

Coding for Group Visits

Many physicians are interested in providing group medical visits. Whether the drop-in group medical appointment (DIGMA), chronic care health clinic (CCHC) or other model is delivered, the coding and billing of these services raise questions about codes and payment policies.

While past instruction on coding for group visits often indicated that physicians should report code 99499 for unlisted evaluation and management services, using this code requires that documentation is sent with the claim to identify the service(s) provided and leaves valuing of the service in the hands of the payer.

No official payment or coding rules have been published by Medicare. However, the question of "the most appropriate CPT code to submit when billing for a documented face-to-face evaluation and management (E/M) service performed in the course of a shared medical appointment, the context of which is educational.", was sent to the Centers for Medicare & Medicaid Services (CMS) with a request for an official response. The request further clarified, "In other words, is Medicare payment for CPT code 99213, or other similar evaluation and management codes, dependent upon the service being provided in a private exam room or can these codes be billed if the identical service is provided in front of other patients in the course of a shared medical appointment?"

The response from CMS was, "...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.

We have been told by members who provide group visits that some private payers have instructed them to bill an office visit (99201-99215) based on the entire group visit. For compliance purposes, we recommend that you ask for these instructions in writing and keep them on file as you would any other advice from a payer.

Where each individual patient is provided a medically necessary, one-on-one encounter, in addition to the time in the group discussions, there should be no problem in billing for the visit based solely on the documented services provided in a direct one-on-one encounter.

If your group visits include the services of nutritionists or a behavioral health specialist, contact payers to determine if that portion of the group visit can be directly billed by the non-physician provider. This typically would include codes for medical nutrition therapy (97804) or health and behavior intervention (96153).

Other codes that may be applicable are the codes for education and training for patient self-management involving a standardized curriculum (98961-98962). Neither these codes nor medical nutrition or behavioral health therapy are billed by physicians. Physicians must use evaluation and management codes to report these services.

Code 99078 describes physician educational services in a group. Again, it is necessary to contact the payer to verify that coverage of this service is a payable benefit.

As with many services, coding for group visits requires that billing and coding staff do preliminary work with payers to identify desired coding applications. To learn more general information about group visits, visit the AAFP Quality Improvement Tools [Group Visits](#) pages. The AAFP has also published guides to help physicians design and deliver group visit services that include some coding and billing information such as the [AIM Group Visits Guide](#) (16-page PDF file. [About downloading](#)) and [Guide to Tobacco Cessation Group Visits](#) (12-page PDF file. [About downloading](#)).