Documenting and Billing tips for Integrative Medical Group Visits

*******New Virtual Visit guidelines are noted by *bold italics with underlines.*********

From Paula Gardiner 1/1/2020 ---- New Virtual visit update from Jeffrey Geller 3/24/2020

This document gives charting and billing information for the Integrative Medical Group Visits model for providing group visits ***with an update on the use of virtual group visits***. At the beginning or conclusion of the group visit or during the course of the visit, the healthcare provider meets with participants for one-on-one appointments. ***With virtual visits this may be done the same way if you have a HIPPA compliant telemedicine environment and can see patients individually in a confidential virtual room.*** When documenting the visit, the facilitator should document what was covered in the course of the group visit as well as any individual medical needs that were addressed (i.e. diabetes, high blood pressure, etc.). For clinicians who can use "quick texts" in their electronic medical record system, below are the quick text scripts that have been created for the content of the IMGV curriculum. You may use these and modify them as needed. ***With virtual group visits we are also recommending a linked visit model. In this model individual visits may happen before or after the virtual group visit. To accommodate this timing the time of the actual group visits may be shortened.***

CODING GROUP VISITS

Currently there are no standardized ICD-10 codes or no nationally accepted standards or explicit guidelines for coding and billing for medical group visits. (AAFP, 2016) Clinicians follow the Center for Medicaid and Medicare Services and standard rules in billing using Evaluation and Management (E/M) coding. ***There are specific billing codes that have been developed for virtual or tele-visits. Traditionally these codes have not been re-imbursed but varies depending on your state billing code. With the current COVID-19 pandemic virtual visits are being treated like in person visits and can be billed and should be coded in the same way.***

The Centers for Medicare and Medicaid Services has this noted on their website

"EXPANSION OF TELEHEALTH WITH 1135 WAIVER: Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Prior to this waiver Medicare could only pay for telehealth on a limited basis: when the person receiving the service is in a designated rural area and when they leave their

home and go to a clinic, hospital, or certain other types of medical facilities for the service. “

The AFP website notes the “Medicare has issued a statement regarding group visits:

"...under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E/M visit (CPT code 99213 or similar code depending on level of complexity) to a patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary." The letter went on to state that any activities of the group (including group counseling activities) should not impact the level of code reported for the individual patient.”

If the group type is provided by a prescribing provider (MD, DO, physician assistant, or nurse practitioner), and a) individual medical evaluation and management and b) care provided in the context of a group visit, it can be billed using a medical E&M code 99213 or 99214, based on appropriate level of medical complexity. Under the CMS guidelines above, there is no limit on the number of patients that can be included, however, it is important to ensure that you provide complete services to each patient during the time period. If you do not provide care you cannot bill for the care of that patient. Based on your staffing, you will have to figure out how many patients you can bill. ***This is unchanged for virtual group medical visits.***

The different models of group visits may require different coding approaches, and each model should be evaluated against Current Procedural Terminology (CPT) coding and documentation guidelines. As with all office visits, industry-standard coding rules and standards for medical record documentation apply to group visits. The following instructions apply to the Medical Group Visit. Since CPT does not specifically provide codes for group visits, we must use Evaluation and Management codes (E/M) visit codes to describe the services provided. The Community Health Care Center (CHCC) model, as described above, meets the criteria for coding a level three or four office visit (99213 or 99214) for an established patient. In order to code 99214 for a group visit the medical record documentation must include two of the three key components required for this E/M code: 1) a problem focused history, 2) a problem focused exam, 3) straightforward medical decision making. ***This is unchanged for virtual group medical visits.***

If a group visit is happening in a virtual environment, then the billing document needs to clearly state the technology / software vendor that was used. The visit documentation needs to clearly identify why the visit is being held virtually as opposed to an in person visits. (To prevent the spread of COVID-19 is a valid rational at this time.)

If the documentation does not meet the CPT criteria for code 99213 or 4, the CPT guidelines should be reviewed for selection of a more appropriate code. E/M codes may only be used if the health care provider is present during the entire group visit and either documents the care or reviews and signs off on the documentation. If a health care provider is not present, the co-facilitator can write the note but not do any billing. Add coding by time as the extent of time spent with the patient in counseling is what often times justifies a CPT 99213 or even a 99214 in the case of an individual appointment on top of the group visit.

	History: CC	**History: HPI**	**History: ROS**	**History: PFSH**	**Medical decision making**
99213	Required	1-3 elements	Pertinent	Not required	Low complexity
99214	Required	4+ elements (or 3+ for chronic diseases)	2-9 systems	1 element	Moderate complexity

Some ways that one could code/ determine the most appropriate code for these visits includes:

- Identify expected reimbursement per visit and calculate what is needed to meet costs – How many patients do you need to see? (At Boston Medical Center, we have calculated 10 to 12 patients per group).
- Approach insurance companies in your area to ask about their reimbursement plans (HMO/capitated payers) and how they reimburse for group visits. We recommend that you ask for these instructions in writing and keep those records on file.

