

Washington Rural Palliative Care Initiative
Billing for Palliative Care Services
In Washington State

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Introduction

This manual focuses on Medicare payment for palliative care services. Palliative care ideally includes an interdisciplinary team, who provide a variety of services. Not all of these services are eligible for payment. This document lays out general information about billing and then details specific codes by setting and service type. The information provided here is for general guidance and is not intended to guarantee payment. Practitioners should always consult their Medicare Administrative Contractors (MACs) and/or local coding experts and auditors regarding documentation requirements. Contact Noridian Healthcare Solutions is the MAC for the Pacific Northwest. Contact Noridian directly with any questions.

<https://med.noridianmedicare.com/>

The Center for Medicare and Medicaid Services (CMS) continually issues new guidance and proposed updates to the “Physician Fee Schedule” yearly and that has great impact on provider billing. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched> Organizations need to ensure someone within the organization reviews the latest rules and regulations issued by CMS to ensure appropriate billing and coding practices. **CMS will make important changes to Evaluation and Management Services effective January 1, 2021.** Each year, plan to conduct billing and coding review sessions with your entire team including billers, coders and providers to assure consistency and compliance with regulations. Additionally, conduct external auditing or compliance checks at least annually.

The information included in this manual was gathered through the materials provided by [The Center to Advance Palliative Care](http://capc.org) (capc.org), The California Health Foundation’s [Documentation & Coding Handbook: Palliative Care](#) developed by Jean Acevedo Consulting, and Kevin Murphy, MD, MSW, Director, Palliative Practice Group at the Institute for Human Caring at Providence St. Joseph Health.

Providers Eligible to Bill Medicare

- Physicians (MD/DOs)
- Physician Assistants (PAs) – depends on state scope of practice
- Advanced Practice Registered Nurses (APRNs) – depends on state scope of practice
- Psychologists (PhD, PsyD)
- Therapists: Physical Therapists (PTs), Occupational Therapists (OTs), Speech and Language Pathologists (SLPs)
- Social Workers (LCSWs/LISWs) – Medicare reimburses LCSW for psychotherapy services only. In POS 11 (Freestanding OP Clinic, Social workers may bill incident-to for ACP codes, also, though not through their own license/specialty.

Billing for Palliative Care Services

- Palliative care services should be identified with ICD-10 code Z51.5 (previously V66.7). This code signifies a palliative care encounter by a physician, nurse practitioner, clinical nurse specialist, physician assistant or social worker and may be used in any setting (inpatient and outpatient) to specify an encounter for palliative care. Diagnoses should be coded that reflect what was addressed in the visit, the), codes for any symptom(s) addressed and the underlying diagnosis for that symptom. Z51.5 should not be the principal diagnosis. It is important to use Z51.5 to capture national data on palliative care visits.
- The majority of palliative care professional services are described by Evaluation & Management (E/M) codes for palliative care services including goals of care conversations.
- Palliative care visits are often longer in duration than other visits.
- Palliative Care visits are often complicated, and your documentation should reflect that complexity. Charges selected for visits should be determined after the visit and documentation have been completed, however coding based on complexity will typically provide a more commensurate reimbursement to the complexity of services provided.
- Provide specific and descriptive documentation about what is going on with the patient. Be careful of non-specific documentation, such as “discussed goals of care”.
- Medical necessity of a service is the overarching criterion for payment.
- Use a time stamp for all activities both with the patient and without the patient to properly document the time spent on each patient.
- Time-based billing differs between outpatient and acute services (hospital and SNF). In the acute setting unit-time is used and includes all preparation, records review, collaboration, and documentation performed on the patient’s medical unit.
- Prolonged services and Advance Care Planning may be added to the E/M code as appropriate. In all care settings, non-face-to-face prolonged service in preparation for

the visit or in collaboration of care after, may be coded using nonF2F codes 99358/99359.

