indicators for therapeutic and diagnostic injections were changed from T to A. Thus, beginning in 2005, the policy on evaluation and management services, other than 99211, that is applicable to a chemotherapy or a nonchemotherapy injection or infusion service applies equally to these codes.

30.6 - Evaluation and Management Service Codes - General (Codes 99201 - 99499)

(Rev. 178, 05-14-04)

B3-15501-15501.1

30.6.1 - Selection of Level of Evaluation and Management Service (Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

A. Use of CPT Codes

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician

collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice. 7-45

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

B. Selection of Level of Evaluation and Management Service

Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C.

Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the Medicare Administrative Contractor (MAC) at the appropriate physician fee schedule amount based on the rendering national provider identifier (NPI) number.

"Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met (refer to sections 60.1, 60.2, and 60.3, chapter 15 in IOM 100-02).

SPLIT/SHARED E/M SERVICE

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

C. Selection of Level of Evaluation and Management Service Based On Duration of Coordination of Care and/or Counseling

Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

7-46

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient's care after the patient has left the office or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

D. Use of Highest Levels of Evaluation and Management Codes

A/B MACs (B) must advise physicians that to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT's definition of a comprehensive history).

The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient's medical, family, and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.

The comprehensive examination may be a complete single system exam such as cardiac, respiratory, psychiatric, or a complete multi-system examination.

30.6.1.1 - Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV)

(Rev. 3096, Issued: 10-17-14, Effective: 01-27-14, Implementation: 11-18-14)

A. Definitions



1. Initial Preventive Physical Examination (IPPE)

The initial preventive physical examination (IPPE), or "Welcome to Medicare Preventive Visit" is a preventive visit authorized by sections 1861(s)(2)(w) and 1861(w) of the Social Security Act (and implementing regulations at 42 CFR 410.16, 411.15(a)(1), and 411.15(k)(1)).

As described in the implementing regulations, the IPPE includes the following:

- (1) review of the individual's medical and social history with attention to modifiable risk factors for disease detection,
- (2) review of the individual's potential (risk factors) for depression or other mood disorders,
- (3) review of the individual's functional ability and level of safety,

- 7-47
- (4) an examination to include measurement of the individual's height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate, based on the beneficiary's medical and social history,
 - (5) end-of-life planning, upon agreement of the individual,
 - (6) education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous 5 elements, and
 - (7) education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are separately covered under Medicare Part B (that is, pneumococcal, influenza and hepatitis B vaccines and their administration, screening mammography, screening pap smear and screening pelvic examinations, prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self-management training services, bone mass measurements, glaucoma screening, medical nutrition therapy for individuals with diabetes or renal disease, cardiovascular screening blood tests, diabetes screening tests, screening ultrasound for abdominal aortic aneurysms, an electrocardiogram, and additional preventive services covered under Medicare Part B through the Medicare national coverage determinations process).

2. Annual Wellness Visit (AWV)

Effective January 1, 2011, Sections 1861(s)(2)(FF) and 1861(hhh) of the Social Security Act and implementing regulations at 42 CFR 410.15, authorize an AWV providing personalized prevention plan services (PPPS). The AWV is a preventive visit available to eligible beneficiaries, and identified by HCPCS codes G0438 (Annual wellness visit, including PPPS, first visit) and G0439 (Annual wellness visit, including PPPS, subsequent visit). Information, including definitions of relevant terms and coverage requirements for the AWV are included in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 280.5.

The first AWV providing PPPS (HCPCS G0438) is a 'one time' allowed Medicare benefit and includes the following elements furnished to an eligible beneficiary by a health professional:

Review (and administration if needed) of a health risk assessment,

- Establishment of the individual's medical/family history,
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual,
- Measurement of the individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure (BP), and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- Detection of any cognitive impairment that the individual may have,
- Review of an individual's potential risk factors for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations,

- Review of the individual's functional ability and level of safety, based on direct observation of the individual, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations,
- Establishment of a written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and Advisory Committee of Immunizations Practices (ACIP), and the individual's health risk assessment, health status, screening history, and age-appropriate preventive services covered by Medicare,
- Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits,
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition, and,
- Any other element(s) determined appropriate by the Secretary through the national coverage determinations process.

Subsequent AWWs providing PPPS (HCPCS G0439) include the following key elements furnished to an eligible beneficiary by a health professional:

- Review (and administration, if needed) of an updated health risk assessment,
- Update of the individual's medical/family history,
- Update to the list of current providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first AWW providing PPPS, or the previous subsequent AWW providing PPPS,
- Measurement of an individual's weight (or waist circumference), blood pressure, and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- Detection of any cognitive impairment that the individual may have,
- Update to the individual's written screening schedule as developed at the first AWW providing PPPS,
- Update to the individual's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, as that list was developed at the first AWW providing PPPS, or the previous subsequent AWW providing PPPS,
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs, and,

- Any other element determined appropriate by the Secretary through the national coverage determinations process.

See chapter 18 of this manual for additional information regarding preventive services that are separately covered under Medicare Part B.

B. Who May Perform an IPPE or AWW

The A/B MAC (B) pays the appropriate physician fee schedule amount based on the rendering National Provider Identification (NPI) number.

The IPPE may be performed by:

- a doctor of medicine or osteopathy as defined in Section 1861(r) (1) of the Social Security Act, or
- a qualified nonphysician practitioner (nurse practitioner, physician assistant or clinical nurse specialist).

The AWW may be performed by a health professional, which is defined as:

- a doctor of medicine or osteopathy as defined in Section 1861(r)(1) of the Social Security Act,

a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act), or
- a medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner) or a team of such medical professionals, working under the direct supervision of a physician (doctor of medicine or osteopathy).

C. Eligibility

1. IPPE

Medicare pays for one IPPE per beneficiary per lifetime for beneficiaries within the first 12 months of the effective date of the beneficiary's first Part B coverage period.

2. AWW

Medicare pays for an AWW for a beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period, and who has not received either an IPPE or an AWW providing PPS within the past 12 months. Medicare pays for only one first AWW (HCPCS G0438), per beneficiary per lifetime. All subsequent AWWs must be billed using HCPCS G0439.

D. Deductible and Coinsurance

1. IPPE

The Medicare deductible and coinsurance apply for the IPPE provided before January 1, 2009.

The Medicare deductible is waived effective for the IPPE provided on or after January 1, 2009. However, the applicable coinsurance continues to apply for the IPPE provided on or after January 1, 2009.

As a result of the Affordable Care Act (ACA), effective for the IPPE provided on or after January 1, 2011, the Medicare deductible and coinsurance (for HCPCS code G0402 only) are waived. **7-50**

2. AWW

As a result of the ACA, effective January 1, 2011, the Medicare deductible and coinsurance for the AWW (HCPCS G0438 and G0439) are waived.

E. The EKG Component of the IPPE

The once-in-a-lifetime screening EKG may be performed, as appropriate, with a referral from an IPPE.

F. HCPCS Codes Used to Bill the IPPE or AWW

1. HCPCS Codes Used to Bill the IPPE

For IPPE and EKG services provided prior to January 1, 2009, the physician or qualified NPP shall bill HCPCS code G0344 for the IPPE performed face-to-face, and HCPCS code G0366 for performing a screening EKG that includes both the interpretation and report. If the primary physician or qualified NPP performs only the IPPE, he/she shall bill HCPCS code G0344 only. The physician or entity that performs the screening EKG that includes both the interpretation and report shall bill HCPCS code G0366. The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0367. The physician or entity that performs the interpretation and report only (without the EKG tracing) shall bill HCPCS code G0368. Medicare will pay for a screening EKG only as part of the IPPE. HCPCS codes G0344, G0366, G0367 and G0368 will not be billable codes effective on or after January 1, 2009.

Effective for a beneficiary who has the IPPE on or after January 1, 2009, and within his/her 12-month enrollment period of Medicare Part B, the IPPE and screening EKG services are billable with the appropriate HCPCS G code(s).

The physician or qualified NPP shall bill HCPCS code G0402 for the IPPE performed face-to-face with the patient.

The physician or entity shall bill HCPCS code G0403 for performing the complete screening EKG that includes the tracing, interpretation and report.

The physician or entity that performs the screening EKG tracing only (without interpretation and report) shall bill HCPCS code G0404.

The physician or entity that performs the screening EKG interpretation and report only, (without the EKG tracing) shall bill HCPCS code G0405.

2. HCPCS Codes Used to Bill the AWW

For the first AWW provided on or after January 1, 2011, the health professional shall bill HCPCS G0438 (Annual wellness visit, including PPPS, first visit). This is a once per beneficiary per lifetime allowable Medicare Part B benefit.

All subsequent AWWs shall be billed with HCPCS G0439 (Annual Wellness Visit, including PPPS, subsequent visit). In the event that a beneficiary selects a new health professional to complete a subsequent AWW, the new health professional will continue to bill the subsequent AWW with HCPCS G0439.

G. Documentation for the IPPE or AWW

Practitioners eligible to furnish an IPPE or an AWW are required to use the 1995 and 1997 E/M documentation guidelines to document the medical record with the appropriate clinical information. (http://xmarks.com/site/www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp). All referrals and a written medical plan must be included in this documentation.

H. Reporting a Medically Necessary E/M Service Furnished During the Same Encounter as an IPPE or AWW

When the physician or qualified NPP, or for AWW the health professional, provides a significant, separately identifiable medically necessary E/M service in addition to the IPPE or an AWW, CPT codes 99201 - 99215 may be reported depending on the clinical appropriateness of the circumstances. CPT Modifier -25 shall be appended to the medically necessary E/M service identifying this service as a significant, separately identifiable service from the IPPE or AWW code reported (HCPCS code G0344 or G0402, whichever applies based on the date the IPPE is performed, or HCPCS code G0438 or G0439 whichever AWW code applies).

NOTE: Some of the components of a medically necessary E/M service (e.g., a portion of history or physical exam portion) may have been part of the IPPE or AWW and should not be included when determining the most appropriate level of E/M service to be billed for the medically necessary, separately identifiable, E/M service.

30.6.2 - Billing for Medically Necessary Visit on Same Occasion as Preventive Medicine Service (Rev. 1, 10-01-03)

See Chapter 18 for payment for covered preventive services.

When a physician furnishes a Medicare beneficiary a covered visit at the same place and on the same occasion as a noncovered preventive medicine service (CPT codes 99381-99397), consider the covered visit to be provided in lieu of a part of the preventive medicine service of equal value to the visit. A preventive medicine service (CPT codes 99381-99397) is a noncovered service. The physician may charge the beneficiary, as a charge for the noncovered remainder of the service, the amount by which the physician's current established charge for the preventive medicine service exceeds his/her current established charge for the covered visit. Pay for the covered visit based on the lesser of the fee schedule amount or the physician's actual charge for the visit. The physician is not required to give the beneficiary written advance notice of noncoverage of the part of the visit that constitutes a routine preventive visit. However, the physician is responsible for notifying the patient in advance of his/her liability for the charges for services that are not medically necessary to treat the illness or injury.

