Coding for 2024

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Speaker Disclosures

Dr. Zorowitz is an employee and stockholder of Humana, Inc. and has no financial conflicts of interest to disclose

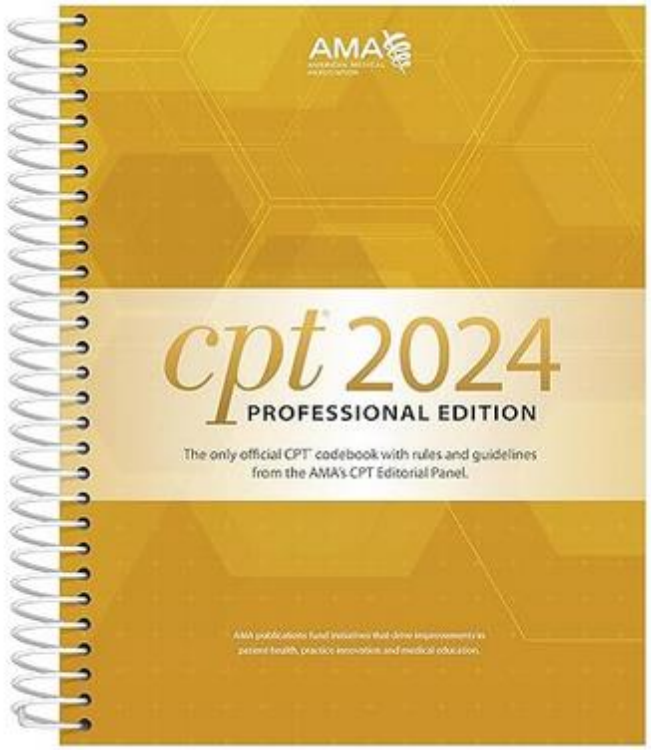
The opinions presented in this presentation represent those of Dr. Zorowitz and do not represent the position(s) of Humana

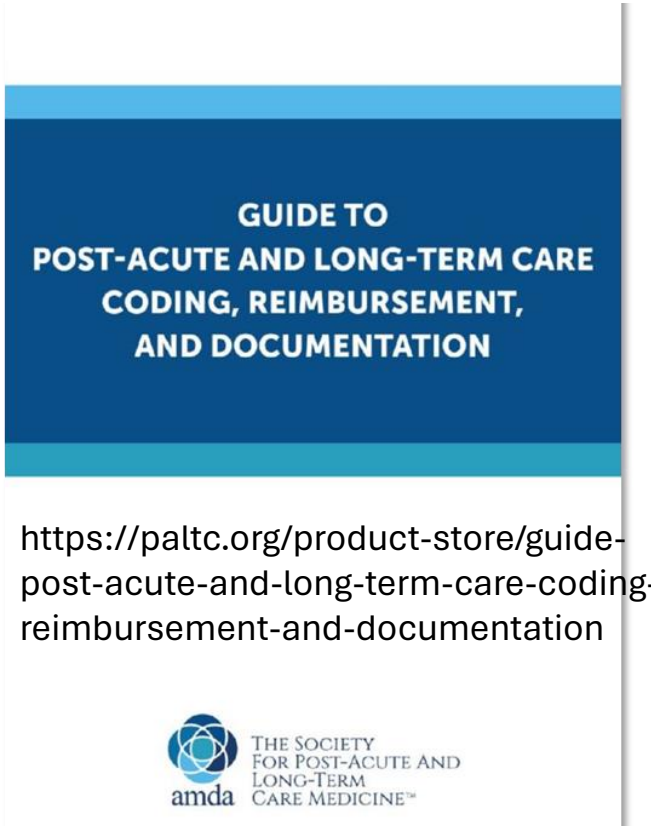
AND THANK YOU TO THE AMERICAN GERIATRICS SOCIETY FOR ALLOWING ME TO STEAL SOME OF THE CONTENT IN THESE SLIDES

Objectives and Agenda

Review Code Selection Criteria: Total Time vs. Medical Decision Making
Review Prolonged Services
Review the Office/Outpatient Complexity Add-on Code G2211
Review Split/Shared Services
Review Revised Guidance for Split/Shared Services
Review Telehealth Updates
Review Other 2024 E&M Revisions
And maybe other stuff if we have time…

Tip for Accurate Coding: Know Your Codes and Reimbursement!



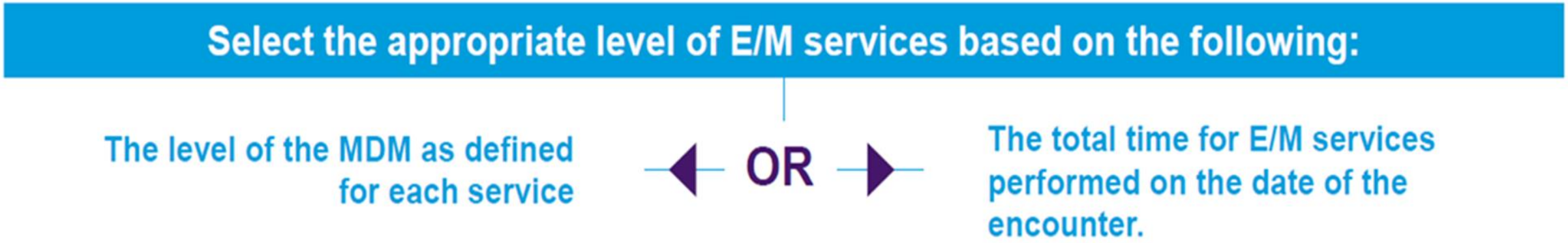


https://paltc.org/product-store/guide-post-acute-and-long-term-care-coding-reimbursement-and-documentation

amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Medicare Physician Fee Schedule Lookup: https://www.cms.gov/medicare/physician-fee-schedule/search

Reminder: Choosing Level of Care for E&M Services



From 8/9/2022 Webinar L, Levy, B, Hollmann P. "E/M 2023: Advancing Landmark Revisions Across More Settings of Care," downloaded on 10/2/2022 from https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

1. History and Physical Examination

- Must be performed and documented as clinically appropriate
- No longer an element in the selection of the level of E&M service codes
- No need to document gratuitous reviews of systems for the purpose of claims unless performed or reviewed as clinically appropriate
- Remain important activities clinically and to support medical necessity of the service

2.Time

Total time on the date of the encounter,

To select the level based on time, the indicated total time must be met or exceeded

Includes both face-to-face time *with the patient* and/or family/caregiver and non-face-to-face time (must include a face-to-face encounter)

Includes time regardless of location

Do not count time spent on:

- Travel
- General teaching not limited to discussion that is required for the management of a specific patient
- Other services that are reported separately

E&M Total Time Spent on Calendar Day of the Encounter

Pre-visit

- Preparing to see patient, review of tests
- Independently reviewing results and communicating results to patient/caregiver

Visit

- Obtaining/reviewing separate history
- Performing exam and evaluation
- Counseling/educating patient and caregiver

Post-visit

- Ordering medications, tests
- Documentation in EMR
- Referring or communicating with other HCP (not separately reported)
- Care coordination (not separately reported)

Document: *"I personally spent ____ minutes on the calendar day of the encounter, including pre and post visit work."*

3. Medical Decision Making 2024

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal	Minimal or None	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

- To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded
- The details and examples of Medical Decision-Making are described entirely in the 2024 CPT Manual

3. Medical Decision Making 2024

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
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High	High	Extensive	High

- To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded
- The details and examples of Medical Decision-Making are described entirely in the 2024 CPT Manual

Why learn Medical Decision Making when I can use time?