- Chronic Care Management service codes or Transitional Care Management service codes for Medicare patients to check in with patients between visits to better support them. These codes have their own requirements and are billed under the provider based on complexity, care plan revision, and time.
- Advance Care Planning codes can be used to report face-to-face service between a physician or other qualified health professional (QHCP) and a patient, family member or surrogate in counseling and discussing goals of care and/or advance directives, with or without completing relevant legal forms.
- A Rural Health Clinic or Federally Qualified Health Center (FQHC) could qualify to be reimbursed for nurse home visits, unless they are completed by a provider. RHCs can bill for visiting nursing services furnished by an RN or LPN to homebound individuals under a written plan of treatment in areas with a shortage of home health agencies (HHAs). **Effective March 1, 2020 and for the duration of the COVID-19 PHE, the area typically served by the RHC is determined to have a shortage of home health agencies, and no request for this determination is required.** RHCs must check the HIPAA Eligibility Transaction System (HETS) before providing visiting nurse services to ensure that the patient is not already under a home health plan of care.
<https://med.noridianmedicare.com/web/jea/provider-types/rhc/rural-health-clinic-visiting-nurse-services>
- There are also codes that could be used by Social Workers for home visits for behavioral health.

Evaluation and Management (E/M) Documentation Requirements

Complexity vs. Time-based Billing – Each E/M service code is associated with an amount of time, known as a threshold time. A unit of time is reached when the mid-point has elapsed¹. For example, 60 minutes is attained when 31 minutes have passed (more than midway between zero and sixty minutes).

Complexity choice of service level is based on the degree of work, medical complexity and documentation of the three key elements (history, physical examination, medical decision making). Bill based on complexity, if time threshold is not met, or, if more than 50% of time is spent on (1) counseling and educating patients and families, (2) formulating and communicating prognosis and goals of care, (3) exploring burden/benefit of various approaches to the patient's goals of care, or (4) coordinating differing medical opinions. Time spent (and the statement that it was greater than 50% of the total) must be documented in the note. There must be "sufficient detail" of the nature of the counseling documented to support the time. If time spent is focused on advance care planning, consider using the Advanced Care Planning codes (ACP codes).

- Location of care
 - Inpatient and Skilled Nursing Center/Nursing Home = time starts upon arrival to the unit. Include time in conversation with the RN & SW, chart review, coordination with the attending, family meetings, charting, etc.
 - Outpatient Clinic, Observation/Emergency Center, Home = time starts upon arrival to the patient's room and must be provided face-to-face with the patient. Discussions about goals for a patient with Dementia present, may not be ideal, and in this type of instance face-to-face with the legally designated decision maker satisfies the face-to-face requirement.
- Type of Service
 - New vs. Established (outpatient) – If patient has been seen within the past three years by anyone in group, then code as established, otherwise code as new. Patient interview and examination must be face-to-face (F2F), and you may include time writing notes in the presence of the patient.
 - Initial vs. Subsequent (inpatient) – there is one initial visit for every acute admission, and all follow-up visits are coded as subsequent. Time may include reviewing current and old records, patient interview and examination, writing notes, communication with other professionals, or communication with families.
- Complexity of Service (documentation of only 2 of 3 required for established patients)
 - History
 - Physical Examination
 - Level of complexity of medical decision-making
- Duration of Service
 - Time recorded for beginning of F2F encounter
 - Time recorded for end of F2F encounter
 - It is also recommended to include your total time spent on the care of this patient (today)
- Place of Service (POS) – must be documented in your note to support accurate billing.

¹ American Medical Association. CPT® Current Procedural Terminology. Chicago, IL: AMA. 2018. <https://www.ama-assn.org/practice-management/cpt-current-procedural-terminology>

Inpatient Codes

Inpatient Codes – Initial Visit					
CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)
99221	Initial Hospital Level 1	Meets either 1) detailed OR comprehensive history, detailed OR comprehensive examination, straightforward OR of low complexity medical decision making	30 min	1.92	\$103.06
99222	Initial Hospital Level 2	Comprehensive history, comprehensive examination, moderate complexity medical decision making	50 min	2.61	\$139.44
99223	Initial Hospital Level 3	Comprehensive history, comprehensive examination, high complexity medical decision making	70 min	3.86	\$204.96
Inpatient Codes – Subsequent Visit					
CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)
99231	Subsequent Hospital Level 1	Problem focused history, problem focused exam, straightforward to low level decision making	15 min	0.76	\$39.80
99232	Subsequent Hospital Level 2	Expanded problem focused history, expanded problem focused exam, moderate level decision making	25 min	1.39	\$73.29
99233	Subsequent Hospital Level 3	Detailed history, detailed examination, moderate complexity medical decision making	35 min	2	\$105.62