There could be covered and noncovered procedures performed during this encounter (e.g., screening x-ray, EKG, lab tests.). These are considered individually. Those procedures which are for screening for asymptomatic conditions are considered noncovered and, therefore, no payment is made. Those procedures ordered to diagnose or monitor a symptom, medical condition, or treatment are evaluated for medical necessity and, if covered, are paid.

30.6.3 - Payment for Immunosuppressive Therapy Management (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 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. 7-52

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. 7-53

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 99201 - 99215)

(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

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.

7-54



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.



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.

30.6.8 - Payment for Hospital Observation Services and Observation or Inpatient Care Services (Including Admission and Discharge Services) (Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

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. **7-55**

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.

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

Similar to initial observation codes, payment for a subsequent observation care code is for all the care rendered by the treating physician on the day(s) other than the initial or discharge date. 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.

When a patient receives observation care for less than 8 hours on the same calendar date, the Initial Observation Care, from CPT code range 99218 - 99220, shall be reported by the physician. The Observation Care Discharge Service, CPT code 99217, shall not be reported for this scenario.

When a patient is admitted for observation care and then is discharged on a different calendar date, the physician shall report Initial Observation Care, from CPT code range 99218 - 99220, and CPT observation care discharge CPT code 99217. On the rare occasion when a patient remains in observation care for 3 days, the physician shall report an initial observation care code (99218-99220) for the first day of observation care, a subsequent observation care code (99224-99226) for the second day of observation care, and an observation care discharge CPT code 99217 for the observation care on the discharge date. When observation care continues beyond 3 days, the physician shall report a subsequent observation care code (99224-99226) for each day between the first day of observation care and the discharge date.

When a patient receives observation care for a minimum of 8 hours, but less than 24 hours, and is discharged on the same calendar date, Observation or Inpatient Care Services (Including Admission and Discharge Services) from CPT code range 99234 - 99236 shall be reported. The observation discharge, CPT code 99217, cannot also be reported for this scenario.

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



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 history, examination, and medical decision making, documentation in the medical record shall include:

- Documentation stating the stay for observation care or inpatient hospital care involved less than 24 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. The physician may not use the subsequent hospital care codes since the patient is not an inpatient of the hospital.

D. Admission to Inpatient Status Following Observation Care

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 an initial hospital visit for the services provided on that date. The physician may not bill the hospital observation discharge management code (code 99217) 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.

E. Hospital Observation Services During Global Surgical Period

The global surgical fee includes payment for hospital observation (codes 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, and 99236) 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. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

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

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. The inpatient hospital visit descriptors contain the phrase “per day” which means that the code and the payment

established for the code represent all services provided on that date. The physician should select a code that reflects all services provided during the date of the service.

7-58

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, then the nursing facility codes apply.

30.6.9.1 - Payment for Initial Hospital Care Services and Observation or Inpatient Care Services (Including Admission and Discharge Services) (Rev. 2282, Issued: 08-26-11, Effective: 01-01-11, Implementation: 11-28-11)

A. Initial Hospital Care From Emergency Room

A/B MACs (B) pay for an initial hospital care service if a physician sees a patient in the emergency room and decides to admit the person to the hospital. They do not pay for both E/M services. Also, they do not pay for an emergency department visit by the same physician 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 physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission.

B. Initial Hospital 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 on the next date, even if fewer than 24 hours has elapsed between the visit and the admission.

C. Initial Hospital Care and Discharge on Same Day

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

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

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



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 history, 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.

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 History and Physical That Is Less Than Comprehensive

When a physician performs a visit that meets the definition of a Level 5 office visit several days prior to an admission and on the day of admission performs less than a comprehensive history and physical, he or she should report the office visit that reflects the services furnished and also report the lowest level initial hospital care code (i.e., code 99221) for the initial hospital admission. A/B MACs (B) pay the office visit as billed and the Level 1 initial hospital care code.

Physicians who provide an initial visit to a patient during inpatient hospital care that meets the minimum key component work and/or medical necessity 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 minimum key component work and/or medical necessity requirements. Physicians must meet all the requirements of the initial hospital care codes, including “a detailed or comprehensive history” and “a detailed or comprehensive

Subsequent hospital care CPT codes 99231 and 99232, respectively, require “a problem focused interval history” and “an expanded problem focused interval history.” An E/M service that could be described by CPT consultation code 99251 or 99252 could potentially meet the component work and medical necessity requirements to report 99231 or 99232. Physicians may report a subsequent hospital care CPT code for services that were reported as CPT consultation codes (99241 - 99255) prior to January 1, 2010, 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.

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 Visit and Hospital Discharge Day Management (Codes 99231 - 99239)

(Rev. 1460, Issued: 02-22-08, Effective: 04-01-08, Implementation: 04-07-08)

A. Subsequent Hospital Visits During the Global Surgery Period

(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 Discharge Day Management Service

Hospital 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 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 visit.

7-61

Medicare pays for the paperwork of patient discharge day management through the pre- and post- service work of an E/M service.

C. Subsequent Hospital Visit and Discharge Management on Same Day

Pay only the hospital 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 Observation or Inpatient Care Services (Including Admission and Discharge Services CPT Codes 99234 - 99236). A/B MACs (B) do not pay both a subsequent hospital visit in addition to hospital discharge day management service on the same day by the same physician. Instruct physicians that they may not bill for both a hospital visit and hospital discharge management for the same date of service.



D. Hospital 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 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.

E. Hospital Discharge Management and Death Pronouncement

Only the physician who personally performs the pronouncement of death shall bill for the face-to-face Hospital 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)

A. Use of Emergency Department Codes by Physicians Not Assigned to Emergency Department

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.

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 advises the emergency department physician by telephone, then the patient's personal physician may not bill.

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. 7-64

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 that date. Thereafter, the physician or NPP will report CPT code 99292 for additional 30-minute time increments provided to the same patient.

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

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).

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

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). **7-86**

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 75 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.

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 pre-operatively, 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).

7-67

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

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

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 scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration and physician supervision shall be met.

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/Mentally Retarded) 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.

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



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.

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.

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.

7-70

Beginning January 1, 2006, the new CPT code, Other Nursing Facility Service (99318), may be used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. For Medicare Part B payment policy, an annual nursing facility assessment visit code may substitute as meeting one of the federally mandated physician visits if the code requirements for CPT code 99318 are fully met and in lieu of reporting a Subsequent Nursing Facility Care, per day, service (codes 99307 - 99310). It shall not be performed in addition to the required number of federally mandated physician visits. The new CPT annual assessment code does not represent a new benefit service for Medicare Part B physician services.

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.

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. **7-74**

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.

F. Use of the Prolonged Services Codes and Other Time-Related Services

Beginning January 1, 2008, typical/average time units for E/M visits in the SNF/NF settings are reestablished. Medically necessary prolonged services for E/M visits (codes 99356 and 99357) in a SNF or NF may be billed with the Nursing Facility Services in the code ranges (99304 - 99306, 99307 - 99310 and 99318).

Counseling and Coordination of Care Visits

With the reestablishment of typical/average time units, medically necessary E/M visits for counseling and coordination of care, for Nursing Facility Services in the code ranges (99304 - 99306, 99307 - 99310 and 99318) that are time-based services, may be billed with the appropriate prolonged services codes (99356 and 99357).

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.

7-72

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.*

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. 7-73

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 to be 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 and Standby Services (Codes 99354 - 99360), and Evaluation and Management service for Power Mobility Devices (PMDs) (G0372)

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

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



30.6.15.1 - Prolonged Services With Direct Face-to-Face Patient Contact Service (ZZZ codes)

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

Prolonged physician services (CPT code 99354) in the office or other outpatient setting with direct face-to-face patient contact which require 1 hour beyond the usual service are payable when billed on the same day by the same physician or qualified nonphysician practitioner (NPP) as the companion evaluation and management codes. The time for usual service refers to the typical/average time units associated with the companion evaluation and management service as noted in the CPT code. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99355.

Prolonged physician services (code 99356) in the inpatient setting, with direct face-to-face patient contact which require 1 hour beyond the usual service are payable when they are billed on the same day by the same physician or qualified NPP as the companion evaluation and management codes. Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99357.

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

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

B. Required Companion Codes

The companion evaluation and management codes for 99354 are the Office or Other Outpatient visit codes (99201 - 99205, 99212 - 99215), the Domiciliary, Rest Home, or Custodial Care Services codes (99324 - 99328, 99334 - 99337), the Home Services codes (99341 - 99345, 99347 - 99350);

The companion codes for 99355 are 99354 and one of the evaluation and management codes required for 99354 to be used;

The companion evaluation and management codes for 99356 are the Initial Hospital Care codes and Subsequent Hospital Care codes (99221 - 99223, 99231 - 99233); Nursing Facility Services codes (99304 - 99318); or

The companion codes for 99357 are 99356 and one of the evaluation and management codes required for 99356 to be used.

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

C. Requirement for Physician Presence

Physicians may count only the duration of direct face-to-face contact between the physician and the patient (whether the service was continuous or not) beyond the typical/average time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable. In the case of prolonged office services, time spent by office staff with the patient, or time the patient remains unaccompanied in the office cannot be billed. In the case of prolonged hospital services, time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient, or waiting for test results, for changes in the patient's condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services.

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

E. Use of the Codes

Prolonged services codes can be billed only if the total duration of the physician or qualified NPP direct face-to-face service (including the visit) equals or exceeds the threshold time for the evaluation and management service the physician or qualified NPP provided (typical/average time associated with the CPT E/M code plus 30 minutes). If the total duration of direct face-to-face time does not equal or exceed the threshold time for the level of evaluation and management service the physician or qualified NPP provided, the physician or qualified NPP may not bill for prolonged services.

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

If the total direct face-to-face time equals or exceeds the threshold time for code 99354, but is less than the threshold time for code 99355, the physician should bill the evaluation and management visit code and code 99354. No more than one unit of 99354 is acceptable. If the total direct face-to-face time equals or exceeds the threshold time for code 99355 by no more than 29 minutes, the physician should bill the visit code 99354 and one unit of code 99355. One additional unit of code 99355 is billed for each additional increment of 30 minutes extended duration. A/B MACs (B) use the following threshold times to determine if the prolonged services codes 99354 and/or 99355 can be billed with the office or other outpatient settings including domiciliary, rest home, or custodial care services and home services codes.

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

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355
99201	10	40	85
99202	20	50	95
99203	30	60	105
99204	45	75	120
99205	60	90	135
99212	10	40	85
99213	15	45	90
99214	25	55	100
99215	40	70	115
99324	20	50	95
99325	30	60	105

Code	Typical Time for Code	Threshold Time to Bill Code 99354	Threshold Time to Bill Codes 99354 and 99355	7-76
99326	45	75	120	
99327	60	90	135	
99328	75	105	150	
99334	15	45	90	
99335	25	55	100	
99336	40	70	115	
99337	60	90	135	
99341	20	50	95	
99342	30	60	105	
99343	45	75	120	
99344	60	90	135	
99345	75	105	150	
99347	15	45	90	
99348	25	55	100	
99349	40	70	115	
99350	60	90	135	

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

G. Threshold Times for Codes 99356 and 99357

(Inpatient Setting) If the total direct face-to-face time equals or exceeds the threshold time for code 99356, but is less than the threshold time for code 99357, the physician should bill the visit and code 99356. A/B MACs (B) do not accept more than one unit of code 99356. If the total direct face-to-face time equals or exceeds the threshold time for code 99356 by no more than 29 minutes, the physician bills the visit code 99356 and one unit of code 99357. One additional unit of code 99357 is billed for each additional increment of 30 minutes extended duration. A/B MACs (B) use the following threshold times to determine if the prolonged services codes 99356 and/or 99357 can be billed with the inpatient setting codes.