HCPCS Code	Short Description	Total Time in Minutes*	Medical Decision Making	Price (2024)	Work RVU
99304	1st nf care sf/low mdm 25	25	Straightforward or low	$78.26	1.5
99305	1st nf care moderate mdm 35	35	Moderate	$129.99	2.5
99306	1st nf care high mdm 50	50	High	$177.47	3.5
99307	Sbsq nf care sf mdm 10	10	Straightforward	$39.29	0.7
99308	Sbsq nf care low mdm 20	20	Low	$72.69	1.3
99309	Sbsq nf care moderate mdm 30	30	Moderate	$105.11	1.92
99310	Sbsq nf care high mdm 45	45	High	$149.97	2.8

*Note highlighted times were increased by 5 minutes over 2023 Total Time
Price is National Payment Amount

2024 conversion factor is $32.74 per RVU

▶Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Straightforward	**Minimal** ■ **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** ■ **2** or more self-limited or minor problems; **or** ■ **1** stable, chronic illness; **or** ■ **1** acute, uncomplicated illness or injury; **or** ■ **1** stable, acute illness; **or** ■ **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **Category 1: Tests and documents** ■ **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

▶Elements of Medical Decision Making			
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Straightforward	**Minimal** ■ **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** ■ **2** or more self-limited or minor problems; **or** ■ **1** stable, chronic illness; **or** ■ **1** acute, uncomplicated illness or injury; **or** ■ **1** stable, acute illness; **or** ■ **1** acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **Category 1: Tests and documents** ■ **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

Could be family member, caregiver, CNA or other staff members

▶Elements of Medical Decision Making

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
Moderate	**Moderate** ■ **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** ■ **2** or more stable, chronic illnesses; **or** ■ **1** undiagnosed new problem with uncertain prognosis; **or** ■ **1** acute illness with systemic symptoms; **or** ■ **1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** ■ **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* ■ Prescription drug management ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social determinants of health

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Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
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What is Prescription Drug Management?

▶Elements of Medical Decision Making

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
Moderate	**Moderate** ■ **1** or more chronic	**Moderate** *(Must meet the requirements of at least 1 out of 3*	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* ■ Prescription drug management ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social determinants of health

Prescription drug management is considered:

- Initiating or increasing a prescription drug that may have significant adverse effects
- Continuing a prescription medication; documenting the decision-making involved
- NOTE: Simply listing medications to be continued or started is not considered prescription drug management

What is Prescription Drug Management?

▶Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Moderate	**Moderate** ■ **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** ■ **2** or more stable, chronic illnesses; **or** ■ **1** undiagnosed new problem with uncertain prognosis; **or** ■ **1** acute illness with systemic symptoms; **or** ■ **1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** ■ **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* ■ Prescription drug management ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social determinants of health

Document any SDOH and reason(s) for impact on care plan

►Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
High	**High** ■ **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** ■ **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** ■ **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* ■ Drug therapy requiring intensive monitoring for toxicity ■ Decision regarding elective major surgery with identified patient or procedure risk factors ■ Decision regarding emergency major surgery ■ Decision regarding hospitalization or escalation of hospital-level care ■ Decision not to resuscitate or to de-escalate care because of poor prognosis ■ Parenteral controlled substances◄

Additional HIGH MDM for Nursing Facility

"When selecting a level of medical decision making (MDM) for nursing facility services, the number and complexity of problems addressed at the encounter is considered. For this determination, a **high-level MDM type specific to initial nursing facility care** by the ***principal**** physician or other qualified health care professional is recognized. This type is:

"**Multiple morbidities requiring intensive management**: A set of conditions, syndromes, or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.

"The definitions and requirements related to the amount and/or complexity of data to be reviewed and analyzed and the risk of complications and/or morbidity or mortality of patient management are unchanged."

*The principal/attending physician should append the modifier **–AI** to the initial nursing facility claim to identify as the principal attending physician responsible for the overall care

Nursing Facility Care Services 2024

Initial Nursing Facility Care

Patient: New or Established			
Code	**99304**	**99305**	**99306**
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making Level			
Straightforward or Low	X		
Moderate		X	
High			X
OR			
Total Time (On Date of the Encounter)			
Minutes	25	35	50

Subsequent Nursing Facility Care

Patient: New or Established				
Code	**99307**	**99308**	**99309**	**99310**
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	10	20	30	45

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal	Minimal or None	Minimal
Low	Low	Limited	Low
Moderate	Moderate	Moderate	Moderate
High	High	Extensive	High

Discharge from SNF/NF

- 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 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.

Medicare Claims Policy Manual, Chapter 12, Section 30.6.13

Nursing Facility Discharge Services

HCPCS Code	Short Description	Natl Pmt Price (2024)	Work RVU
99315	Nf dschrg mgmt 30 min/less	$79.57	1.5
99316	Nf dschrg mgmt 30 min+	$127.70	2.5

Home *and* Assisted Living Facility Care 2024

(Place of service codes have not changed)

"The following codes are used to report evaluation and management services provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short-term accommodation (eg, hotel, campground, hostel, or cruise ship).

"**These codes are also used when the residence is an assisted living facility**, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility."