Critical Care Codes					
CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)
99291	Critical Care – A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition - first 30 minutes	Critical care is defined as the direct delivery by a provider(s) of medical care for a critically ill or critically injured patient	30-74 min	4.5	\$283.49
99292	Critical Care – add'l 30 min	Used for each ‘additional 30 minutes’ of critical care beyond the first 74 min	>74 min	2.25	\$125.06

Outpatient Codes

Office/Outpatient Codes – New Patient					
CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)
99201	Office/Outpatient Visit New Level 1	Problem focused History & Physical Examination (H&P), low level problem, straightforward decision making	10 min	0.48	\$46.57
99202	Office/Outpatient Visit New Level 2	Expanded problem focused H&P, low to moderate problem severity, straightforward decision making	20 min	0.93	\$77.14
99203	Office/Outpatient Visit New Level 3	Detailed H&P, moderate problem severity, low level decision making	30 min	1.42	\$109.16

99204	Office/Outpatient Visit New Level 4	Comprehensive H&P, moderate to high problem severity, moderate level decision making	45 min	2.43	\$166.55
99205	Office/Outpatient Visit New Level 5	Comprehensive H&P, moderate to high problem severity, high level decision making	60 min	3.17	\$210.37

Office/Outpatient Codes – Established Patient

CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)
99211	Office/Outpatient Visit Established Level 1	Problem focused	5 min	0.18	\$23.59
99212	Office/Outpatient Visit Established Level 2	At least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making	10 min	0.48	\$46.20
99213	Office/Outpatient Visit Established Level 3	At least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity	15 min	0.97	\$76.10
99214	Office/Outpatient Visit Established Level 4	At least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity	25 min	1.5	\$110.36
99215	Office/Outpatient Visit Established Level 5	At least two of these three key components: comprehensive history; a comprehensive examination; medical decision making of high complexity	40 min	2.11	\$148.17

Home Care Codes

CPT codes 99341 - 99350: Home Services codes, are used to report E/M services furnished to a patient residing in his or her own private residence. Private residence considered: a private home, an apartment, or town home.

Home – New Patient					
CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)
99341	Home Visit New Level 1	Problem focused H&P, low level problem severity, straightforward decision making	20 min	1.01	\$55.47
99342	Home Visit New Level 2	Expanded problem focused H&P, low to moderate problem severity, straightforward decision making	30 min	1.52	\$79.51
99343	Home Visit New Level 3	Detailed H&P, moderate problem severity, low level decision making	45 min	2.53	\$130.59
99344	Home Visit New Level 4	Comprehensive H&P, moderate to high problem severity, moderate level decision making	60 min	3.38	\$185.13
99345	Home Visit New Level 5	Comprehensive H&P, moderate to high problem severity, high level decision making	75 min	4.09	\$225.32
Home – Established Patient					
CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)
99347	Home Visit Established Level 1	Problem focused	15 min	0.18	\$55.47
99348	Home Visit Established Level 2	At least two of these three key components: a problem focused history; a problem focused examination;	25 min	0.48	\$85.27

		straightforward medical decision making			
99349	Home Visit Established Level 3	At least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity	40 min	0.97	\$130.68
99350	Home Visit Established Level 4	At least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity	60 min	1.50	\$181.88

Nursing Facility Codes

Nursing Facility – Initial Visit					
CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)
99304	Nursing Facility Initial Visit Level 1	Detailed or comprehensive H&P; straightforward or low medical decision making complexity	25 min	2.59	\$91.67
99305	Nursing Facility Initial Visit Level 2	Comprehensive H&P; moderate medical decision making complexity	35 min	3.78	\$131.40
99306	Nursing Facility Initial Visit Level 3	Comprehensive H&P; high medical decision making complexity	45 min	4.85	\$169.40
Nursing Facility – Subsequent Visit					
CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)

99307	Nursing Facility Subsequent Visit Level 1	Problem focused	10 min	1.27	\$44.62
99308	Nursing Facility Subsequent Visit Level 2	Expanded problem focused H&P; low medical decision making complexity	15 min	2	\$70.17
99309	Nursing Facility Subsequent Visit Level 3	Detailed H&P; moderate medical decision making complexity	25 min	2.7	\$92.58
99310	Nursing Facility Subsequent Visit Level 4	Comprehensive H&P, moderate to high medical decision making complexity	35 min	3.96	\$136.52

Assisted Living/Domiciliary/Rest Home Codes

CPT codes 99324 - 99337: Domiciliary, Rest Home (e.g. Boarding Home or Adult Family Home), or Custodial Care Services, are used to report E/M services to individuals residing in a facility which provides room, board, and other personal assistance services, generally on a long-term basis. Assisted living facilities may be known as adult living facilities. 99324-99337 are all encompassing for any non-skilled patient living, e.g., ALF, AFH, etc.