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

Code	Typical Time for Code	Threshold Time to Bill Code 99356	Threshold Time to Bill Codes 99356 and 99357
99221	30	60	105
99222	50	80	125
99223	70	100	145
99231	15	45	90
99232	25	55	100

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

When an evaluation and management service is dominated by counseling and/or coordination of care (the counseling and/or coordination of care represents more than 50% of the total time with the patient) in a face-to-face encounter between the physician or qualified NPP and the patient in the office/clinic or the floor time (in the scenario of an inpatient service), then the evaluation and management code is selected based on the typical/average time associated with the code levels. The time approximation must meet or exceed the specific CPT code billed (determined by the typical/average time associated with the evaluation and management code) and should not be “rounded” to the next higher level.

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

I. Examples of Billable Prolonged Services

EXAMPLE 1

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

EXAMPLE 2

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

EXAMPLE 3

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

J. Examples of Nonbillable Prolonged Services

EXAMPLE 1

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

EXAMPLE 2

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

EXAMPLE 3

A physician provided a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician cannot code 99214, which has a typical

time of 25 minutes, and one unit of code 99354. The physician must bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services. **7-78**

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

(Rev. 3678, Issued: 12-16-16, Effective: 01-01-17, Implementation: 01-03-17)

Until CY 2017, CPT codes 99358 and 99359 were not separately payable and were bundled (included for payment) under the related face-to-face E/M service code. Practitioners were not permitted to bill the patient for services described by CPT codes 99358 and 99359 since they are Medicare covered services and payment was included in the payment for other billable services.

Beginning in CY 2017, CPT codes 99358 and 99359 are separately payable under the physician fee schedule. The CPT prefatory language and reporting rules for these codes apply for Medicare billing. For example, CPT codes 99358 and 99359 cannot be reported during the same service period as complex chronic care management (CCM) services or transitional care management services. They are not reported for time spent in non-face-to-face care described by more specific codes having no upper time limit in the CPT code set. We have posted a file that notes the times assumed to be typical for purposes of PFS rate-setting. That file is available on our website under downloads for our annual regulation at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>. We note that while these typical times are not required to bill the displayed codes, we would expect that only time spent in excess of these times would be reported under CPT codes 99358 and 99359. We note that CPT codes 99358 and 99359 can only be used to report extended qualifying time of the billing physician or other practitioner (not clinical staff). Prolonged services cannot be reported in association with a companion E/M code that also qualifies as the initiating visit for CCM services. Practitioners should instead report the add-on code for CCM initiation, if applicable.

30.6.15.3 - Physician Standby Service (Code 99360)

(Rev. 1, 10-01-03)

Standby services are not payable to physicians. Physicians may not bill Medicare or beneficiaries for standby services. Payment for standby services is included in the Part A payment to the facility. Such services are a part of hospital costs to provide quality care. If hospitals pay physicians for standby services, such services are part of hospital costs to provide quality care.

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. **7-79**

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

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 our regulations.

B. Definition of Substantive Portion



(1) More Than Half of the Total Time

Beginning January 1, 2023, substantive portion means more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

During a transitional year from January 1, 2022 through December 31, 2022, except for critical care visits, the substantive portion can be one of the three key E/M visit components (history, 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 2022, the practitioner who spends more than half of the total time, or performs the history, exam, 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 2022, 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 and both practitioners take part of the history, the billing practitioner must perform the level of history

required to select the visit level billed. If physical exam is used as the substantive portion and both practitioners examine the patient, the billing practitioner must perform the level of exam required to select the visit level billed. 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. **7-80**

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 Definition of Substantive Portion	2023 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 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).

7-81

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

Beginning January 1, 2023, the physician or practitioner who spent more than half the total time (the substantive portion starting in 2023) 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.

During the transitional calendar year 2022, when practitioners use a key component as the substantive portion, there will need to be different approaches for hospital outpatient E/M visits than other kinds of E/M visits:

- For shared hospital outpatient visits where practitioners use a key component as the substantive portion, prolonged services can be reported by the practitioner who reports the primary service, when the combined time of both practitioners meets the threshold for reporting prolonged hospital outpatient services (HCPCS code G2212).
- For all other types of E/M visits (except emergency department and critical care visits), prolonged services can be reported by the practitioner who reports the primary service, when the combined time of both practitioners meets the threshold for reporting prolonged E/M services other than office/outpatient E/M visits (60 or more minutes beyond the typical time in the CPT code descriptor of the primary service). (Emergency department and critical care visits are not reported as prolonged services).

We summarize these policies in the following table.



E/M Visit Code Family	2022		2023
	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 HCPCS G2212	Combined time of both practitioners must meet the threshold for reporting HCPCS G2212	Combined time of both practitioners must meet the threshold for reporting HCPCS G2212
Inpatient/Observation/Hospital/SNF	Combined time of both practitioners must meet the threshold for reporting CPT 99354-9 (60+ minutes > typical)	Combined time of both practitioners must meet the threshold for reporting CPT 99354-9 (60+ minutes > typical)	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 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.

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.

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

Field 16 of the Medicare Fee Schedule Data Base (MFSDB) provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY.

Codes with “090” in Field 16 are major surgeries. Codes with “000” or “010” are either minor surgical procedures or endoscopies.

Codes with “YYY” are A/B MAC (B)-priced codes, for which A/B MACs (B) determine the global period (the global period for these codes will be 0, 10, or 90 days). Note that not all A/B MAC (B)-priced codes have a “YYY” global surgical indicator; sometimes the global period is specified.

While codes with “ZZZ” are surgical codes, they are add-on codes that are always billed with another service. There is no postoperative work included in the fee schedule payment for the “ZZZ” codes. Payment is made for both the primary and the add-on codes, and the global period assigned is applied to the primary code.

A. Components of a Global Surgical Package **B3-15011, B3-4820-4831**

A/B MACs (B) apply the national definition of a global surgical package to all procedures with the appropriate entry in Field 16 of the MFSDB.

The Medicare approved amount for these procedures includes payment for the following services related to the surgery when furnished by the physician who performs the surgery. The services included in the global surgical package may be furnished in any setting, e.g., in hospitals, ASCs, physicians’ offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, critical care services (CPT codes 99291 and 99292) are payable separately in some situations. (See section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.)

- Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
- Intra-operative Services - Intra-operative services that are normally a usual and necessary part of a surgical procedure;

- Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;
- Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
- Postsurgical Pain Management - By the surgeon;
- Supplies - Except for those identified as exclusions; and
- Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

B. Services Not Included in the Global Surgical Package

A/B MACs (B) do not include the services listed below in the payment amount for a procedure with the appropriate indicator in Field 16 of the MFSDB. These services may be paid for separately.

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Please note that this policy only applies to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure;
- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record;
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
- Diagnostic tests and procedures, including diagnostic radiological procedures;
- Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy (codes 61533, 61534-61536, 61539, 61541, and 61543) which may be performed in succession within 90 days of each other;
- Treatment for postoperative complications which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR);
- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;
- For certain services performed in a physician's office, separate payment can no longer be made for a surgical tray (code A4550). This code is now a Status B and is no longer a separately payable service on or after January 1, 2002. However, splints and casting supplies are payable separately under the reasonable charge payment methodology;
- Immunosuppressive therapy for organ transplants; and
- Critical care services (CPT codes 99291 and 99292) unrelated to the surgery, for example, where a seriously injured or burned patient is critically ill and requires constant attendance of the physician. See section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.

Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.

A postoperative period of 10 days applies to some minor surgeries. The postoperative period for these procedures is indicated in Field 16 of the MFSDB. If the Field 16 entry is 010, A/B MACs (B) do not allow separate payment for postoperative visits or services within 10 days of the surgery that are related to recovery from the procedure. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is payable separately. Services by other physicians are not included in the global fee for a minor procedures except as otherwise excluded. If the Field 16 entry is 000, postoperative visits beyond the day of the procedure are not included in the payment amount for the surgery. Separate payment is made in this instance.

See section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.

D. Physicians Furnishing Less Than the Full Global Package B3-4820-4831

There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative, post-discharge care is split between two or more physicians where the physicians agree on the transfer of care.

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global allowed amount).

Where a transfer of care does not occur, the services of another physician may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case.

E. Determining the Duration of a Global Period

To determine the global period for major surgeries, A/B MACs (B) count 1 day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.

EXAMPLE:

Date of surgery - January 5

Preoperative period - January 4

Last day of postoperative period - April 5

To determine the global period for minor procedures, A/B MACs (B) count the day of surgery and the appropriate number of days immediately following the date of surgery.

EXAMPLE:

Procedure with 10 follow-up days:

Date of surgery - January 5

Last day of postoperative period - January 15

40.2 - Billing Requirements for Global Surgeries

To ensure the proper identification of services that are, or are not, included in the global package, the following procedures apply.

A. Procedure Codes and Modifiers

Use of the modifiers in this section apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers “-22” and “-25”).

1. Physicians Who Furnish the Entire Global Surgical Package

Physicians who perform the surgery and furnish all of the usual pre-and postoperative work bill for the global package by entering the appropriate CPT code for the surgical procedure only. Billing is not allowed for visits or other services that are included in the global package.

2. Physicians in Group Practice

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician. (For dates of service prior to January 1, 1994, however, where a new physician furnishes the entire postoperative care, the group billed for the surgical care and the postoperative care as separate line items with the appropriate modifiers.)

3. Physicians Who Furnish Part of a Global Surgical Package

Where physicians agree on the transfer of care during the global period, the following modifiers are used:

- “-54” for surgical care only; or
- “-55” for postoperative management only.

Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier.

Providers need not specify on the claim that care has been transferred. However, the date on which care was relinquished or assumed, as applicable, must be shown on the claim. This should be indicated in the remarks field/free text segment on the claim form/format. Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary’s medical record.

Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service. Once the physician has seen the patient, that physician may bill for the period beginning with the date on which he/she assumes care of the patient.

EXCEPTIONS:

- Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate evaluation and management code. No modifiers are necessary on the claim.
- If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care bills using subsequent hospital

care codes for the inpatient hospital care and the surgical code with the “-55” modifier for the post-discharge care. The surgeon bills the surgery code with the “-54” modifier. **7-87**

- Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier.
- If the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate evaluation and management code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular conditions of a patient.



4. Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery

Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.

In addition to the CPT evaluation and management code, modifier “-57” (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery. (Modifier “-QI” was used for dates of service prior to January 1, 1994.)

If evaluation and management services occur on the day of surgery, the physician bills using modifier “-57,” not “-25.” The “-57” modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.

5. Return Trips to the Operating Room During the Postoperative Period

When treatment for complications requires a return trip to the operating room, physicians must bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unspecified procedure code in the correct series, i.e., 47999 or 64999. The procedure code for the original surgery is not used except when the **identical** procedure is repeated.