Home or Residence Services

Patient: New				
Code	99341	99342	99344	99345
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	15	30	60	75

Home or Residence Services

Patient: Established				
Code	99347	99348	99349	99350
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	20	30	40	60

Home Care, Assisted Living, Residential Care Codes Now Combined into a Single Code Set : Home/Residence Visits

HCPCS Code	Short Description	Total Time in Minutes	Level of Medical Decision Making	2024 National Payment Amount	Work RVU
99341	Home/res vst new sf mdm 15	15	Straightforward	$48.13	1
99342	Home/res vst new low mdm 30	30	Low	$76.29	1.65
99344	Home/res vst new mod mdm 60	60	Moderate	$138.51	2.87
99345	Home/res vst new high mdm 75	75	High	$196.79	3.88
99347	Home/res vst est sf mdm 20	20	Straightforward	$44.21	0.9
99348	Home/res vst est low mdm 30	30	Low	$74.66	1.5
99349	Home/res vst est mod mdm 40	40	Moderate	$124.10	2.44
99350	Home/res vst est high mdm 60	60	High	$180.75	3.6

Prolonged Services

The CY 2023 Physician Fee Schedule Final Rule:

- "G" codes for prolonged services
  - G0316 Prolonged Hospital or Observation Services
  - G0317 Prolonged Nursing Home Services
  - G0318 Prolonged Home or Residence Services
  - G2212 Prolonged Office/outpatient
- Converted Non-face-to-face prolonged service codes 99358-99359 to status "I," i.e. "Not valid for Medicare purposes" or "Ineligible."
- Other CPT Codes for Prolonged Services are not reimbursed by CMS, but may be paid by commercial, Medicaid or some Medicare Advantage payers—check with your payers
- Clarified the time horizon for nursing home prolonged service codes

https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

G0317

- ***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*
  - *(list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services).*
  - *(Do not report G0317 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418).*
  - *(Do not report G0317 for any time unit less than 15 minutes)*

How to Use G0317

- May only be used if reporting the following nursing facility codes, using ***time***:
  - 99306 Initial nursing facility care, per day, 50 minutes must be met or exceeded, *but threshold is 95 minutes to report G0317 X 1*
  - 99310 Subsequent nursing facility care, per day, 45 minutes must be met or exceeded, *but threshold is 85 minutes to report G0317 X 1*
- May be reported for prolonged time within the surveyed time frame:
  - One day before the E&M service
  - On the day of the E&M service
  - Up to 3 days after the E&M service
- May be reported only when the prolonged time equals or exceeds 15 minutes beyond the maximum time specified by the codes
- May be reported for each 15-minute increment beyond the maximum time specified in the codes; ***there is no frequency limitation***
- Includes both face-to-face and non-face-to-face time; may be discontinuous

G0318

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

How to Use G0318

- Would be reportable when the total time for the **home or residence** visit (specified in the time file) is exceeded by 15 or more minutes
- Reportable as add on code to:
  - 99345 Home or residence visit for the evaluation of a new patient, 75 minutes must be met or exceeded; *threshold of 140 minutes total to report G0318 X 1*
  - 99350 Home or residence visit for the evaluation of an established patient, 60 minutes must be met or exceeded*; threshold of 110 minutes to report G0318 X 1*
- May be reported for prolonged service(s) spent during:
  - The pre-service 3-days before the E&M visit
  - During the intraservice time on the day of the visit
  - The post-service time up to 7 days after the day of the visit

When prolonged services for a nursing facility visit (e.g. 99306, 99210) spans several days, what date of service is reported for the prolonged service code G3017?

Answer: In CY 2023, care relative to the initial nursing facility service (99306), and prolonged time for the service (G0317), may occur over a 5-day timespan. This includes the date prior to 99306, the date of on which 99306 is completed and the 3 dates subsequent to the 99306.

For example, 99306 performed on January 5th would include the timespan of January 4th through January 8th for services by the same billing provider/group. Since 99306 requires 95 minutes of time before prolonged service(s) can be added, 99306 may be performed over a period of more than one date. When this is the case, 99306 should be billed for the DOS on which the 95 minute timeframe has been completed. Prolonged services performed beyond the date of 99306 **should be billed with the DOS on which they were completed**, within a 3 day timeframe after the date of 99306.

NOTE: Some payers' systems may not be able to recognize G0317 if the date of service differs from the date of service of the index service, i.e. 99306 or 99310.

https://www.ngsmedicare.com/ca/evaluation-and-management?selectedArticleId=5205244&lob=96664&state=97133&rgion=93623

Time Thresholds for Prolonged Services

Primary E/M Service	Prolonged Code*	Service Time (as per code descriptor)	Time Threshold to Report Prolonged Service	Count Physiican/NPP time spent within this time period (surveyed time frame)
Initial NF Visit (99306)	G0317	50 mins	95 mins	1 day before visit + date of visit + 3 days after
Subsequent NF visit (99310)	G0317	45 mins	85 mins	1 day before visit + date of visit + 3 days after
NF Discharge Day Mngmt	n/a	n/a	n/a	n/a
Home/Residence Visit New (99345)	G0318	75 mins	140 mins	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. (99350)	G0318	60 mins	110 mins	3 days before visit + date of visit + 7 days after

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

https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

Prolonged Services: Payment and wRVU for 2024

HCPCS Code	Short Description	Non-Facility Price	Facility Price	Work RVU
G0316	Prolong inpt eval add15 m	$31.11	$29.47	0.61
G0317	Prolong nursin fac eval 15m	$31.11	$29.47	0.61
G0318	Prolong home eval add 15m	$30.45	$29.14	0.61

https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf
(see page 211 of the PDF document or page 69614 of the Federal Register, Vol 87, No. 222)

Time Thresholds to Report Prolonged E&M Services: 2024

Code	Primary E/M service	Prolonged Code	Service Time (as per code descriptor)	Time Threshold to Report Prolonged Service	Count Physican/NPP time spent within this time period (surveyed time frame)
99205	Office/Outpatient Visit New	G2212	60 mins	89 mins	Date of Visit
99215	Office/Outpatient Visit Est	G2212	40 mins	69 mins	Date of Visit
99223	Initial IP/Obs Visit	G0316	75 mins	90 mins	Date of Visit
99233	Subsequent IP/Obs Visit	G0316	50 mins	65 mins	Date of Visit
99238-9	IP/Obs Discharge Day Management	n/a	n/a	n/a	n/a
	Consults	n/a	n/a	n/a	n/a
99345	Home/Residence Visit New	G0318	75 mins	140 mins	3 days before visit + date of visit + 7 days after
99350	Home/Residence Visit Est.	G0318	60 mins	110 mins	3 days before visit + date of visit + 7 days after
99306	Initial NF Visit	G0317	50 mins	95 mins	1 day before visit + date of visit + 3 days after
99310	Subsequent NF Visit	G0317	45 mins	85 mins	1 day before visit + date of visit + 3 days after
99483	Cognitive Assessment and Care Planning	G2212	60 mins (typical)	100 mins	3 days before visit + date of visit + 7 days after

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

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Prolonged Office/Outpatient E/M visits

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

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

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Office/Outpatient Visit Complexity Add-on Code G2211