Assisted Living/Domiciliary/Rest Home – New Patient					
CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)
99324	Level 1 new patient domiciliary, rest home or custodial care visit	A problem focused history; a problem focused examination; and straightforward medical decision making	20 min		\$55.47
99325	Level 2 new patient domiciliary, rest home or custodial care visit	An expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity.	30 min		\$80.61
99326	Level 3 new patient domiciliary, rest home or custodial care visit	A detailed history; a detailed examination; and medical decision	45 min		\$140.41

		making of moderate complexity.			
99327	Level 4 new patient domiciliary, rest home or custodial care visit	A comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.	60 min		\$188.58
99328	Level 5 new patient domiciliary, rest home or custodial care visit	A comprehensive history; a comprehensive examination; and medical decision making of high complexity.	75 min		\$222.96

Assisted Living/Domiciliary/Rest Home – Established Patient					
CPT Code	Description	Required Elements	Time Based Coding Thresholds	wRVU	Revenue (approx.) Varies by geography and type of hospital)
99334	Level 1 established patient domiciliary, rest home or custodial care visit	A problem focused interval history; a problem focused examination; straightforward medical decision making.	15 min		\$61.22
99335	Level 2 established patient domiciliary, rest home or custodial care visit	An expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity.	25 min		\$96.89
99336	Level 3 established patient domiciliary, rest home or custodial care visit	A detailed history; a detailed examination; medical decision making of moderate complexity.	40 min		\$136.83
99337	Level 4 established patient domiciliary, rest home or custodial care visit	A comprehensive interval history; a comprehensive examination; medical decision making of moderate to high complexity.	60 min		\$197.09

Prolonged Services

Codes 99354-99359 are add-on codes used when a physician or other qualified health care professional provides prolonged service(s) beyond the usual time.

Prolonged Services – Inpatient with Patient

99356 - Prolonged service in the inpatient setting with patient, requiring unit/floor time beyond the usual service; first hour (select in addition to code for inpatient E/M service). Use when counseling, education or exploration of goals of care constitute more than 50% of the encounter time – the visit may be billed based on time. Document details of total time of discussion including, time-in, time-out and what was discussed.

- Code 99356 reports the first hour of prolonged services on a given date, but may be reported if at least 30 minutes are spent providing prolonged care (30-74 min)
- All payers accept 99356 to be billed in conjunction with inpatient CPTs 99221-99223, 99231-99233
- Only one 99356 per day
- 1.71 wRVU
- Approx. \$93.83

99357 - Prolonged service in the inpatient setting with patient, requiring unit/floor time beyond the usual service; each additional 30 minutes (select separately in addition to 99356).

- Code 99357 reports each additional 30 minutes for that date of service, but is only reported when the service extends 15 minutes or more into the next time period (> 74 min)
- 99357 must be reported in conjunction with CPT 99356
- Can report as many as total time indicates
- 1.71 wRVU
- Approx. \$94.56

Prolonged Services – Outpatient

99354 - Prolonged service in the office/outpatient setting, requiring direct patient contact beyond the usual service; first hour (list separately in addition to code for outpatient E/M service); when counseling, education or exploration of goals of care constitute more than 50% of the encounter time – the visit may be billed based on time. Document details of total time of discussion including, time-in, time-out and what was discussed.

- Code 99354 reports the first 30 minutes of prolonged services beyond the usual service on a given date, but may be reported if at least 30 minutes are spent providing prolonged care
- All payers accept 99354 to be billed in conjunction with outpatient CPTs 99201- 99205, 99211-99215
- 2.33 wRVU
- Approx. \$131.64

99355 - Prolonged service in the office/outpatient setting, requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code 99354)

- Code 99355 reports each additional 30 minutes for that date of service, but is only reported when the service extends 15 minutes or more into the next time period.
- 99355 must be reported in conjunction with CPT 99354
- 1.77 wRVU
- Approx. \$100.02

Prolonged Services – Non Face-to-Face (F2F)

99358 - Prolonged service in any setting before and/or after direct patient care, requiring time beyond the usual service; first hour (list separately in addition to code for E/M service). Can bill a maximum of two hours of non-F2F time using CPT codes 99358 and 99359 per patient on any given day.