In addition to the CPT code, physicians use CPT modifier “-78” for these return trips (return to the operating room for a related procedure during a postoperative period.)

The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first procedure and requires the use of the operating room, this circumstance may be reported by adding the modifier “-78” to the related procedure.

NOTE: The CPT definition for this modifier does not limit its use to treatment for complications.

6. Staged or Related Procedures

Modifier “-58” was established to facilitate billing of staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.

The physician may need to indicate that the performance of a procedure or service during the postoperative period was:

7-88

- a. Planned prospectively or at the time of the original procedure;
- b. More extensive than the original procedure; or
- c. For therapy following a diagnostic surgical procedure.

These circumstances may be reported by adding modifier “-58” to the staged procedure. A new postoperative period begins when the next procedure in the series is billed.

7. Unrelated Procedures or Visits During the Postoperative Period

Modifiers were established to simplify billing for visits and other procedures which are furnished during the postoperative period of a surgical procedure, but which are not included in the payment for the surgical procedure.

Modifier “-79”: Reports an unrelated procedure by the same physician during a postoperative period. The physician may need to indicate that the performance of a procedure or service during a postoperative period was unrelated to the original procedure.

A new postoperative period begins when the unrelated procedure is billed.

Modifier “-24”: Reports an unrelated evaluation and management service by same physician during a postoperative period. The physician may need to indicate that an evaluation and management service was performed during the postoperative period of an unrelated procedure. This circumstance is reported by adding the modifier “-24” to the appropriate level of evaluation and management service.

Services submitted with the “-24” modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. A diagnosis code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

A physician who is responsible for postoperative care and has reported and been paid using modifier “-55” also uses modifier “-24” to report any unrelated visits.

For critical care visits that are unrelated to the surgical procedure and performed postoperatively, report modifier –FT as discussed in section 30.6.12.7 of this chapter.

8. Significant Evaluation and Management on the Day of a Procedure



Modifier “-25” is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made.

It is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier “-25” to the appropriate level of evaluation and management service.

Claims containing evaluation and management codes with modifier “-25” are not subject to prepayment review except in the following situations:

- Effective January 1, 1995, all evaluation and management services provided on the same day as inpatient dialysis are denied without review with the exception of CPT Codes 99221-99223, 99251-99255, and 99238. These codes may be billed with modifier

“-25” and reviewed for possible allowance if the evaluation and management service is unrelated to the treatment of ESRD and was not, and could not, have been provided during the dialysis treatment;

7-89

- When preoperative critical care codes are being billed within a global surgical period; and
 - When A/B MACs (B) have conducted a specific medical review process and determined, after reviewing the data, that an individual or group has high statistics in terms of the use of modifier “-25,” have done a case-by-case review of the records to verify that the use of modifier “-25” was inappropriate, and have educated the individual or group as to the proper use of this modifier.

For critical care visits that are unrelated to the surgical procedure but performed on the same day, report modifier -FT as discussed in section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.

9. Critical Care



Critical care services provided during a global surgical period must be unrelated to a surgical procedure and appended with the modifier -FT. For further information see section 30.6.12.7 of this chapter for further discussion of critical care visits unrelated to the procedure with a global surgical period.

10. Unusual Circumstances

Surgeries for which services performed are significantly greater than usually required may be billed with the “-22” modifier added to the CPT code for the procedure. Surgeries for which services performed are significantly less than usually required may be billed with the “-52” modifier. The biller must provide:

- A concise statement about how the service differs from the usual; and
- An operative report with the claim.

Modifier “-22” should only be reported with procedure codes that have a global period of 0, 10, or 90 days. There is no such restriction on the use of modifier “-52.”

B. Date(s) of Service

Physicians, who bill for the entire global surgical package or for only a portion of the care, must enter the date on which the surgical procedure was performed in the “From/To” date of service field. This will enable A/B MACs (B) to relate all appropriate billings to the correct surgery. Physicians who share postoperative management with another physician must submit additional information showing when they assumed and relinquished responsibility for the postoperative care. If the physician who performed the surgery relinquishes care at the time of discharge, he or she need only show the date of surgery when billing with modifier “-54.”

However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician. The physician providing the remaining postoperative care must show the date care was assumed. This information should be shown in Item 19 on the paper Form CMS-1500. See the related implementation guide for where to show this information on the ASC X12 837 professional claim transaction format.

C. Care Provided in Different Payment Localities

April 7, 2022

FAQs: Split (or Shared) Visits and Critical Care Services

The following Frequently Asked Questions (FAQs) address frequent questions we received regarding recent policy revisions for payment of split (or shared) visits and critical care services under the Medicare Physician Fee Schedule (PFS).

Split (or Shared) Services

Q1. Under the new policies effective January 1, 2022, can a split (or shared) visit be billed for visits furnished in a Nursing Facility (NF) setting?

A1. No, a split (or shared) visit cannot be billed for visits furnished in a NF setting. We revised our regulation at 42 CFR § 415.140 to define a split (or shared) visit as an E/M visit in a facility setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is not available under § 410.26(b)(1).

Critical Care Services (CPT 99291 and 99292)

Q1. Under CMS policy, what is the time duration for the correct reporting of critical care services by a single physician or NPP (CPT codes 99291 and 99292)?

A1. Our CY 2022 final rule provides that the physician or NPP will report CPT code 99291 for the first 30–74 minutes of critical care services provided to a patient on a given date. Thereafter, the physician or NPP will report CPT code 99292 for additional 30-minute time increments provided to the same patient.

Q2. Does the CY 2022 final rule provide that a physician or NPP providing critical care services to a patient on a given date may report CPT code 99291 once 30 minutes has been reached?

A2. Yes, 99291 can be billed by a physician or NPP providing critical care services to a patient on a given date if between 30-74 minutes is spent.

Q3. Does the CY 2022 final rule provide that a physician or NPP spending more than 74 minutes providing critical care services to a patient on a given date may report CPT code 99292?

A3. No, as finalized in the CY 2022 rule a physician or NPP spending more than 74 minutes providing critical care services to a patient on a given date may report CPT code 99292 only when they have spent a whole additional 30-minute time increment (in other words, when 104 minutes have been spent), and may bill 99292 for each additional 30-minute time increment completed.

April 7, 2022


Q4. Do I have to report modifier FT on a claim for critical care services when a decision for surgery is made?

A4. Yes, the modifier must be reported. Critical care must be unrelated to the surgery in order to be separately paid, even if a decision for surgery is made during the critical care visit.

Version 02/15/2023
Check for Updates

practitioners would not need to re-record these elements (or parts thereof) if there is evidence that the practitioner reviewed and updated the previous information.

Comment: Commenters were very supportive of this proposal. Many commenters included this proposal in a list of appropriate changes CMS should make immediately regarding documentation of E/M visits, effective January 1, 2019.

 *Response:* We are finalizing this policy to simplify the documentation of history and exam for established patients for E/M office/outpatient visits as proposed, effective January 1, 2019. Accordingly, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so. We note that this policy to simplify and reduce redundancy in documentation is optional for practitioners, and they may choose to continue the current process of entering, re-entering and bringing forward information (83 FR 35838). The option to continue current documentation processes may be particularly important for practitioners who lack time to adjust workflows, templates and other aspects of their work by January 1, 2019.

We solicited comment on whether there may be ways to implement a similar provision for any aspects of medical decision-making, or for new patients, such as when prior data is available to the billing practitioner through an interoperable EHR or other data exchange. We stated our belief that there would be special challenges in realizing documentation efficiencies with new patients, since they may not have received exams or histories that were complete or relevant to the current complaint(s), and the information in the transferred record could be more likely to be incomplete, outdated or inaccurate.


Comment: A few commenters indicated that there might be ways to recognize some documentation efficiencies for referred new patients or situations where data are available through an interoperable EHR, but did not provide detail about what kinds of data are commonly available and how they might be relevant to the receiving

practitioner for purposes of visit documentation.

Response: We appreciate the commenters' feedback in this area and will continue to consider this issue.

We similarly proposed that for both new and established patients, practitioners would no longer be required to re-enter information in the medical record regarding the chief complaint and history that are already entered by ancillary staff or the beneficiary. The practitioner could simply indicate in the medical record that they reviewed and verified this information. Our goal was to allow practitioners more flexibility to exercise greater clinical judgment and discretion in what they document, focusing on what is clinically relevant and medically necessary for the patient.

Comment: Commenters were very supportive of this proposal. Many commenters included this proposal in a list of appropriate changes CMS should make immediately regarding documentation of E/M visits, effective January 1, 2019.

 *Response:* We are finalizing our proposal that, effective January 1, 2019, for new and established patients for E/M office/outpatient visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information. We note that this policy to simplify and reduce redundancy in documentation is optional for practitioners, and they may choose to continue the current process of entering, re-entering and bringing forward information (83 FR 35838). The option to continue current documentation processes may be particularly important for practitioners who lack time to adjust workflows, templates and other aspects of their work by January 1, 2019.

(c) Podiatry Visits

As described in the CY 2019 PFS proposed rule (83 FR 35843), as part of our proposal to improve payment accuracy by creating a single PFS payment rate for E/M visit levels 2 through 5 (with one proposed rate for new patients and one proposed rate for established patients), we proposed to create separate coding for podiatry visits that are currently reported as E/M office/outpatient visits. We proposed that, rather than reporting visits under the general E/M office/outpatient visit code set, podiatrists would instead report visits under new G-codes that

more specifically identify and value their services. We proposed to apply substantially the same documentation standards for these proposed new podiatry-specific codes as we proposed for other office/outpatient E/M visits.

If a practitioner chose to use time to document a podiatry office/outpatient E/M visit, we proposed to apply substantially the same rules as those we proposed for documenting on the basis of time for other office/outpatient E/M visits. For practitioners choosing to use time to provide supporting documentation for the podiatry visit, we would require documentation supporting the medical necessity of the visit and showing the total amount of time spent by the billing practitioner face-to-face with the patient. We solicited public comment on what that total time would be for payment of the proposed new podiatry G-codes. The typical times for these proposed codes were 22 minutes for an established patient and 28 minutes for a new patient, and we noted we could use these times. Alternatively, we noted we could apply the AMA's CPT codebook provision that, for timed services, a unit of time is attained when the mid-point is passed,⁶ such that we would require documentation that at least 12 minutes for an established patient (more than half of 22 minutes) or at least 15 minutes for a new patient (more than half of 28 minutes) were spent face-to-face by the billing practitioner with the patient, to support making payment for these codes when the practitioner chose to document the visit using time. We solicited comment on the use of time as a basis for documentation of our proposed podiatric E/M visit codes, and whether we should adopt any of these approaches or further specify other requirements with respect to this proposed option for podiatric practitioners to document their visits using time.

Comment: We did not receive any comments on how the proposed podiatric codes should be documented. A few commenters noted that our proposal to apply the same documentation rules to the proposed new podiatric codes as for all other office/outpatient E/M visits demonstrated that these visits were essentially the same, and that podiatry should not be singled out for the creation of separate codes.

Response: We believe the absence of comments on our proposals for documentation of the proposed podiatric codes is due to a lack of general support for creation of the new

⁶ 2017 CPT Codebook Introduction, p.xv.