Office/Outpatient Visit Complexity Add-on Code G2211

- Became effective January 1, 2024
- Created by CMS (HCPCS Code)
- Reflects complexity associated with comprehensive primary care or ongoing medical care of patient with single serious or complex condition
- May be reported as add-on only with Office/Outpatient codes 99202-99215
- Reimbursement: $16.04 in addition to reimbursement for accompanying Office/Outpatient E&M code

Office/Outpatient Visit Complexity Add-on Code G2211

Code Descriptor

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

Office/Outpatient Visit Complexity Add-on Code G2211

- Per CMS, the patient-clinician relationship determines the code's use; not the specific clinical condition being treated in the visit
- May be used when clinician is the continuing focal point for all health care services that the patient needs
- May be used for ongoing care of a patient with a single serious or complex condition
- Level of E&M code at any given visit does not matter
- May be reported when patient has Office/Outpatient visit on the same day of visit or procedure performed by another clinician
- No frequency limitations, but CMS will monitor

Office/Outpatient Visit Complexity Add-on Code G2211 Restrictions

- May not be submitted with visits reported with modifier -25
- May not be submitted with Medicare Wellness Visits
- CMS will monitor whether clinicians avoid performing preventive services on the same day as Office/Outpatient visits to avoid reporting modifier -25
- Probably can be reported in Hospital/Facility Based Office/Outpatient office, but opinions differ…

G2211 Examples from the Final Rule

- Primary care clinician who is the continuing focal point for all health care services for a patient may submit G2211 when evaluating the patient for sinus congestion due to cognitive load of the continued responsibility of being the focal point for all needed services for this patient
- May be submitted for service that is part of ongoing care for a patient's single, serious or complex condition, e.g. an infectious disease specialist managing a patient with HIV over time
  - G2211 not restricted to specialty
  - Must demonstrate ongoing longitudinal care of the patient

Split or Shared Services

Split or Shared Visits

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 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.

--Medicare Claims Processing Manual, Chapter 12

Split or Share Visits-Background

- Revised definition effective January 1, 2024
- Simplified policy by revising definition to be consistent with CPT manual:

"…for Medicare billing purposes, the "substantive portion" means more than half of the total time spent by the physician or NPP performing the split (or shared) visit, or a substantive part of the medical decision-making except concerning critical care visits which do not use MDM and only use time, "substantive portion" continues to mean more than half of the total time spent by the physician or NPP performing the split (or shared) visit…"

Split or Shared Visit: Substantive Portion

"For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM."

2024 CPT Manual

Split or Shared Visit: Substantive Portion

"If the amount and/or complexity of data to be reviewed and analyzed is used by the physician or other QHP to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP because the relevant items would be considered in formulating the management plan Independent interpretations of tests and discussion of management plan or test interpretation must be personally performed by the physician or other QHP if these are used to determine the reported code level by the physician or other QHP"

2024 CPT Manual

Split or Shared Visits

E/M Visit Code Family	Place of Service Code(s), examples	2023 Definition of Substantive Portion	2024 Definition of Substantive Portion
Other Outpatient	05, 09, 22, 24, etc.	History, or exam, or MDM or more than half of total time	More than half the total time OR MDM*
Inpatient/Observation/ Hospital/**SNF**	21, 31	History, or exam, or MDM or more than half of total time	More than half the total time OR MDM*
NF	**32**	Cannot use split visit **or** "incident to"	Cannot use split visit **or** "incident to"
Office	11	Cannot use ("incident to" applies)	Cannot use ("incident to" applies)
Home/Residence	12-16	Cannot use ("incident to" applies)	Cannot use ("incident to" applies)
Emergency Department	23	History, or exam, or MDM or more than half of total time	More than half the total time OR MDM*
Critical Care	23, 21, etc.	More than half of total time	More than half the total time

*Substantive portion of MDM requires clinician made or approved management plan for the **number and complexity of problems addressed at the encounter** and takes responsibility for that plan with its inherent **risk of complications and/or morbidity or mortality of patient management**.

https://public-inspection.federalregister.gov/2023-24184.pdf

Some 2024 E&M Revisions

Changes in Time Threshold for 99306, 99308 (Increased by 5 minutes)

Initial Nursing Facility Care

Patient: New or Established			
Code	99304	99305	99306
REQUIRED ELEMENTS			
Medically Appropriate History and/or Examination	X	X	X
Medical Decision Making Level			
Straightforward or Low	X		
Moderate		X	
High			X
OR			
Total Time (On Date of the Encounter)			
Minutes	25	35	50

Subsequent Nursing Facility Care

Patient: New or Established				
Code	99307	99308	99309	99310
REQUIRED ELEMENTS				
Medically Appropriate History and/or Examination	X	X	X	X
Medical Decision Making Level				
Straightforward	X			
Low		X		
Moderate			X	
High				X
OR				
Total Time (On Date of the Encounter)				
Minutes	10	20	30	45

