California Academy of Family Physicians
Advancing the Personal and Professional Development of California's Family Physicians

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The Challenge of Coding and Billing Group Visits

More and more physicians are becoming interested in providing group visits for their patients. Patients have overwhelmingly expressed appreciation of the group visit environment, often reporting greater satisfaction with their medical care. Group visits are being provided for a variety of conditions such as asthma, congestive heart failure, GERD, and diabetes.

As part of CAFP's New Directions in Diabetes Care (NDDC) initiative, several of the practices participating in Collaboratory have started offering group visits.

Managing coding and billing for group visits can be a challenge. Currently, there are very few CPT codes that describe services provided in group settings, and those that are available specifically describe services provided by someone other than a physician such as a medical assistant or a trained health care educator. Until a specific CPT code is developed for group visits run by a physician, it is recommended that physicians use code 99499 ("unlisted evaluation and management service") to report the service. Because it is an "unlisted" service, documentation describing the service provided must be submitted with each claim. Since no set value is assigned to this code, however, it is important to find out in advance if your payer reimburses for this code.

Typically, it is up to the carrier as to not only whether it will cover (pay for) the service but how much it will pay for that service. Medicare has weighed in on the subject of group visits and stated that only those services provided face-to-face between a physician and one patient are covered. Each practice should check with its primary insurance payers to determine if there is payment for group visits.

If at the time of a group visit, each patient is provided a one-on-one encounter with the physician in addition to the time spent in the group, there should be no problem in billing for the visit based solely on that one-on-one encounter, which is an evaluation and management (E&M) service. CPT codes 99201–99215 should be used to bill this service (1). You should document appropriately to support the level of service billed. For an established patient this might be a level 1 or 2 visit. If vital signs were taken (by the nurse), a second system examined (foot check), and a change of medication made, then this visit could possibly be a level 3.

Let's look at how a group visit for diabetes management might be billed in the following example.

A group of 15 patients with diabetes and its co-morbidities meets for two hours once a month, for six months. The goal of the series is to address medical and other issues of concern to them and to effectively promote chronic disease management. The group visit is led by a physician, and nurses or medical assistants take everyone's vitals at some point during the visit. The large group is broken up into groups of three patients each; each patient meets *individually* with the physician for a short time — either during the 30 minutes prior to the group visit, during the 30 minute break in

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the group visit or during the 30 minutes immediately following the group visit. During the individual encounter, the patient confers with the physician for a brief history of present illness; a foot check is performed (which can also be done during the group setting, however, Medicare does not pay for anything done in a group environment); and an inspection of the skin is done for any sites of irritation or ulceration. An inquiry is made about medication compliance and changes are made, if appropriate. If new symptoms or problems are encountered during this brief meeting that require more physician time, the patient is asked to make an appointment to see the physician again within a few days.

Correct Coding and Billing

CPT/HCPCS	Service	Diagnosis	Expected Payment
99212	Established Patient Visit	250.00 V58.67	$37.76*

If the practice chooses to bill the group visit as an unlisted E&M service as discussed above, in addition to the one-on-one physician to patient encounter, the correct billing would be:

Correct Coding and Billing

CPT/HCPCS	Service	Diagnosis	Expected Payment
99212-25*	Established Patient Visit	250.00 V58.67	$37.76**
99499-GA***	Unlisted E&M Service – Group Visit	250.00	$15.00

** The "-25" modifier is used to indicate that this service (99212) is a significantly,separately identifiable service from the other service provided that day (99499) and it should not be bundled with the other service.*
*** = Expected Payment Amount is Medicare, California Area 99*
**** GA indicates an Advanced Beneficiary Notice was signed by patient before the service was provided*

Note: Total due from the patient is $22.55 ($7.55 co-insurance from office visit and a group visit participation fee of $15).

Other Group Visit Considerations
When providing services in a group environment, several other things warrant consideration:

1. If a non-physician is providing the education and training for patient self-management, there are CPT codes to describe this service in a small group setting. The codes specify that the health care professional must be qualified (trained) and use a standardized curriculum. These codes are:

    98961 for 2–4 patients per group
    98962 for 5–8 patients per group

    For health and behavior intervention that is provided by a non-physician, but is not part of a standardized curriculum, use CPT code 96153 – *Health & Behavior Intervention, each 15 minutes, face-to-face; group (two or more patients).*

    Remember, this code is for each fifteen minutes of face-to-face time with the non-

on the dotted line, consider having your contract reviewed by a knowledgeable attorney familiar with health care law and medical practice employment issues.
E-mail Katie Achermann.

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physician and patient.

2. Medicare, as well as other commercial insurance plans such as Blue Shield, Blue Cross, and Aetna, pays for a service known as "Diabetes Self-Management Training." There are HCPCS codes, also known as G codes, to report these services, and the services are provided either in an individual setting or in a group setting. The services are time-based and reported in 30 minute increments. These services are not considered Medical Nutrition Therapy and should not be reported as such. The services can usually be provided by physicians, non-physicians, or a combination of physicians and non-physicians.

The HCPCS codes used to report these services and related reimbursement are:

HCPCS Code	**Description of Service**	**Expected Reimbursement***		
		Medicare	Blue Shield	Aetna
G0108	DSMT, individual session, each 30 minutes	$41.40	$43.71	$41.29
G0109	DSMT, group session, each 30 minutes	$24.04 **	$25.39 **	$23.97 **

** Reimbursement is approximate and will vary based on geographic location in which service is provided.*

*** Reimbursement per patient.*

Some payers, such as Medicare, have staff certification requirements to provide this service, while other payers require no particular certification. For Medicare, you must submit a certificate from the American Diabetes Association along with the modified CMS 855i or 855b form to be eligible. Each practice should check with major insurance payers for their patients to see how each handles the service. You should also inquire about any quantity of service or frequency limitations with each plan. Medicare allows 10 hours per patient of initial training and two hours per patient of follow-up training each year. A description of Medicare's coverage for DSMT (Diabetes Self-Management Training) can be found here.

3. CPT code 99078 is used to report physician educational services rendered to patients in a group setting. This is a service code that is often not paid by payers, including Medicare. On the Medicare Physician Fee Schedule database, this is a bundled service, which means it is never paid separately even if it is the only service provided to the patient on a particular day. This eliminates any possibility of asking the patient to pay for the service. Therefore, it is not advisable to use this CPT code to bill any services provided at a group visit. It is worth a check with other insurers to see if this service is allowed. Remember, services reported with this CPT code should be educational in nature.

4. Private payers will likely not provide a carve-out for your capitated patients. Many practices, including some involved in NDDC, still choose to make group visits available to all of their patients. But it's important to know your patient mix in advance.

In summary, any family physician should be aware that while group visits are becoming a reality in the way family medicine is delivered or provided, the billing and collection of payment for this

type of service can be challenging. Some important things to remember are:

- Know what types of service are being provided in the group setting.
- Investigate billing opportunities, other than a physician-to-patient evaluation and management service.
- Check with major insurance payers in advance to collect and review coverage guidelines and billing parameters for group visits.
    - Phone calls
    - Online access
    - Patient participation in contacting insurance
- Be prepared to submit documentation to support the group visit concept/service.

Mary Jean Sage is a coding and practice management consultant in Pismo Beach, CA. She can be reached here. In addition to writing for Practice Management News, she responds to individual member questions, and we post her responses here.

Reference

1. " Group Visits for Chronic Illness Care," in the January 2006 edition of *Family Practice Management*, recommends using CPT codes 99212 to 99214.

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