- Code 99358 reports the first hour of prolonged services on a given date, but may be reported if at least 30 minutes are spent providing prolonged care
- Billed in conjunction with inpatient or outpatient E/M CPT codes
- wRVU 2.1
- Approx. \$113.25

99359 - Prolonged service in any setting, requiring time beyond the usual service; each additional 30 min (list separately in addition to 99358). Time spent must occur on a given day, but may be a different day than the related E/M code was performed.

- Code 99359 reports each additional 30 minutes for that date of service, but is only reported when the service extends 15 minutes or more into the next time period
- 99359 must be reported in conjunction with CPT 99358
- wRVU 1
- Approx. \$55.27

“Incident to” Billing

Incident to is defined as services or supplies that are furnished incident to a physician's professional services when the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness and services are performed in the physician's office or in the patient's home. To qualify for payment under the incident to rules, services must be part of the patient's normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the ongoing course of treatment.

Medicare pays for services rendered by employees (including leased employees and independent contractors, hereafter referred to collectively as employees) of a physician or a physician directed clinic only when all 'incident to' criteria are met. Coverage is available for the services of such nonphysician personnel as nurses, technicians and therapists when furnished 'incident to' the professional services of a physician/nonphysician practitioner. Medicare also pays for services rendered by employees of a Clinical Psychologist (CP), Nurse Practitioner (NP), Certified Nurse Midwife (CNM) or Clinical Nurse Specialist (CNS) only when all 'incident to' criteria are met. Remember that 'incident services' supervised by non-physician practitioners are reimbursed at 85% of the Medicare Physician Fee Schedule (MPFS). The services of the employee are covered when:

1. The services are rendered under the direct supervision of the physician, CP, NP, CNM, CNS, or in the case of a physician directed clinic, the Physician Assistant (PA).
2. The services are furnished as an integral, although incidental, part of the physician's, CP's, NP's, CNM's or CNS's professional services in the course of the diagnosis or treatment of an injury or illness.
3. Billing 'incident to' the physician, the physician must initiate treatment and see the patient at a frequency that reflects his/her active involvement in the patient's case. This includes both new patients and established patients being seen for new problems. The claims are then billed under the physician's NPI.
4. Billing 'incident to' the CP, NP, CNM, CNS or PA, the nonphysician practitioners may initiate treatment and see the patient at a frequency that reflects his/her active involvement in the patient's case. The claims are then billed under the nonphysician practitioner's NPI.

There must be a valid employment arrangement between the physician, CP, NP, CNM, CNS or physician directed clinic, and the employee. Since NPs, CNSs and PAs can enroll with Medicare Part B to receive their own PTAN number, services provided by these specialties would only be considered 'incident to' if all the above conditions are met. If all the above conditions are not met, the service is not truly 'incident to' and cannot be billed under the physician's NPI.

The physician/nonphysician practitioner cannot hire and supervise a professional whose scope of practice is outside the provider's own scope of practice as authorized under State law or whose professional qualifications exceed those of the "supervising" provider. For example, a

CNM may not hire a psychologist and bill for that psychologist's services under the 'incident to' provision, since a psychologist's services are not integral to a CNM's personal professional services and are not regularly included in the CNM's bill.

A physician may also have the services of certain nonphysician practitioners covered as services 'incident to' a physician's professional services. These nonphysician practitioners, who are being licensed by the States under various programs to assist or act in the place of the physician, include for example Certified Registered Nurse Anesthetists (CRNAs), CP, Clinical Social Workers (CSWs), PAs, NPs and CNSs.

Services performed by these nonphysician practitioners 'incident to' a physician's professional services include not only services ordinarily rendered by a physician's office staff person (e.g. medical services such as taking blood pressure and temperatures, giving injections and changing dressings), but also the services ordinarily performed by the physician himself or herself such as minor surgery, setting casts or simple fractures, reading X-rays and other activities that involve evaluation or treatment of a patient's condition.