Pelvic Exam with Office/Outpatient or Preventive Medicine Visit

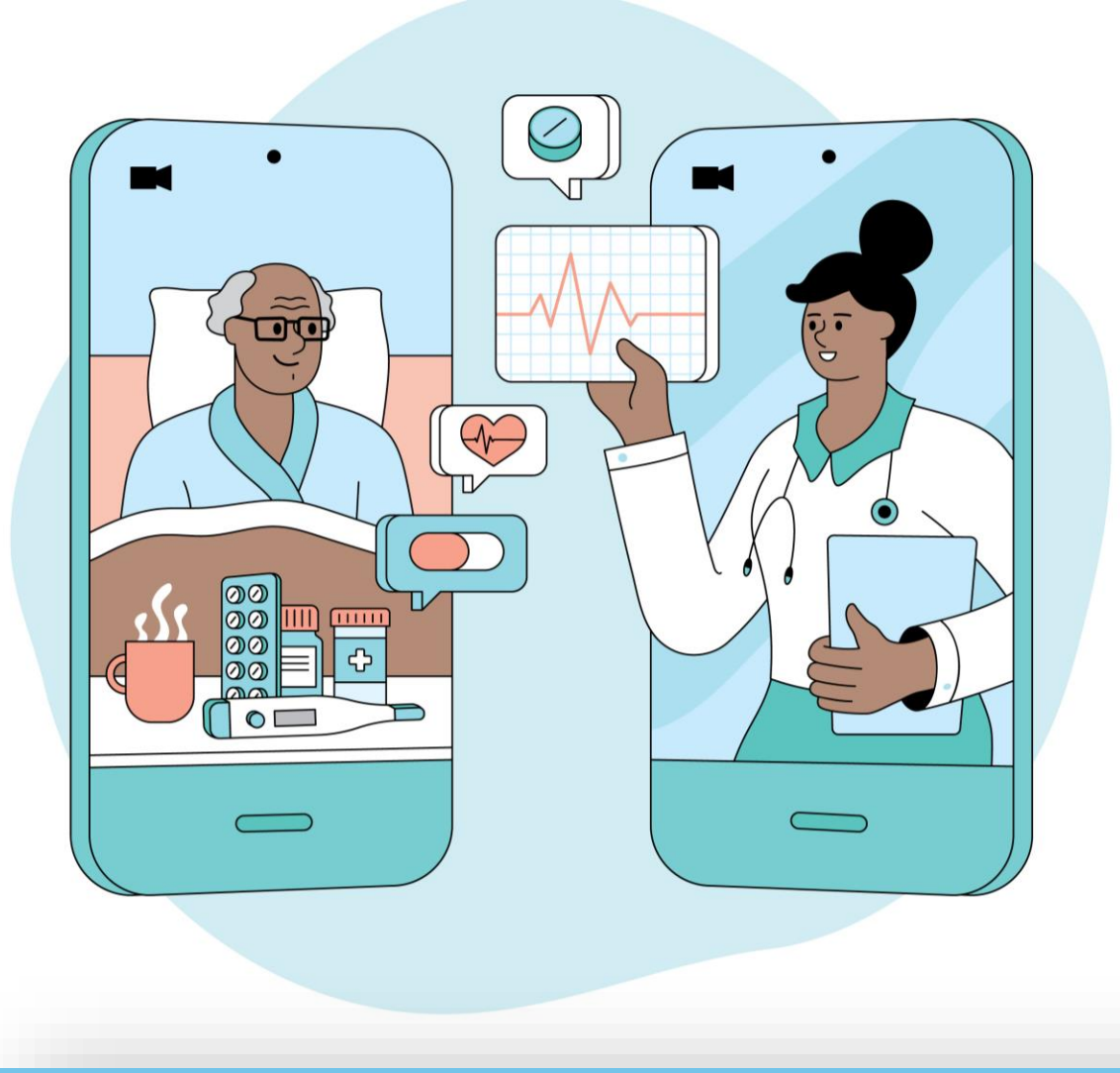
+99459- Pelvic Exam

The new CPT code 99459 (pelvic exam) is a practice expense-only code and therefore has no work RVU associated with the service. May be reported with E&M services or Preventative Medicine services in the non-facility/office setting

Practice expense (PE) RVU=0.68 = $22.26 on Medicare fee schedule

Multiple E&M Services on the Same Date

- An opportunity to address nuances and questions regarding these issues
- Adopts long-standing, generally accepted rules and CMS policy and makes them more accessible (CPT vs. Medicare Manuals)
  - Example: Hospital Discharge + Initial Nursing Facility Visit permitted on same day
- A major exception is that CPT codes allow reporting two services by the same clinician on the date of another E&M service (e.g. office/outpatient + initial inpatient), whereas CMS does not
  - Therefore, CPT provided instructions for when only one service is reported and these instructions are consistent with CMS policy
  - Add up time and MDM if reporting only one



Telehealth

Key Telehealth Flexibilities Extended through Statute

At the end of 2022, Congress approved the Consolidated Appropriations Act of 2023, which extended key Medicare telehealth flexibilities:

- Continued coverage and payment for audio-only telehealth services and telephone E&M services (99441-99443) through 2024
- Lifted geographic and originating site requirements on Medicare telehealth service through December 31, 2024
- Extended the ability for FQHCs and RHCs to furnish telehealth services
- Delayed the in-person requirement on Medicare tele-behavioral health services until on or after January 1, 2025

Additional Flexibilities Finalized by CMS

- Extended through 2024 direct supervision vis use of two-way audio-video (A/V) communications technology, other than teaching physician in an Office of Management and Budget (OMB) defined Metropolitan Statistical Area (MSA). Use for 99211, labs, etc.
- Also extended removal of frequency limitations through 2024 for subsequent inpatient visit CPT codes: 99231, 99232, 99233; subsequent nursing facility visit CPT codes: 99307-99310; and critical care consultation services: G0508, G0509.
- Both policies initially suspended during the Public Health Emergency
- CMS plans to consider further extensions or changes in future rulemaking
- Teaching physician rules (including primary care exception) return to pre-PHE other than remote supervision of trainee outside an MSA and virtual supervision when the service itself is virtual

Office/Outpatient Codes and Telehealth - 2024

Code	Short Descriptor	Status
99202	Office/Outpatient Visit New	Permanent
99203	Office/Outpatient Visit New	Permanent
99204	Office/Outpatient Visit New	Permanent
99205	Office/Outpatient Visit New	Permanent
99211	Office/Outpatient Visit Est	Permanent
99212	Office/Outpatient Visit Est	Permanent
99213	Office/Outpatient Visit Est	Permanent
99214	Office/Outpatient Visit Est	Permanent
99215	Office/Outpatient Visit Est	Permanent

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

NOTE: Audio-Only Interaction Cannot Meet the Requirements of these codes.

Home and Residence Codes and Telehealth

Code	Short Descriptor	Status
99341	Home visit new patient	Provisional
99342	Home visit new patient	Provisional
~~99343~~	~~Home visit new patient~~	~~Provisional~~ 99343 was deleted
99344	Home visit new patient	Provisional
99345	Home visit new patient	Provisional
99347	Home visit est patient	Permanent
99348	Home visit est patient	Permanent
99349	Home visit est patient	Provisional
99350	Home visit est patient	Provisional

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

NOTE: Audio-Only Interaction Cannot Meet the Requirements of these codes.

Telemedicine Tips

Use the correct Place of Service (POS) code:

POS 10 is for services delivered to the patient's home (broadly defined) and pays the full non-facility allowance (same as office visit)

POS 2 (Telehealth Provided Other than in Patient's Home) is the older telehealth service from a facility to a remote healthcare site and is paid at the facility rate

Don't use virtual check-in codes when allowed to use telephone visit or A/V office visit

OT/PT/SLP and audiologists may do telehealth

References

Source	Location
Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule Final Rule	https://public-inspection.federalregister.gov/2023-24184.pdf
Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
CMS Evaluation and Management Services Guide	https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/mln-publications-items/cms1243514
CMS Hospital Outpatient Prospective Payment System CY 2024 Final Rule	https://www.govinfo.gov/content/pkg/FR-2023-11-22/pdf/2023-24293.pdf
CPT 2024 Professional Edition	Published by the AMA

Questions?

And thanks again to the American Geriatrics Society for content from the slides.

AGS Geriatrics Healthcare Professionals
Leading Change. Improving Care for Older Adults.