Behavioral Health Integration Services



What's Changed?

No substantive content updates.

Table of Contents

Background	3
General BHI	6
Eligible Conditions	7
Relationships and Roles of Care Team Members	7
Table 1. BHI Coding Summary	9
Need More Information?	11
Resources	12

Version 02/15/2023
Check for Updates

The medical community now widely considers integrating behavioral health care with primary care (behavioral health integration or BHI) an effective strategy for improving outcomes for millions of Americans with mental or behavioral health conditions. Medicare makes separate payment to physicians and non-physician practitioners for BHI services they supply to patients over a calendar month service period.

BHI is a type of care management service. In recent years, CMS updated the Medicare Physician Fee Schedule (MPFS) policies to improve payment for care management services. Working with the CPT Editorial Panel and other clinicians, CMS expanded the suite of codes describing care management services. New codes describe services that involve direct patient contact (that is in-person, face-to-face services) or that don't involve direct patient contact; that represent a single encounter, a monthly service, or both; that are timed services; that address specific conditions; and that represent the work of the billing practitioner, auxiliary personnel (specifically, clinical staff), or both.

Background

On January 1, 2017, Medicare began making separate payment to physicians and non-physician practitioners supplying BHI services using the Psychiatric Collaborative Care Model (CoCM) approach to patients during a calendar month. The following year (CY 2018), Medicare began making payment for these services using CPT codes 99492, 99493, and 99494, and established payment for general BHI services using models of care other than CoCM.

In the [CY 2021 MPFS Final Rule \(CMS-1734-F\)](#), CMS added a new BHI service by refining coding for CoCM services. On January 1, 2021, CMS began making payment for the services of HCPCS code G2214 (Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional).

CMS developed HCPCS code G2214 in response to requests from stakeholders who reported the need for additional coding to capture shorter increments of time spent with a patient. This type of situation may occur, for example, when a patient is seen for services, but is then hospitalized or referred for specialized care and the number of minutes required to bill for services using the current coding isn't met. Thus, to accurately account for these resources, CMS created HCPCS code G2214.

CPT Disclaimer-American Medical Association (AMA) Notice

CPT codes, descriptions and other data only are copyright 2021 American Medical Association. All Rights Reserved. Applicable FARS/HHSAR apply.

CPT only copyright 2021 American Medical Association. All rights reserved.

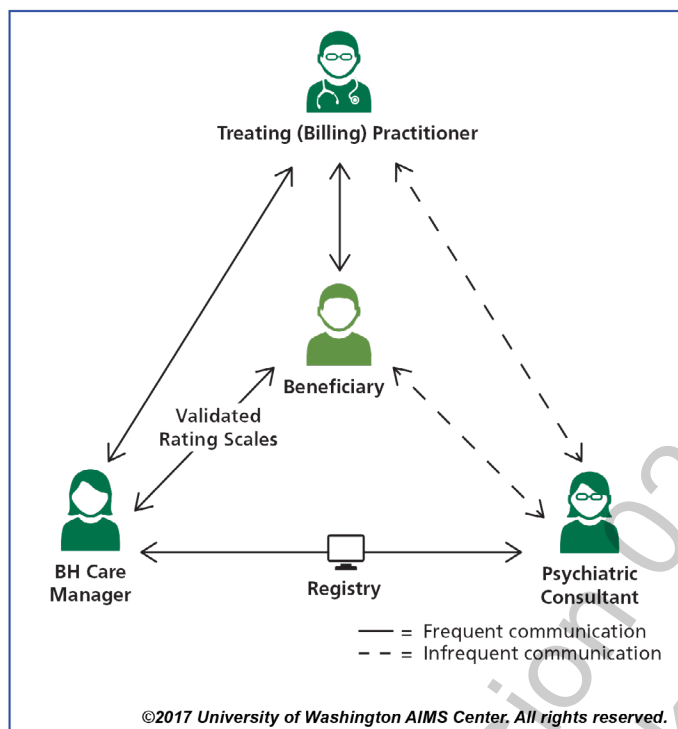
CPT is a registered trademark of the American Medical Association. Applicable FARS/HHSAR Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Psychiatric Collaborative Care Model (CoCM)

Use CPT codes 99492, 99493, and 99494, and HCPCS code G2214 to bill for monthly services delivered using the CoCM, an approach to BHI shown to improve outcomes in multiple studies.

What is CoCM? This figure is a model of behavioral health integration that enhances usual primary care by adding 2 key services to the primary care team, particularly patients whose conditions aren't improving:



- Care management support for patients receiving behavioral health treatment
- Regular psychiatric inter-specialty consultation
- A team of 3 individuals deliver CoCM: the Behavioral Health Care Manager, the Psychiatric Consultant and the Treating (Billing) Practitioner

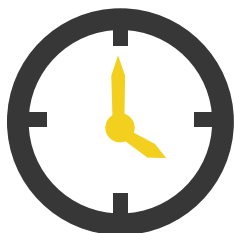
Care Team Members



- **Treating (Billing) Practitioner** – A physician or non-physician practitioner (physician assistant or nurse practitioner); typically primary care, but may be of another specialty (for example, cardiology, oncology)
- **Behavioral Health Care Manager** – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner
- **Psychiatric Consultant** – A medical professional trained in psychiatry and qualified to prescribe the full range of medications
- **Patient** – The patient is a member of the care team

Service Components

- The primary care team (billing practitioner and behavioral health care manager) initial assessment
 - Administration of validated rating scale(s)
- The primary care team's joint care planning with the patient, with care plan revision for patients whose condition isn't improving adequately. Treatment may include pharmacotherapy, psychotherapy, or other indicated treatments
- Behavioral health care manager following up proactively and systematically using validated rating scales and a registry



- Assesses treatment adherence, tolerability, and clinical response using validated rating scales; delivers brief evidence-based psychosocial interventions such as behavioral activation or motivational interviewing
- 70 minutes of behavioral health care manager time the first month
- 60 minutes following months
- Add-on code for 30 more minutes any month
- Regular case load review with psychiatric consultant:
 - The primary care team regularly (at least weekly) reviews the patient's treatment plan and status with the psychiatric consultant
 - The primary care team continues or adjusts treatment, including referral to behavioral health specialty care, as needed

General BHI

Providers use CPT code 99484 to bill monthly services delivered using BHI models of care other than CoCM that also include service elements such as systematic assessment and monitoring, care plan revision for patients whose condition isn't improving adequately, and a continuous relationship with an appointed care team member.

You may also use CPT code 99484 to report models of care that do not involve a psychiatric consultant, or an appointed behavioral health care manager (although these personnel may deliver General BHI services). CMS expects to refine this code over time, as more information becomes available about other BHI care models in use.

Service Components

- Initial assessment
 - Administration of applicable validated rating scale(s)
- Systematic assessment and monitoring, using applicable validated clinical rating scales
- The primary care team's joint care planning with the patient, with care plan revision for patients whose condition is not improving
- Facilitation and coordination of behavioral health treatment
- Continuous relationship with an appointed member of the care team

Note: Psychiatric consultants and other members of the care team are allowed to provide certain services remotely under the BHI codes.

Care Team Members



- **Treating (Billing) Practitioner** – A physician or non-physician practitioner (PA, NP, CNS, CNM); typically primary care, but may be of another specialty (for example, cardiology, oncology, psychiatry).
- **Patient** – The patient is a member of the care team.
- **Potential Clinical Staff** – The billing practitioner delivers the service in full or uses qualified clinical staff to deliver services using a team-based approach. Clinical staff includes contractors who meet the qualifications for the CoCM behavioral health care manager or psychiatric consultant.

CPT only copyright 2021 American Medical Association. All rights reserved.

Eligible Conditions

Medicare classifies eligible conditions as any mental, behavioral health, or psychiatric condition treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, calls for BHI services. The patient may have pre-existing conditions, or the billing practitioner may make the diagnosis(es) and refine them over time.

Patients may, but aren't required to have, comorbid, chronic, or other medical condition(s) that are managed by the billing practitioner.

Relationships and Roles of Care Team Members

Providers use BHI codes to bill and get paid for services using models of care with well-defined roles and relationships among the care team members. The following roles and relationships describe all BHI services unless noted.

Incident To

Medicare considers BHI services delivered by other members of the care team, under the direction of the billing practitioner, incident to the billing practitioner's services. These services are subject to the state law, licensure, and scope of practice that applies to their practice specialty. The billing practitioner either contracts with or employs the other care team members. Medicare pays the billing practitioner directly.

Initiating Visit

Medicare requires an initiating visit for new patients or patients not seen within 1 year prior to start of BHI services. This visit establishes the patient's relationship with the billing practitioner and ensures the billing practitioner assesses the patient prior to starting BHI services.

Treating (Billing) Practitioner



- Directs the behavioral health care manager or clinical staff
- Oversees the patient's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed
- Remains involved through ongoing oversight, management, collaboration and reassessment
- May deliver the General BHI service in its entirety

Behavioral Health Care Manager (required for CoCM; optional for General BHI)

- Provides assessment and care management services, including:
 - The administration of validated rating scales
 - Behavioral health care planning concerning behavioral or psychiatric health problems
 - Revisions for patients not progressing or whose status changes
 - Brief psychosocial interventions
 - Ongoing collaboration with the billing practitioner
 - Maintenance of the registry
 - Consultation with the psychiatric consultant
- Has a continuous relationship with the patient
 - Available to deliver services face-to-face with the patient
 - Collaborative, integrated relationship with the rest of the care team
- Can work with the patient outside of regular clinic hours as necessary to perform the behavioral health care manager's duties
- May or may not be a professional who meets all the requirements to independently deliver and report services to Medicare
- Does not include administrative or clerical staff; you don't count time spent in strictly administrative or clerical duties towards the time threshold to bill the BHI codes

Psychiatric Consultant (required for CoCM; optional for General BHI)

- Participates in regular review of clinical status of patients receiving BHI services
- Advises the billing practitioner (and behavioral health care manager) about diagnosis; indicates options for resolving issues with patient adherence and tolerance of behavioral health treatment; makes adjustments to behavioral health treatment for patients who are not progressing; manages any negative interactions between patients' behavioral health and medical treatments
- Can (and typically will) be remotely located; is generally not expected to have direct contact with the patient, prescribe medications or deliver other treatment directly to the patient
- Can and should offer a referral for direct provision of psychiatric care when clinically indicated

Clinical Staff (may be used in provision of General BHI)

- Continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team
- May or may not be a professional who meets all the requirements to independently deliver and report services to Medicare
- Doesn't include administrative or clerical staff time
- May include (but not required to include) a behavioral health care manager or psychiatric consultant

Supervision

Medicare assigns BHI services not personally performed by the billing practitioner as general supervision under the Medicare Physician Fee Schedule (MPFS).^{*} General supervision doesn't, by itself, create a qualifying relationship between the billing practitioner and other members of the care team. Medicare defines general supervision as the service delivered under the overall direction and control of the billing practitioner, and that doesn't require their physical presence during provision of services.