Note: Title 18, Section 1861 clearly states that the practice of medicine and all allied services are dependent on the rules and regulations within the state in which the individual practices. It is the responsibility of the physician/nonphysician practitioner to be in compliance with state regulations governing the licensing requirements of employees to provide specific services and limitations on the number of employees that can be adequately supervised.

<https://med.noridianmedicare.com/web/jeb/topics/incident-to-services>

Advance Care Planning

Advance Care Planning (ACP) is a process that support adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of ACP is to help ensure people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.²

ACP includes the explanation and discussion of advance directives such as standard forms (including the completion of such forms, when performed), by the physician or advanced practice provider (clinical nurse specialists, nurse practitioners, physician assistants). ACP may be performed as “Incident to” for established patients in an outpatient setting (unless outpatient clinic is hospital owned) meaning other team members (e.g. SW, RN) may be delegated by an onsite supervising physician to perform ACP in collaboration with a qualified provider. There is no limit to the number of times the code may be billed for a patient, as long as documentation demonstrates that repeated discussion are associated with a progression or change in health status or directives. ACP is considered included in Critical Care, so cannot be separately coded, but may be provided and billed for patients in critical care settings, when the Palliative Care team is not also managing the critical care, i.e. regular consults.

99497 – First 30 minutes of face-to-face time in any clinical setting by the physician or other qualified health professional with the patient, family member(s) and/or surrogate discussing advance directives.

- Billing provider spends at least 16 minutes of time performing services described in the code
- 1.5 wRVU
- Approx. \$86.76
- List separately in addition to primary E/M code
- Indicate the time spent on ACP ‘separate from and in addition to’ other service codes
- **Must document the diagnosis in addition to the ACP topics discussed including total time of discussion, face time start, face time stop, time-in, time-out and specific topics discussed**

99498 – Each additional 30 minutes

- Billing provider spends at least 16 minutes beyond the first 30 minutes; may be billed as many times as needed to cover the time spent
- 1.4 wRVU
- Approx. \$75.84

ACP Billing Threshold Times	
Time	CPT Code
≤ 15 minutes	Included in E/M Code
16-45 minutes	99497
46-75 minutes	99497 + 99498
76-105 minutes	99497 + 99498 x 2
106-135 minutes	99497 + 99498 x 3

² Reference: Sudore RL, Lum HD, You JJ, et al. Defining Advance Care Planning for Adults: A Consensus Definition from a Multidisciplinary Delphi Panel. *Journal of pain and symptom management*. 2017;53(5):821-832.e1. doi:10.1016/j.jpainsymman.2016.12.331.

ACP Codes and E/M Billing

- The supervising physician must be the billing clinician, but the ACP services may be ordered by a different physician
- Nursing and social work are considered part of the provision of care in a hospital and cannot be counted towards ACP in the hospital setting
- ACP codes do not need an accompanying E/M code to be billed
- ACP may be billed independently on a separate day of service
- ACP may be reported in addition to an E/M code, when performed on the same day
- If providing both E/M and ACP services on the same day, choose E/M code based on complexity, and ACP code(s) based on face-to-face time
- Some organizations use modifier 25 when billing for same day ACP services. Modifier 25 is used to show when a “separately billable service” is provided on the same day another service is being billed. From: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>, “the physician is to bill a modifier 25 with the visit code, indicating that the patient’s condition required a significant, separately identifiable visit service above and beyond the (blank) service provided.”
- Consult Medicare Administrative Contractors (MACs) and/or local coding experts and auditors regarding documentation requirements in your area
- ACP may be billed during the billing periods when providing Transitional Care Management (TCM) and Chronic Care Management (CCM) services

ACP during the Annual Wellness Visit

- When a beneficiary elects to receive ACP services outside of the Annual Wellness Visit (AWV), practitioners are encouraged to notify the beneficiary that Part B cost sharing applies
- Medicare waives both the coinsurance and the Medicare Part B deductible for ACP when it is:
 - Provided on the same day as a covered AWV
 - Furnished by the same provider as a covered AWV
 - Meets CPT time requirements (i.e. greater than 15 minutes of ACP service)
 - Billed with modifier -33 (Preventive Services)