Robert A. Zorowitz, MD, MBA, FACP, AGSF

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"To answer your question, we may or may not be trying to have it both ways."

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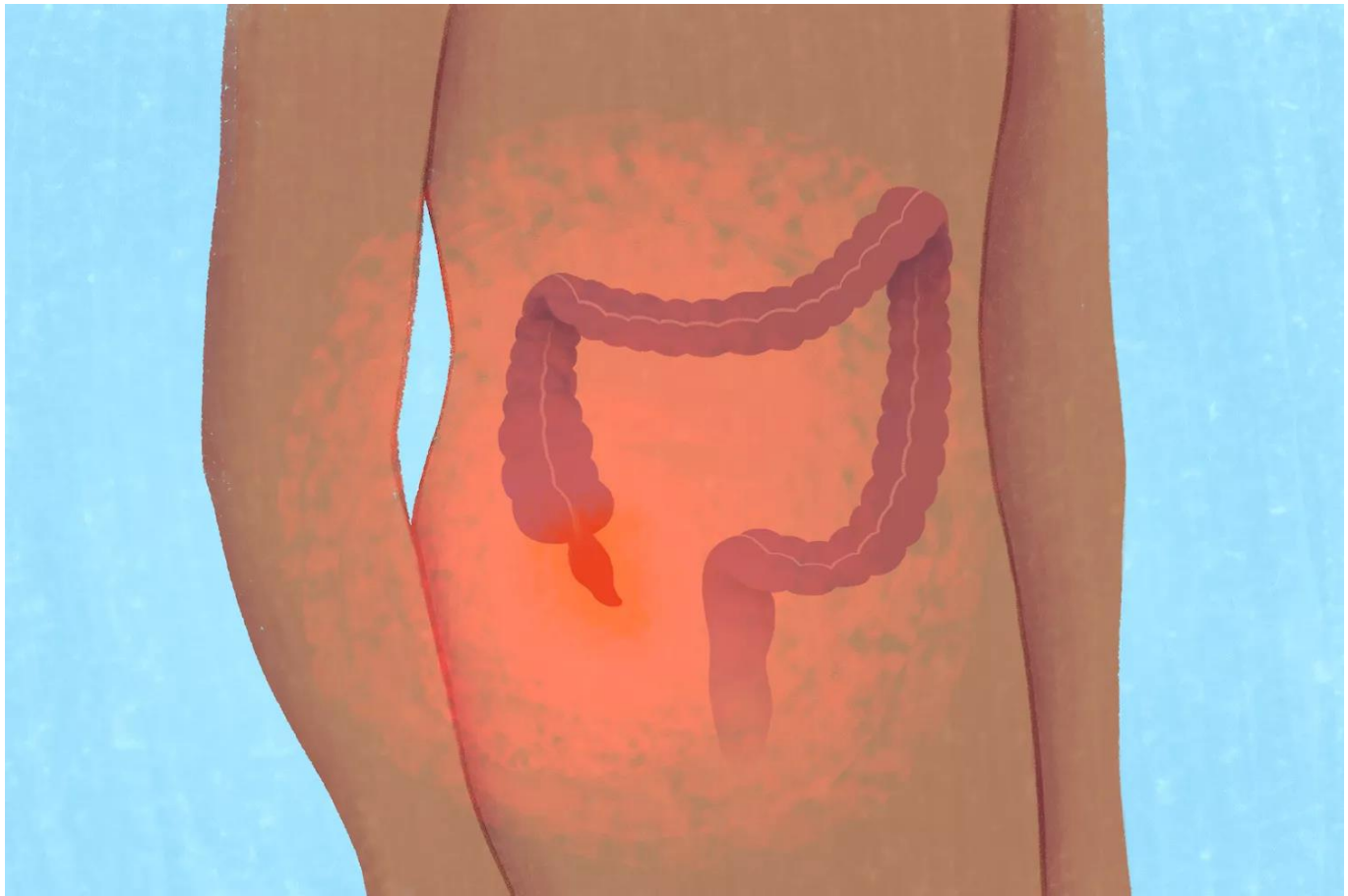
APPENDIX



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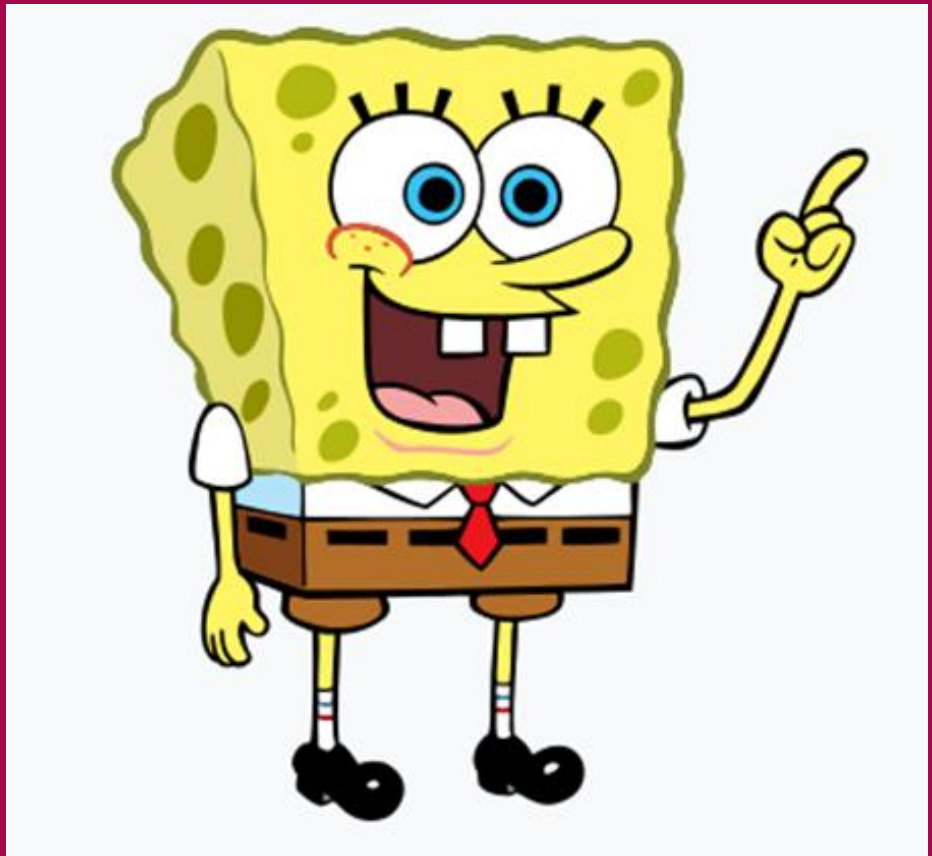
Payment: Fun Facts to Know and Tell!