Advance Consent

Prior to beginning BHI services, the patient must give the billing practitioner permission to consult with relevant specialists, which includes talking with a psychiatric consultant. The billing practitioner must inform the patient that cost sharing applies for both face-to-face and non-face-to-face services even if supplemental insurers cover cost sharing. You may get verbal consent from the patient (Medicare doesn't require written consent) but you must document it in the medical record.

^{*}Medicare Physician Fee Schedule (MPFS) payment is available under the MPFS whether the patient spends part or all of the month in a facility stay or institutional setting. Report the place-of-service (POS) where the billing practitioner would ordinarily deliver face-to-face care to the patient. Separate Part B payment can be made to hospitals (including critical access hospitals) when the billing practitioner reports a hospital outpatient POS.

Table 1. BHI Coding Summary

BHI Codes	Behavioral Health Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
Add-On CoCM (Any month) (CPT code 99494)	Each additional 30 minutes per calendar month	13 minutes
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M) _†	N/A	Usual work for the visit code
CoCM First Month (CPT code 99492)	70 minutes per calendar month	30 minutes
CoCM Subsequent Months ^{**} (CPT code 99493)	60 minutes per calendar month	26 minutes

CPT only copyright 2021 American Medical Association. All rights reserved.

BHI Codes	Behavioral Health Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
General BHI (CPT code 99484)	At least 20 minutes per calendar month	15 minutes
Initial or subsequent psychiatric collaborative care management (HPCS code G2214)	30 minutes of behavioral health care manager time per calendar month	Usual work for the visit code

**CoCM is delivered monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).

†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services (TCM).

Full Code Descriptors

CPT code 99484 Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales
- Behavioral health care planning in relation to behavioral or psychiatric health problems, including revision for patients not progressing or whose status changes
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling or psychiatric consultation
- Continuity of care with a designated member of the care team

CPT code 99492 Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and that the treating physician or other qualified health care professional directs, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan
- Review by the psychiatric consultant with modifications of the plan, if recommended
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies

CPT only copyright 2021 American Medical Association. All rights reserved.

CPT code 99493 Follow up psychiatric collaborative care management, first 60 minutes in a following month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation
- Participation in weekly caseload consultation with the psychiatric consultant
- 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
- Other review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations supplied by the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies
- Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms or other treatment goals and are prepared for discharge from active treatment

CPT code 99494 Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and that the treating physician or other qualified health care professional directs (list separately from the code for the primary procedure)

HCPCS code G2214 - Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional:

- Tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant
- 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
- Other review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations supplied by the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies
- Monitoring of patient outcomes using validated rating scales
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment)

Need More Information?

[Find your MAC's website](#)

Resources

- [Agency for Healthcare Research and Quality-Develop a Shared Care Plan](#)
- [BHI FAQs](#)
- [CoCM Implementation Resources](#)
- [CY 2022 Medicare Physician Fee Schedule \(MPFS\) Final Rule](#)
- [Institute for Healthcare Improvement-My Shared Care Plan](#)
- [New England Journal of Medicine \(NEJM\) Catalyst-Making the Comprehensive Shared Care Plan a Reality](#)
- [New England Journal of Medicine \(NEJM\) Medicare Payment for Behavioral Health Integration](#)
- [The Kennedy Forum-A Core Set of Outcome Measures for Behavioral Health Across Service Settings \(Content on Validated Rating Scales pg. 4\)](#)

[Medicare Learning Network® Content Disclaimer, Product Disclaimer, and Department of Health & Human Services Disclosure](#)

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

Frequently Asked Questions About Practitioner Billing for Chronic Care Management Services

Last updated 8/16/2022

This document answers frequently asked questions about billing chronic care management (CCM) services to the Physician Fee Schedule (PFS).

What chronic care management codes are currently billable under the PFS?

Under the Physician Fee Schedule, Medicare will pay for:

- CPT codes 99487 – complex CCM, first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
 - CPT code 99489 – add-on code for CPT code 99487; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
- CPT code 99490 – CCM services, at least 20 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month
 - CPT code 99439 – add-on code for CPT code 99490; each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month; note this code, which was adopted in the CY 2021 PFS final rule, replaced HCPCS code G2058
- CPT code 99491 – CCM services provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month
 - CPT code 99437 – add-on code for CPT code 99491; each additional 30 minutes by a physician or other qualified health care professional, per calendar month

Certain CCM codes describe time spent per calendar month by “clinical staff.” Who qualifies as “clinical staff?”

Practitioners should consult the CPT definition of the term “clinical staff.” In addition, time spent by clinical staff may only be counted if Medicare’s “incident to” rules at 42 CFR 410.26 are met for auxiliary staff (which include clinical staff). Of course, other staff may help facilitate CCM services, but only time spent by clinical staff can be counted towards clinical staff time.

How can pharmacists, social workers, registered dietitians, psychologists, and other nonphysician practitioners (NPPs) who aren’t able to bill directly for CCM engage in CCM services?

There are a number of NPPs who cannot bill directly for CCM, either because they are limited by their scope of practice or because they cannot bill directly for E/M services (including CCM). Under CMS guidelines, many of these NPPs may participate in CCM delivery as “clinical staff”

who can provide CCM services within their scope of practice under general supervision of a qualified NPP, so long as the requirements for “incident to” are met. As a member of the care team, clinical staff may perform activities such as: collect structured data, maintain/inform updates for the care plan, manage care, provide a 24/7 access to care, document CCM services, and provide support services to facilitate CCM.

Can CCM services billed under CPT code 99491 be furnished “incident to” the billing practitioner’s services by other practitioners or clinical staff?

No. As noted in the CY 2019 final rule (83 FR 59577), CPT code 99491 is specifically for use when the billing practitioner personally performs care management services, so this code cannot be furnished incident to a practitioner's professional services.

Can CCM services be completely delegated to clinical staff?

No. The billing practitioner must retain a certain level of involvement in CCM. The CCM service codes for reporting clinical staff time are valued to include a certain amount of ongoing practitioner work, including oversight, management, collaboration, and reassessment by the billing practitioner consistent with the included service elements. This work cannot be delegated or subcontracted to any other individual. Additionally, complex CCM (CPT codes 99487, 99489) includes moderate to high complexity medical decision-making by the billing practitioner during the service period, an activity that cannot be subcontracted to any other individual.

The CCM service codes for reporting services furnished directly by the billing practitioner (CPT code 99491, 99437) cannot be delegated or subcontracted to auxiliary personnel; the work must be personally furnished by the practitioner to be reported.

Can the clinical staff portion of CCM be performed by external third-party companies?

A billing practitioner may arrange to have the clinical staff portion of CCM services provided by clinical staff external to the practice (such as by a case management company) if all of the “incident to” and other rules for billing CCM to the PFS are met. As discussed in the CY 2017 PFS final rule (at 81 FR 80249), if there is little oversight by the billing practitioner or a lack of clinical integration between a third party providing CCM and the billing practitioner, we do not believe CCM could actually be furnished and therefore the practitioner should not bill for CCM.

Can CCM be provided by physicians/NPPs or staff located outside of the United States?

No. Because there is a regulatory prohibition against payment for non-emergency Medicare services furnished outside of the United States (42 CFR 411.9), CCM services cannot be billed if they are provided by individuals located outside of the United States (or provided to beneficiaries who are located outside of the United States).

Does the billing practice have to furnish all of the scope of service elements in a given service period, even those that may not apply to an individual patient?

It is our expectation that all of the scope of service elements will be routinely provided in a given service period, unless a particular service is not medically indicated or necessary (for example, the beneficiary has no hospital admissions that month, so there is no management of a care transition after hospital discharge). Additionally, in order to bill for complex CCM (CPT codes 99487, 99489), it is always necessary that the billing practitioner personally perform moderate to high complexity medical decision-making during the service period, as the CPT code descriptors include these services.

If clinical staff or the practitioner perform CCM activities that will benefit multiple beneficiaries, can a CCM code be billed for each beneficiary?

First, we note that all time counted towards CCM codes must be spent performing activities that are part of the CCM scope of service, as described in the PFS rules. Additionally, Section 1862(a)(1)(A) of the Social Security Act prohibits Medicare payment for services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve function. CCM services are largely designed to be person-centered and focused on individual patient needs.

However, there may be limited circumstances when clinical staff or practitioners provide CCM services to multiple beneficiaries at the same time, or perform a single activity that will benefit multiple beneficiaries. In these instances, the time spent by the clinical staff or practitioner must be split among the beneficiaries. For instance, if a clinical staff person spends 30 minutes on an activity that will benefit three CCM patients (and the activity is reasonable and necessary for all three), the 30-minute time interval would be split among the three beneficiaries. Ten minutes would be counted towards each beneficiary's CCM service time.

What elements are required to be included in the CCM care plan?

As discussed in the CY 2020 final rule (84 FR 62691), CMS updated the typical care plan elements. Note that these are “typical” care plan elements, and do not comprise a set of strict requirements that must be included in a care plan for purposes of billing for CCM services. The elements are intended to reflect those that are typically, but perhaps not always, included in a care plan as medically appropriate for a particular beneficiary.

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

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

- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers

What date of service should be used on the practitioner claim and when should the claim be submitted?

The CCM service period is one calendar month.

For complex CCM (CPT codes 99487, 99489), billing practitioners should report the service code(s) at the conclusion of the service period. In addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making; medical decision-making is determined by the problems addressed by the practitioner throughout the service period.

For CCM provided by clinical staff (CPT codes 99490, 99439) and CCM furnished directly by practitioners (CPT codes 99491, 99437), the billing practitioner may report the appropriate claim(s) at the conclusion of the service period. Practitioners may also choose to report the appropriate claim(s) after completion of the service time for the code. When the time threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month. Note that for these CCM services, CMS expects the billing practitioner to continue furnishing services during a given month as medically necessary, even after the billing threshold for the billed code(s) has been met.

What place of service (POS) should be reported on the practitioner claim?

CCM is priced in both facility and non-facility settings. The billing practitioner should report the POS for the location where they would ordinarily provide face-to-face care to the beneficiary. Our goal is to pay an accurate rate that reflects the resource costs of the practitioner.

We welcome information from impacted parties who provide CCM services on the following: how often they furnish CCM to beneficiaries who reside or remain in facility settings during part or all of the service period; the kind of facilities; and how often the resources and staff of the billing practitioner are used rather than facility resources and staff. We recognize that there could be many different arrangements based on the location(s) of the beneficiary during the month and individual practice patterns.

Can I bill for CCM services furnished to beneficiaries I provide care to in skilled nursing facilities, nursing facilities, assisted living or other facility settings?

Yes. CCM is priced in both facility and non-facility settings. The POS on the claim should be the location where the billing practitioner would ordinarily provide face-to-face care to the beneficiary.

Is a new patient consent required each calendar month or annually?

There is not a requirement to obtain patient consent either monthly or annually. Consent must be obtained from the patient once prior to the start of CCM. Patient consent must be obtained again if the patient changes billing practitioners - in which case, consent must be obtained and documented by the new billing practitioner prior to furnishing the service. We also note that in the CY 2017 PFS final rule (81 FR 80250), we updated consent requirements to allow for verbal (rather than written) consent from the patient.

Do the billing practitioners need to ever see their CCM patients face-to-face?