Advance Care Planning vs Prolonged Services Billing

Advance Care Planning	Prolonged Services
→ Does not require another E/M service to be reported	→ Requires another E/M service to be reported prior to adding “prolonged services”
→ Can be reported at 16 minutes of service, with or without accompanying E/M	→ Can be reported at 31 minutes of service, with an accompanying E/M
→ RVUs are the same in any site of service	→ Outpatient RVUs higher than inpatient

Chronic Care Management (CCM) Services

Comprehensive care plan established for patients who have two or more chronic conditions expected to last at least 12 months and who are at significant risk of death, acute exacerbation/decompensation or functional decline. Reimbursed in both facility and non-facility settings. Directed by a physician or other qualified health care professional.

99490 – Comprehensive care plan established, implemented, revised or monitored.

- At least 20 minutes of clinical staff time, per calendar month
- 0.61 wRVU
- Approx. \$42.13
- Only one unit of service can be billed each calendar month

99487 – Establishment or substantial revision of a comprehensive care plan

- 60 minutes of clinical staff time, per calendar month
- 1 wRVU
- Approx. \$92.66

99489 – Comprehensive care plan established, implemented, revised, or monitored.

- Additional 30 minutes of clinical staff time, per calendar month
- 0.5 wRVU
- Approx. \$44.87

G0506 – If the initial CCM visit is complex and additional billing practitioner time and effort is needed, you can use HCPCS G0506 as an add-on to the initiating visit.

- \$63.49 add-on to the CCM initiating visit
- Accounts for the billing practitioner's time and effort personally providing extensive comprehensive assessment and CCM care planning to patients, outside of the usual effort described by the initiating visit code
- Reportable once per CCM billing practitioner, in conjunction with CCM initiation

<https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf>

Transitional Care Management (TCM) Services

Designed for health professionals to provide post-discharge care for patients with moderate or high complexity medical decision making who have been discharged from particular levels of care in various facilities (e.g. acute hospital care, observation stay, acute or subacute rehabilitation, etc.) Patient must be discharged from qualifying inpatient setting and be returned to home/ALF/domiciliary or other community based setting with goal of preventing readmission. The health professional assumes responsibility for coordinating medical and psychosocial needs during transition back to the community patient's care from the time of discharge. There is a specific 30-day period for TCM which begins on the date the beneficiary is discharged from the inpatient setting and continues for the next 29 days – based on 30 days from discharge, not calendar month. Services provided by MDs, DPs, ARNPs (including CNMs, CNSs, NPs, PAs). Only one health professional may report TCM services. ARNPs may also provide non-face-to-face TCM services “incident to” the services of a physician or other CNMs, CNSs, NPs, and PAs. Three components are needed to bill: (1) Required initial interaction within 2 days of discharge – phone, telehealth, IT; (2) Non F2F interaction throughout the TCM period; (3) F2F visit within 7 days of discharge (for high complexity patients) or 14 days of discharge (for moderate complexity).

99495 – Transitional care management services with moderate level decision making.

- F2F visit within 14 days of discharge
- 2.11 wRVU
- Approx. \$188.01

99496 – Transitional care management services with high level decision making.

- F2F visit within 7 days of discharge
- 3.05 wRVU
- Approx. \$248.27

The face-to-face visit is part of the TCM service, and should not be reported separately.

When you report CPT codes 99495 and 99496 for Medicare payment, **the following codes may not be reported** during the TCM service period:

–Care Plan Oversight Services (CPO) (CPT codes G0181 and G0182)

–End-Stage Renal Disease services (CPT codes 90951–90970)

–Chronic Care Management (CCM) services (CCM and TCM service periods cannot overlap) (CPT codes 99487, 99489, 99490)

–Prolonged E/M Services Without Direct Patient Contact (CPT codes 99358 and 99359)

<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN908628>

Behavioral Health Codes for Social Workers

Psychiatrists, clinical psychologists, and licensed clinical social workers are recognized by Medicare to provide behavioral health services. Behavioral health diagnosis is common among palliative care patients. The 2018 edition of the [National Consensus Project Guidelines for Quality Palliative Care](#) document the importance of the skills palliative social workers bring to patient care. Some of their time is not billable but where it meets the codes, it is billable. LCSWs cannot bill separately if they are seeing the patient through Home Health or hospice. But these CPT codes may be billable in any outpatient setting for patients not on HH or hospice