Some options as to how to classify these visits:

1. As a Federally Qualified Health Center (pay-per-visit model).
    a. Consider billing a subset of group visit attendees each visit (Standard recommendation is to triple the number of patients a provider could see in the same amount of time by individual visits, for example if you see 10 patients, then you should have 30 people in your groups)
    b. Consider billed and non-billed groups (no medical provider needed at non-billed group)

   Note: If you choose to bill this way, you may be limited in visit frequency.
2. Non-FQHC billing: 99213, 99214, using these codes depends on time and comorbidities addressed.

Adapted from Group Visit Worksheet and Timeline the Integrative Medicine for the Underserved website https://im4us.org/app/General+Group+Visit+Materials?structure=Toolkit and the American Academy of Family Medicine (http://www.aafp.org/practice-management/payment/coding/group-visits.html)

EXAMPLE OF A NOTE AND QUICK TEXT FOR GROUP VISITS

Medical Group Visit Session 1 Example

Subjective: Document as you would for any chief complaint or ongoing problems. Everyone has their quick texts so feel free to document as you think is best.

For example - Patient is here for chronic pain. Pain described as XXX and is has been XXX on a scale of 1-10. Pain is located in the XXX. Pain is negatively affecting function. Pain is currently affecting the following: poor sleep, worsening depression. Pain is improved by XXX and pain is made worse by XXX. Medications include:

Objective– vitals and physical exam

Assessment and Plan
Today the following conditions were addressed: (Hint: Use Problem List)
Example: Chronic pain improving this last week – continue medications, referral to osteopathic manipulation, etc.
Other Medical Diagnosis
Welcomed participants
Confidentiality form reviewed and signed and ground rules reviewed
Introduction to the participant manual and how to use
Taught participant to take own vitals including blood pressure, pulse, weight and BMI
Reviewed how high blood pressure, weight and BMI negatively affect our health and strategies to improve these outcomes
Overview of group model, integrative medicine, and the integrative medicine group model
Review of mindfulness
Reviewed what to do in an emergency medical situation and who to contact
Awareness of Breath meditation
Orientation to home practice assignments

- When documenting do NOT use the term **class** – use term group medical appointment, shared medical appointment

TIME BASED documentation in the EMR Option 1
>2 hour visit with face to face medical counseling in a group setting re: stress management and nutrition for >50% of the visit. XXX minutes was spent in direct face to face care with patient discussing XXX

TIME BASED documentation in the EMR Option 2
120 minute spent in this group medical appointment, discussing: example – stress reduction, nutrition, and lifestyle modification. Individual face to face check in was done during the visit in front of group. Session led by xxx and xxx.

If you spent one on one time not in front of the group (I spent >50% of this 15 minute visit face-to-face with the patient, coordinating care, or reviewing medications, and counseling the patient on risks and benefits of integrative treatments for XXX.)

Medical Group Visit Session 2 example
Participant checked in and recorded own vital signs, reviewed the vitals with the patient
Reviewed pain level with patient
Individual check in with the provider
Centering meditation: Awareness of Breath (AOB)
Go around: participant reviewed and reflected upon home practice
Discussed health prevention strategies for their pain and stress**,** Introduction to mindful eating: raisin exercise
Health topic discussion: Stress and its effect on the body and mind as well as healthy and unhealthy ways to cope with stress**,** Introduction to Body Scan Meditation
Reviewed home practice assignments for next week

If you spent one on one time not in front of the group (I spent >50% of this 15 minute visit face-to-face with the patient, coordinating care, or reviewing medications, and counseling the patient on risks and benefits of integrative treatments for XXX.)

>2 hour visit with face to face counseling in a group setting re: stress management, prescription and nonprescription treatments for pain and associated conditions >50% of the visit
XXX minutes was spent in direct face to face care with patient discussing XXX

120 minute spent in this group medical appointment, discussing: example – stress reduction, stress management, prescription and nonprescription treatments for pain and associated conditions, and lifestyle modification. Individual face to face check in was done during the visit in front of group. Session led by xxx and xxx.

DIAGNOSTIC CODES

Select the ICD-10 code that reflects the primary reason for the patient visit. This code should be designated as the primary diagnosis by placing a “1” or a “P” next to it on the Treatment Record Form (TRF). If additional problems, symptoms or chronic diseases were addressed during the visit, add these conditions as secondary diagnoses. All diagnoses must be documented in the medical record.

Resources

This is the best web based resource I have found:

https://www.aafp.org/practice-management/payment/coding/group-visits.html