What is a medically necessary visit?

- “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.”—Medicare Claims Processing Manual, Chapter 12, Physicians/Non-physician Practitioners
- “Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.”—CMS at https://www.cms.gov/apps/glossary/search.asp?Term=medically+necessary&Language=English&SubmitTermSrch=Search
- “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”—Medicare Claims Processing Manual, Chapter 12, Physicians/Non-physician Practitioners

In other words

The visit must be medically necessary AND

The level of service reported must be medically necessary

(supported by H&P, MDM etc.)

THEREFORE:

Documentation must support both the medical necessity of the visit itself AND the level of service being reported

Mandated regulatory physician visits: Frequency

F712
(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)
§483.30(c) Frequency of physician visits

- **§483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.**
- **§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.**
- **§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.**
- **§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.**

Mandated regulatory physician visits: Content

DEFINITIONS §483.30(c) Must be seen, for purposes of the visits required by §483.30(c)(1), means that the physician or NPP must make actual face-to-face contact with the resident, and at the same physical location, not via a telehealth arrangement. There is no requirement for this type of contact at the time of admission, since the decision to admit an individual to a nursing facility (whether from a hospital or from the individual's own residence) generally involves physician contact during the period immediately preceding the admission.

--State Operations Manual; Appendix PP—Guidance to Surveyors, page 445. Downloaded on 10/11/2022 from: https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf

IMPLICATIONS

- Though payment policy allows nursing home visits to be performed via Telehealth (payment policy), this does not apply to regulatory visits (federal regulations)
- **Mandated regulatory** visits must be face-to-face
- Other visits may be performed via Telehealth

Mandated regulatory physician visits: Content

F711

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.30(b) Physician Visits

The physician must—

- **§483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;**
- **§483.30(b)(2) Write, sign, and date progress notes at each visit; and**
- **§483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.**

Authority for Non-Physician Practitioners to Perform Visits, Sign orders and Sign Medicare Part A Certifications/Recertifications When Permitted by the State

	Initial Comprehensive Visit /Orders	Other Required Visits^	Other Medically Necessary Visits & Orders+	Certification/ Recertification ±
SNFs				
PA, NP & CNS employed by the facility	May not perform/ May not sign	May perform alternate visits	May perform and sign	May not sign
PA, NP & CNS not a facility employee	May not perform/ May not sign	May perform alternate visits	May perform and sign	May sign subject to State Requirements
NFs				
PA, NP, & CNS employed by the facility	May not perform/ May not sign	May not perform	May perform and sign	Not applicable
PA, NP, & CNS not a facility employee	May perform/ May sign*	May perform	May perform and sign	Not applicable

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

*A NPP may provide admission orders if a physician personally approved in writing a recommendation for admission to the facility prior to admission. For additional requirements on physician recommendation for admission and admission orders, see §483.30(a), F710.

^Other required visits are the physician visits required by §483.30(c)(1) other than the initial comprehensive visit.

+Medically necessary visits are independent of required visits and may be performed prior to the initial comprehensive visit.

±Though not part of a compliance determination for this section, this requirement is provided for clarification and relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.

Are Counseling and Coordination of Care visits without a patient exam still allowed in the in-patient and Nursing Home and Assisted Living settings? If so, I assume it must be a time-based service and how should the service be documented?

Counseling and Coordination of Care remain important clinical services

They are no longer separate components for the purposes of selecting a level of service

Counseling and Coordination of Care may be included in the total time of the encounter, if using time to select the level of care, or medical-decision making

Now that 99318 Annual Nursing Home Visit has been deleted, how can I report an annual comprehensive exam?

- May use subsequent nursing facility visit codes 99307-99310, selecting the level by either total time of the visit or medical decision-making
- Alternately, consider incorporating the Medicare Wellness Visit into your practice
- Note: Components of Wellness Exams may not be goal-concordant with frail, elderly nursing home residents; may need to customize components of wellness visits to appropriately meet the needs of nursing home residents

Nursing Home Admission and Other Visits on the Same Day

- Emergency department visit services provided on the same day as a nursing facility assessment are not paid
- Hospital discharge and nursing facility admission may be reported separately even if performed on the same day
- Payment for evaluation and management services provided in sites other than the nursing facility are included in the payment for initial nursing facility care when performed on the same date
- 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.

Medicare Claims Policy Manual, Chapter 12, Section 30.6.13

Can I report G2211 with a Nursing Facility Service Code?

- G2211 Ofice/Outpatient Visit Complexity Add-on Service
- Add-on to E&M Service to recognize additional complexities associated with longitudinal patient relationship due to:
  - Primary care **OR**
  - Ongoing medical care of patient with single serious or complex condition
  - Is specialty-agnostic
- May be reported **only** with Office/Outpatient Services 99202-99215
- May **not be** reported with Nursing Facility Services 99304-99310
- May **not be** reported with Home/Residence Services 99341-99350
- May **not be** reported when service with –25 modifier is reported

https://www.cms.gov/files/document/mm13473-how-use-office-and-outpatient-evaluation-and-management-visit-complexity-add-code-g2211.pdf

Consultation Services

- Consultation service codes are not recognized by CMS for Part B Medicare Payment
- 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
- "New vs established" patient is irrelevant in selecting the appropriate E&M code to report for a consultation
- According to both CPT and the 2023 Physician Fee Schedule Final Rule:
  - "An initial service is one that occurs when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty who belongs to the same group ***during the stay***."

Coding Dementia

If you search “dementia” in ICD-10, you’ll see something like this:

- **Dementia (degenerative (primary)) (old age) (persisting) (unspecified severity) (without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety)** **F03.90**
  - with
  - alcoholic F10.97

  Alzheimer's type - see Disease , Alzheimer's

  arteriosclerotic - see Dementia , vascular

  atypical, Alzheimer's type - see Disease , Alzheimer's , specified NEC

  congenital - see Disability , intellectual
  - frontal (lobe) - see also Dementia , in , diseases specified elsewhere G31.09 [F02.80]
  - frontotemporal G31.09 [F02.80]
  - in (due to)

  infantile, infantilis F84.3
  - Lewy body - see also Dementia , in , diseases specified elsewhere G31.83 [F02.80]
  - mild F03.A0
  - moderate F03.B0

  multi-infarct - see Dementia , vascular
  - paralytica, paralytic (syphilitic) - see also Dementia , in , diseases specified elsewhere A52.17 [F02.80]

  paretic A52.17

  praecox - see Schizophrenia
  - presenile F03

  primary degenerative F03

  progressive, syphilitic A52.17
  - senile F03
  - severe F03.C0
  - vascular (acute onset) (mixed) (multi-infarct) (subcortical) (unspecified severity) (without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety) F01.50