Yes. For new patients or patients not seen by the billing practitioner within a year prior to the commencement of CCM services, CCM must be initiated by the billing practitioner during a “comprehensive” E/M visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE).

What types of visits may serve as CCM initiating visits?

If an initiating visit is required (see prior question), CCM must be initiated by the billing practitioner during a “comprehensive” E/M visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the CCM service and can be separately billed to the PFS.

Levels 2 through 5 E/M visits (CPT codes 99212 through 99215) qualify as a “comprehensive” E/M visit for CCM purposes. The face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) also qualifies as a “comprehensive” visit for CCM initiation. CPT codes that do not involve a face-to-face visit by the billing practitioner or are not separately payable by Medicare cannot be used as the “comprehensive” E/M visit for CCM initiation.

Note that if the practitioner furnishes a “comprehensive” E/M, AWV, or IPPE, and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.

Can the initiating visit for CCM be conducted using telehealth?

As part of the COVID-19 Public Health Emergency, CMS expanded a number of flexibilities for telehealth services. If an E/M visit that can otherwise qualify as an initiating visit for CCM is allowed to be furnished via telehealth under these flexibilities, this telehealth visit can be used

for the CCM initiating visit. Please visit <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth> for a list of services that may be delivered via telehealth as well as additional resources regarding telehealth services.

Does informed consent for CCM have to be obtained at the initiating visit?

The initiating visit for CCM and informed consent are two separate requirements for CCM services. The billing practitioner must discuss CCM with the patient at the initiating visit. While the initiating visit presents an opportunity to obtain the required informed consent, informed consent does not have to be obtained during the initiating visit.

Do face-to-face activities count as billable time?

CCM includes, in large part, activities that are not typically or ordinarily furnished face-to-face with the beneficiary and others, such as telephone communication, review of medical records and test results, and coordination and exchange of health information with other practitioners and providers.

Prior to separate payment for CCM, these activities were primarily included in the payment for face-to-face visits (though they usually occurred before or after), and we tend to refer to them as “non-face-to-face” activities because generally, they are such. If these activities are occasionally provided face-to-face for convenience or other reasons, the time may be counted towards a CCM service code(s). CCM also includes activities such as patient education or motivational counseling, that are frequently provided to patients either in person or non-face-to-face (such as by phone). If the practitioner believes a given beneficiary would benefit or engage more in person, or for similar reasons recommends a given beneficiary receive certain CCM services in person, they may still count the activity as billable time. In all cases, the time and effort cannot count towards any other code if it is counted towards CCM.

Medicare and CPT allow billing of E/M visits during the same service period as CCM. If an E/M visit or other E/M service is furnished the same day as CCM services, how do I allocate the total time between CCM and the other E/M code(s)?

CCM services are E/M services. Time or effort that is spent providing services within the scope of the CCM service, on the same day as an E/M visit or other E/M service that Medicare and CPT allow to be reported during the CCM service period, can be counted towards CCM codes, as long as the time is not counted towards other reported E/M code(s). We note that time and effort cannot be counted twice, whether face-to-face or non-face-to-face, and Medicare and CPT provisions specify certain codes that can never be billed during the CCM service period.

Are there services that cannot be billed under the PFS during the same calendar month as CCM?

Yes, Medicare does not allow the CCM service codes to be billed during the same service period as home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182), or certain ESRD services (CPT 90951-90970) because the comprehensive care management included in CCM could significantly overlap with these services. Please refer to CPT coding guidance for a list of additional codes that cannot be billed during the same month as the CCM service codes.

Note that CPT codes for CCM provided by clinical staff (CPT codes 99490, 99439) cannot be reported in the same calendar month as CPT codes for CCM services furnished directly by physicians/NPPs (CPT codes 99491, 99437) or for complex CCM (CPT codes 99487, 99489). CPT codes for CCM furnished directly by physicians/NPPs (CPT codes 99490, 99437) cannot be reported in the same calendar month as complex CCM (CPT codes 99487, 99489).

There may be additional restrictions on billing for practitioners participating in a CMS model or demonstration program; if you participate in one of these separate initiatives, please consult the CMS staff responsible for these initiatives with any questions on potentially duplicative billing.

Can TCM and CCM codes be billed concurrently?

In the CY 2020 PFS final rule (84 FR 62685) and CY 2021 PFS final rule (85 FR 84547), CMS indicated that TCM may be billed concurrently with CCM codes when relevant and medically necessary. Note that the minutes counted for TCM services cannot also be counted towards other services (including CCM).

Can CCM and principal care management (PCM) be billed concurrently? Can they be billed for the same practice in a multispecialty group that has a PCP and a specialist?

Yes. As discussed in the CY 2020 PFS final rule (84 FR 62697), CCM and PCM cannot be billed by the same practitioner for the same patient in the same month. However, it is allowable, for instance, for a primary care practitioner to offer CCM and a specialist to offer PCM (or vice versa, as appropriate). The conditions being addressed by CCM and PCM must be different.

If CCM and PCM are provided concurrently, two care plans would be required. Note, however, that for PCM, the care plan needs only to be “disease-specific.” Refer to the CY 2020 PFS final rule (84 FR 62695-62696) for a comparison of the CCM and PCM scope of service requirements, including the care plan.

Can I bill for CCM if the beneficiary dies during the service period?

The CCM service code(s) can be billed if the beneficiary dies during the service period, as long as the required service time for the code(s) was met that calendar month and all other billing requirements are met.

If a beneficiary declines to receive CCM services or does not provide consent, or if other conditions of payment for CCM are not met, can the practitioner bill the beneficiary for CCM services?

No. The beneficiary must provide the required consent and all other Medicare conditions of payment must be met in order to bill Medicare or the beneficiary for CCM. If the beneficiary does not provide consent or if other conditions for payment are not met, the practitioner cannot bill Medicare or the beneficiary for CCM. Medicare would consider any CCM services furnished to the beneficiary (but not separately billable under a CCM CPT code) as included in payment for the face-to-face E/M visit(s) furnished to the beneficiary. As we noted in the CY 2014 PFS final rule with comment period (78 FR 74414-74415), payment for non-face-to-face care management services was previously bundled into payment for face-to-face visits; we did not revalue these E/M visits under the PFS to account for separate payment of CCM services. We also note that CCM would be considered a reasonable and necessary covered Medicare service, so it would not be appropriate to issue the beneficiary an Advance Beneficiary Notice of Noncoverage (ABN).

Will Medigap cover the beneficiary cost sharing for CCM?

Yes. If services are covered under Medicare Part B, Medigap insurers do not have authority to deny the coinsurance, copayments or other benefits that are payable on behalf of the beneficiary under the provisions of the Medigap insurance contract. Private insurers providing standardized Medigap plans agree to accept a notice of Medicare payment as a claim for the payment of benefits under the Medigap plan, unless the Medigap policy itself has a deductible that has not yet been met.

Will Medicaid cover the beneficiary cost sharing for CCM for dually eligible beneficiaries?

We wish to ensure that Medicare-Medicaid dually eligible beneficiaries have access to CCM services. The majority of dually eligible beneficiaries (approximately 8 million of the 11.9 million dually eligible beneficiaries) are Qualified Medicare Beneficiaries who will not be responsible for CCM cost sharing. For Qualified Medicare Beneficiaries, Medicaid is responsible for deductibles/coinsurance for Medicare services, including CCM, even if the services are not covered in the State Plan.

However, as permitted by federal statute, most states limit payment of Medicare cost sharing to the “lesser-of” Medicaid or Medicare rates. If the service is not covered in the State plan, states can set other reasonable payment limits, approved by CMS, for the service. The net effect of these policies is that many states pay little to none of the Medicare deductible/coinsurance,

leaving practitioners to absorb the costs for Qualified Medicare Beneficiaries. In states where there would be coverage of some or all of the beneficiary cost sharing, practitioners need to be enrolled as Medicaid providers to be paid for the Medicare cost sharing; however, Medicare automatically “crosses over” claims to states for dual eligible beneficiaries, so practitioners need not submit their own bill.

Will practitioners be able to use acceptably certified electronic health record (EHR) technology for which certification expires mid-year in order to bill for CCM?

Yes. Under the CCM scope of services, practitioners must record certain patient health information in a structured format, using technology certified to the edition(s) of certification criteria that is acceptable for the EHR Incentive Programs as of December 31st of the year preceding each CCM payment year. In certain years, this may mean that practitioners can fulfill the scope of services requirement using multiple versions of certification criteria that are valid during that year. This remains true for a given PFS payment year even after ONC-Authorized Certification Bodies (ONC-ACBs) have removed the certifications issued to certified technology as a result of the relevant version of the criteria being removed from the Code of Federal Regulations. Thus, practitioners using an acceptable EHR technology that loses its certification mid-year may still use that technology to fulfill the certified EHR criteria for billing CCM during the applicable payment year.

Where can I find more guidance on CCM billing requirements?

Fact Sheets and other materials on CCM are available on the CMS website on the Physician Fee Schedule (PFS) page under the “Care Management” hyperlink at

(<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/>).

CCM materials are also available on the Office of Minority Health web page

(<http://go.cms.gov/omh>). Materials for CCM in federally qualified health centers (FQHCs) and rural health centers (RHCs) are available on the FQHC web page

(<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>).

CCM policy guidance and discussions can be found in the following Physician Fee Schedule rules:

- CY 2022 (86 FR 65117), <https://www.federalregister.gov/d/2021-23972/p-1094>
- CY 2021 (85 FR 84639), <https://www.federalregister.gov/d/2020-26815/p-1578>
- CY 2020 (84 FR 62684), <https://www.federalregister.gov/d/2019-24086/p-1160>
- CY 2019 (83 FR 59577), <https://www.federalregister.gov/d/2018-24170/p-1500>
- CY 2018 (82 FR 53166), <https://www.federalregister.gov/d/2017-23953/p-1529>
- CY 2017 (81 FR 80225), <https://www.federalregister.gov/d/2016-26668/p-862>
- CY 2016 (80 FR 70918), <https://www.federalregister.gov/d/2015-28005/p-584>
- CY 2015 (79 FR 67715), <https://www.federalregister.gov/d/2014-26183/p-1226>
- CY 2014 (78 FR 74414), <https://www.federalregister.gov/d/2013-28696/p-1713>

Note that all Physician Fee Schedule proposed and final rules are on the CMS Physician Fee Schedule web page, available at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices>.

You may direct questions to the Division of Practitioner Services or your Medicare Administrative Contractor.

Version 02/15/2023
Check for Updates



Medicare Physician Fee Schedule Final Rule Summary: CY 2023

MLN Matters Number: MM12982

Related Change Request (CR) Number: 12982

Related CR Release Date: November 17, 2022 Effective Date: January 1, 2023

Related CR Transmittal Number: R11708CP Implementation Date: January 3, 2023

Related CR Title: Summary of Policies in the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

Provider Types Affected

This MLN Matters Article is for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about the following CY 2023 MPFS updates:

- Telehealth originating site facility fee payment amount
- Expansion of coverage for colorectal cancer screening
- Coverage of Audiology services
- Other covered services

Background

This Article gives a summary of the policies in the CY 2023 MPFS. CMS issued the [2023 Physician Fee Schedule](#) final rule updating payment policies and Medicare payment rates for services we pay providers under the MPFS in CY 2023. The final rule also addresses public comments on Medicare payment policies proposed earlier this year. We summarize the payment policies under the MPFS in CY 2023 in this Article.