CPT Code	SHORT DESCRIPTION	Medicare 2018	WORK RVU	Time Needed
90832	Psychotherapy w/ pt 30 minutes	\$70.89	1.5	16-37 min
90834	Psychotherapy w/ pt 45 minutes	\$94.28	2	38-52 min
90837	Psychotherapy w/ pt 60 minutes	\$141.12	3	53 min or longer
90846	Family Psychotherapy w/o pt 50 min	\$103.17	2.4	27 min or longer
90847	Family Psychotherapy w/pt 50 min	\$106.78	2.5	27 min or longer
90839	Psychotherapy crisis initial 60 min	\$147.27	3.13	31-75 min
90840	Psychotherapy crisis ea addl 30 min	\$70.53	1.5	add on after 76 min
90785	Interactive Complexity	\$15.49	NA	NA

Psychiatric Collaborative Care Services

Psychiatric Collaborative care is a specific type of integrated care that treats common mental health conditions such as depression and anxiety that require systematic follow-up due to their persistent nature. Based on [principles of effective chronic illness care](#), collaborative care focuses on defined patient populations tracked in a registry, measurement-based practice and treatment to target. Trained primary care providers and embedded behavioral health professionals provide evidence-based medication or psychosocial treatments, supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected.

Medicare makes separate payments to physicians and non-physician practitioners for behavioral health integration (BHI) services they furnish to beneficiaries over a calendar month service period. **CPT codes 99492, 99493, and 99494** are used to bill for monthly services furnished using the Psychiatric Collaborative Care Model (CoCM), an approach to BHI shown to improve outcomes in multiple studies. These are mental health/psychiatric codes but many palliative care patients require these services.

CMS overview: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>

WA's HCA's policy: <https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules>

Excerpt from the Physician-related/professional services fee schedule.

99492	\$157.39	\$157.39	N	EPA/PA*	*EPA or PA may be required, please see the Physician Related billing guide
99493	\$126.55	\$126.55	N	EPA/PA*	*EPA or PA may be required, please see the Physician Related billing guide
99494	\$63.95	\$63.95	N	EPA/PA*	*EPA or PA may be required, please see the Physician Related billing guide

One challenge might be how the managed care organizations manage this benefit. Sometimes it is managed differently than fee-for-service and from one MCO to the next MCO.

Physician Billing for Medicare Hospice Patients

Once a Medicare patient elects hospice, care related to the terminal diagnosis is paid directly by the Centers for Medicare and Medicaid Services (CMS) to the hospice provider. Physician services are billed by the hospice according to the nature of the service performed.

Attending Physician Services

- The hospice attending physician is an MD, DO, PA or NP who may or may not be an employee of the hospice.
- An interdisciplinary hospice team includes a physician who oversees elements of the patient's care. In addition, a hospice patient may elect to have their primary care physician (PCP), another doctor or a physician assistant/nurse practitioner be their attending physician.
- If the selected clinician agrees to be the hospice patient's attending clinician, any focused treatment related to the patient's terminal status that this clinician provides can be billed to Medicare directly. Only an attending clinician who is not employed by the hospice can bill Medicare Part B for hospice care using the CPT E/M code.
- If the hospice physician serves as the attending physician, all services related to the terminal condition are billed to Medicare by the hospice, not directly by the physician. The patient's PCP/other clinician is kept informed of the patient's status by the hospice team and contributes to the dialogue but does not assume any direct care related to the terminal diagnosis.

Following Physician Services

- The attending MD or DO (although not a PA or NP) may opt to be the patient's following physician, responsible for providing actual hospice care, i.e. writing orders, conferring with the hospice team nurse and giving direction.

Non-Attending (Consulting) Physician Services

- In cases where the patient requires services related to the terminal condition by a physician who is not the attending physician, this specialty physician must have a contractual agreement with the hospice for their services. Payments toward any treatment or care services related to the patient's terminal illness and provided by a specialist contracted with the hospice are the responsibility of the hospice, and not Medicare Part B or Part A.

Administrative Activities

- Administrative or supervisory activities include establishing, reviewing or updating plans of care, supervising the implementation of care, etc. These services are performed by a medical director or physician employed by the hospice and are included in the hospice payment rate. In other words, they are covered by the Medicare hospice benefit. No additional billing occurs for administrative activities.