Notice that some dementia codes cross-reference other codes:

infantile, infantilis F04.0

- Lewy body - see also Dementia , in , diseases specified elsewhere G31.83 [F02.80]
  with behavioral disturbance - see also Dementia , in , diseases specified elsewhere G31.83 [F02.81 -]

Alzheimer's type - see Disease , Alzheimer's

Note: Some conditions require more than one ICD-10 code to accurately identify the condition

To code Alzheimer's Disease:

✓4th G30 Alzheimer's disease

INCLUDES Alzheimer's dementia senile and presenile forms

Use additional code, if applicable, to identify:

delirium, if applicable (F05) (F05)

dementia with anxiety (F02.84, F02.A4, F02.B4, F02.C4) (F02.84, F02.A4, F02.B4, F02.C4)

dementia with behavioral disturbance (F02.81-, F02.A1-, F02.B1-, F02.C1-) (F02.81-F02.818, F02.A1-F02.A18, F02.B1-F02.B18, F02.C1-F02.C18,)

dementia with mood disturbance (F02.83, F02.A3, F02.B3, F02.C3) (F02.83, F02.A3, F02.B3, F02.C3)

dementia with psychotic disturbance (F02.82, F02.A2, F02.B2, F02.C2) (F02.82, F02.A2, F02.B2, F02.C2)

dementia without behavioral disturbance (F02.80, F02.A0, F02.B0, F02.C0) (F02.80, F02.A0, F02.B0, F02.C0)

mild neurocognitive disorder due to known physiological condition (F06.7-) (F06.7-F06.71)

EXCLUDES1 senile degeneration of brain NEC (G31.1) (G31.1)

senile dementia NOS (F03) (F03-F03.91)

senility NOS (R41.81) (R41.81)

Notice the "✓4th". This means that a fourth digit is necessary.

To code Alzheimer’s Disease:

- G30.0 Alzheimer's disease with early onset
- G30.1 Alzheimer's disease with late onset
- G30.8 Other Alzheimer's disease
- G30.9 Alzheimer's disease, unspecified

Physician Tip: A code from subcategory F02.8 should always be assigned with a code from this category, even in the absence of documented dementia.

Remember: In ICD-10 coding, what code you select, depends on what you document

To code Lewy Body Dementia:

G31.83 Neurocognitive disorder with Lewy bodies

Lewy Body Dementia

Lewy Body disease

Use additional code, if applicable, to identify mild neurocognitive disorders due to known physiological condition (F06.7-) (F06.7-F06.71)

Should I use one code or two codes?

If this is documented:	Select code #1:	And add code #2:
Dementia with behavioral disturbance	Unspecified dementia with behavioral disturbance F03.91	2nd Code unnecessary
Dementia w/o behavioral disturbance	Unspecified dementia w/o behavioral disturbance F03.90	2nd Code unnecessary
Alzheimer's dementia or disease	Dementia in disease classified elsewhere (+/- behavioral disturbance) F02.8-	Alzheimer's disease G30- (specify if early, late or unspecified onset)
Vascular dementia	Vascular dementia F01.5- (+/- behavioral disturbance)	2nd Code unnecessary
Lewy Body Dementia	Dementia in disease classified elsewhere (+/- behavioral disturbance) F02.8-	G31.83 Lewy Body Dementia

Note: It's always useful to have either an up-to-date ICD-10 manual or application handy and know how to look up ICD-10 codes. For guidelines on ICD-10 coding, see: https://www.cms.gov/files/document/fy-2024-icd-10-cm-coding-guidelines-updated-02/01/2024.pdf

The End

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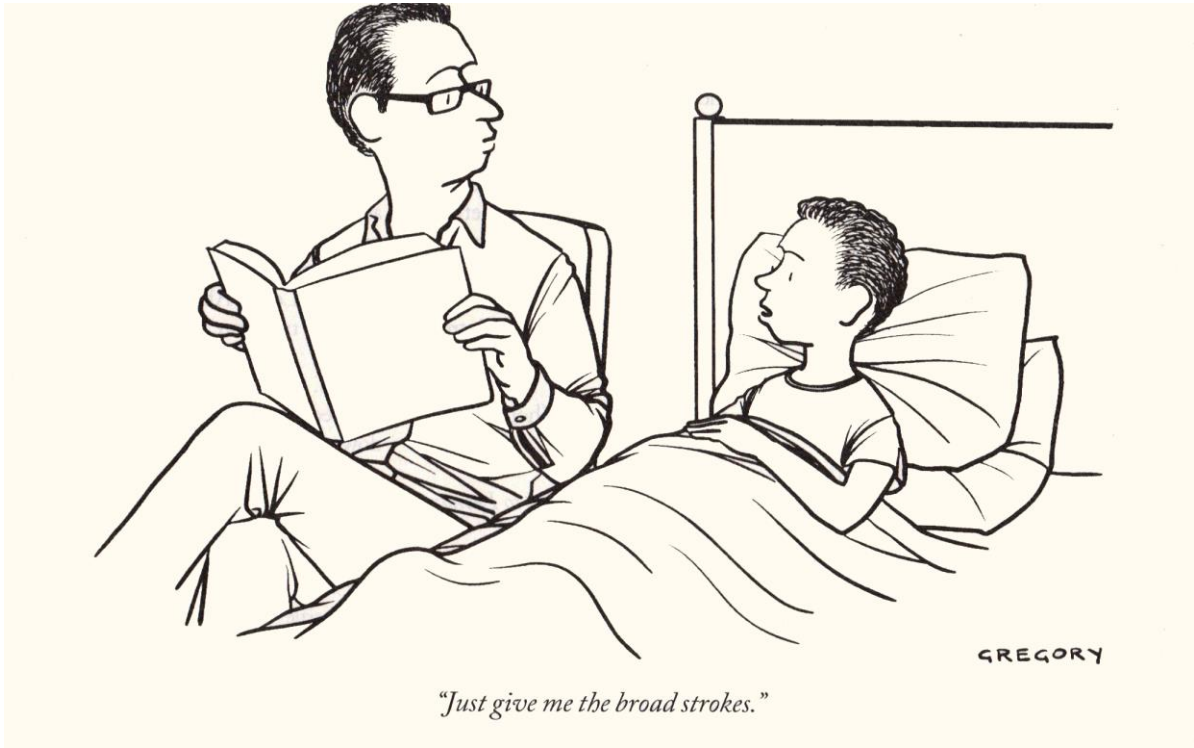

"Just give me the broad strokes."