Medicare Telehealth Services

For CY 2023, we're adding new HCPCS codes to the list of Medicare telehealth services on a Category 1 basis, specifically HCPCS codes G0316, G0317, G0318, G3002, and G3003. We're keeping many services that are temporarily available as telehealth services for the duration of

the COVID-19 Public Health Emergency (PHE) on a Category 3 basis through CY 2023; including: CPT codes 90875, 90901, 92012, 92014, 92550, 92552, 92553, 92555-92557, 92563, 92567, 92568, 92570, 92587, 92588, 92601, 92625-92627, 94005, 95970, 95983, 95984, 96105, 96110, 96112, 96113, 96127, 96170, 96171, 97129, 97130, 97150-97158, 97530, 97537, 97542, 97763, 98960-98962, 99473, 0362T, and 0373T. The status of these codes on the Medicare Telehealth Services List will change to: "Available up Through December 31, 2023". We're extending the time services are temporarily included on the Medicare Telehealth Services List during the PHE, but aren't included on a Category I, II, or III basis for a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act, 2022 (CAA, 2022).

We're implementing the 151-day extensions of Medicare telehealth flexibilities in the CAA, 2022, including allowing telehealth services to be provided in any geographic area and in any originating site setting, including the patient's home, allowing certain services to be provided via audio-only telehealth, and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to provide telehealth services. The CAA, 2022 also delays the in-person visit requirements for mental health services you provide via telehealth until 152 days after the end of the PHE.

For 2023, you should continue billing telehealth claims with the place of service indicator you would bill for an in-person visit. You must use modifier 95 to identify them as telehealth services through the end of CY 2023 or the end of the year in which the PHE ends. See [list of codes added to the telehealth services list](#).

Telehealth Origination Site Facility Fee Payment Amount Update

The payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge, or \$28.64 for CY 2023 services. We base this on the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the [Social Security Act](#). The 2023 MEI increase is 3.8%. The patient is responsible for any unmet deductible amount and Medicare coinsurance.

Evaluation and Management (E/M) Visits

For CY 2023, we're finalizing changes for Other E/M visits that parallel the changes we made in recent years for office/outpatient E/M visit coding and payment.

Coding

Other E/M visits include hospital inpatient, hospital observation, emergency department, nursing facility, home services, residence services, and cognitive impairment assessment visits. For 2023, we're adopting the revised CPT codes for Other E/M visits (except for prolonged services). This includes:

- Merger of hospital inpatient and observation visits into a single code set, and merger of domiciliary, rest home (for example, boarding home), or custodial care and home visits

- into a single code set.
- Choice of medical decision making or time to select visit level (except for visits that aren't timed, such as emergency department visits).
- Eliminated use of history and exam to decide visit level (instead, there's a requirement for a medically appropriate history or exam or both).
- New descriptor times (where relevant).
- Revised CPT E/M guidelines for levels of medical decision making.

We're finalizing Medicare-specific coding for prolonged Other E/M services and creating 3 new G codes (one per E/M family). These are:

- G0316 for reporting prolonged hospital inpatient or observation services
- G0317 for prolonged nursing facility services
- G0318 for prolonged home or residence services

Report prolonged cognitive impairment assessment services using G2212, the Medicare-specific code for prolonged office/outpatient services. Don't use CPT codes to report these services.

Split (or Shared) Visits

We're delaying for another year our CY 2022 final policy defining the substantive portion of a split (or shared) visit as more than half of the total practitioner time. For CY 2023, as in CY 2022, the substantive portion can be 1 of the following:

- History
- Physical exam
- Medical decision making
- More than half of the total practitioner time

Critical Care

We issued a technical correction clarifying that the reporting threshold time for the add-on code for critical care services is the same for split (or shared) critical care as for critical care that isn't split (or shared). Use CPT Code 99292 to report additional, complete 30-minute time increments provided to the same patient, therefore it isn't reported until at least 104 minutes are spent ($74 + 30 = 104$ minutes).

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

For CY 2023, we're modifying our policies to expand coverage of colorectal cancer (CRC) screening in 2 ways:

- First, we're modifying coverage and payment requirements for certain CRC screening tests to start when the individual is 45 years of age or older, including Blood-based Biomarker Tests, The Cologuard™ – Multi-target Stool DNA (sDNA) Test, Immunoassay-based Fecal Occult Blood Test (iFOBT), Guaiac-based Fecal Occult Blood Test (gFOBT),

Barium Enema Test, and Flexible Sigmoidoscopy Test. Screening Colonoscopy will continue with no minimum age limitation. We aren't modifying existing maximum age limitations.

- Second, we're expanding the regulatory definition of CRC screening tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based CRC screening test returns a positive result. We added the regulatory definition to [42 CFR 410.37](#).

See MLN Matters Article [MM12656](#) for more information.

Audiology Services

For CY 2023, we're finalizing a policy to allow patients direct access to an audiologist for certain diagnostic tests for non-acute hearing conditions without an order from a treating physician or NPP, including nurse practitioners, clinical nurse specialists, and physician assistants. The finalized policy requires the use of the new AB modifier. This is instead of using HCPCS code GAUDX (that encompassed a list of 36 CPT codes) as we proposed.

Services billed with modifier AB, with any of those on the finalized list of 36 CPT codes, would include those the audiologist personally:

- Provided by the audiologist on a single treatment day to allow patients to get care for non-acute hearing assessments (gradual loss of hearing, typically in both ears)
- Related to implanted auditory prosthetic devices (including cochlear, osseointegrated, and auditory brainstem implants) unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids.

As proposed, we're finalizing to permit audiologists to bill for this direct access (without an order) once every 12 months, per patient, effective January 1, 2023.

We show the permissible use of the AB modifier on the list of Audiology Services on the [PFS website](#), as follows:

- Must be used alongside any of the codes on the finalized list of 36 CPT codes, but only when the patient has directly accessed the audiologist (that's, without a physician or NPP order). Although there'll be times that audiologists will bill for these services, as appropriate, when the patient presents with an order/referral from a physician or NPP that won't have the modifier appended.
- Isn't applicable to the remainder of the codes on the Audiology Services code list – 14 CPT codes for vestibular function tests – for which codes billed with the AB modifier won't be payable.

For each patient, we allow only 1 visit to an audiologist without a physician or NPP order every 12 months. Audiologists may bill using modifier AB once every 12 months – regardless of the number of applicable CPT codes billed with the modifier on that date of service. For example, if you bill 1 CPT code with the AB modifier on a certain date, none of the codes on the list of 36

applicable CPT codes will be payable under the PFS for another 12 months without a qualifying order.

Behavioral Health

We're finalizing a proposal to create a new HCPCS code (G0323) describing General Behavioral Health Integration performed by clinical psychologists (CP) or clinical social workers (CSW) to account for monthly care integration where the mental health services provided by a CP or CSW are serving as the focal point of care integration.

Chronic Pain Management

We're finalizing a CY 2023 proposal to create 2 new G codes (G3002 and G3003) performed by physicians and other qualified health professionals, describing monthly CPM for payment starting January 1, 2023.

Opioid Treatment Programs (OTPs)

To stabilize methadone pricing for CY 2023 and subsequent years, we're finalizing our proposal to revise our method for pricing the drug component of the methadone weekly bundle and the add-on code for take-home supplies of methadone. As proposed, we'll base the payment amount for the drug component of HCPCS codes G2067 and G2078 for CY 2023 and subsequent years on the payment amount for methadone in CY 2021 and update this amount annually to account for inflation using the Producer Price Index for Pharmaceuticals for Human Use (Prescription).

Also, based on the severity of needs of the patient population diagnosed with opioid use disorder (OUD) and getting services in the OTP setting, we're finalizing our proposal to modify the payment rate for the non-drug component of the bundled payments for episodes of care. We're basing the rate for individual therapy on a crosswalk code describing a 45-minute session, rather than the current crosswalk to a code describing a 30-minute session. This will increase overall payments for medication-assisted treatment and other treatments for OUD, recognizing the longer therapy sessions that are usually required.

We're also finalizing our proposal to allow the OTP intake add-on code you provide via 2-way, interactive, audio-video technology when you bill for the initiation of treatment with buprenorphine using audio-video technology to start treatment with buprenorphine as authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) at the time you provide the service. We're also finalizing our proposal to permit the use of 2-way, interactive, audio-only technology to start treatment with buprenorphine in cases where audio-video technology isn't available to the patient and all other applicable requirements are met.

Also in CY 2023, we're:

- Allowing you to provide periodic assessments with audio-only when video isn't available for the duration of CY 2023, when SAMHSA and DEA authorizes it at the time you provide the service.
- Clarifying that OTPs can bill Medicare for medically reasonable and necessary services provided via mobile units in accordance with SAMHSA and DEA guidance. We'll apply locality adjustments for services you provide via mobile units as if you provided the service at the physical location of the OTP registered with DEA and certified by SAMHSA.

Dental and Oral Health Services

Medicare currently pays for dental services in a limited number of circumstances, such as when that service is an integral part of specific treatment of a patient's primary medical condition. Some examples include:

- Reconstruction of the jaw following accidental injury
- Tooth extractions done in preparation for radiation treatment for cancer involving the jaw
- Oral exams preceding kidney transplantation.

We proposed to clarify and codify certain aspects of our current Medicare Fee-for-Service (FFS) payment policies for dental services. We also proposed and sought comment on payment for other dental services, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures that may be inseparably linked to the clinical success of an otherwise covered medical service.

Effective for CY 2023, we're finalizing both policies as proposed and finalizing a process to review public submissions of other potentially analogous medical services where dental services are inseparably linked. Lastly, starting in CY 2024, we're finalizing Medicare FFS payment for dental services, such as dental exams and necessary treatments prior to the treatment for head and neck cancers.

Skin Substitutes

We proposed several changes to the policies for skin substitute products to streamline the coding, billing, and payment rules and to establish consistency with these products across the various settings. Specifically, we proposed to change the terminology of skin substitutes to 'wound care management products', and to treat and pay for these products as incident to supplies under the MPFS starting on January 1, 2024. We plan to conduct a Town Hall in early CY 2023 with interested parties to address commenters' concerns as well as discuss potential approaches to the method for payment of skin substitute products under the MPFS.

FY Modifier Reduction Changes from 7% to 10%

As required by Medicare law, effective January 1, 2018, a payment reduction of 7% applies to imaging services that are X-rays taken using computed radiography (including the X-ray

component of a packaged service). The payment reduction increases to 10% in 2023 and subsequent years. (See [CR 10188](#) for more information.)

More Information

We issued [CR 12982](#) to your MAC as the official instruction for this change.

For more information, [find your MAC's website](#).

Document History

Date of Change	Description
November 17, 2022	Initial article released.

[Medicare Learning Network® Content & Product Disclaimer, and Department of Health & Human Services Disclosure](#)

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).

CPT only copyright 2021 American Medical Association. All rights reserved.

Intentionally

Blank

Version 02/14/2023
Check for Updates