RHODE ISLAND OFFICE OF
HealthyAging

RHODE ISLAND DEPARTMENT OF HEALTH

Point

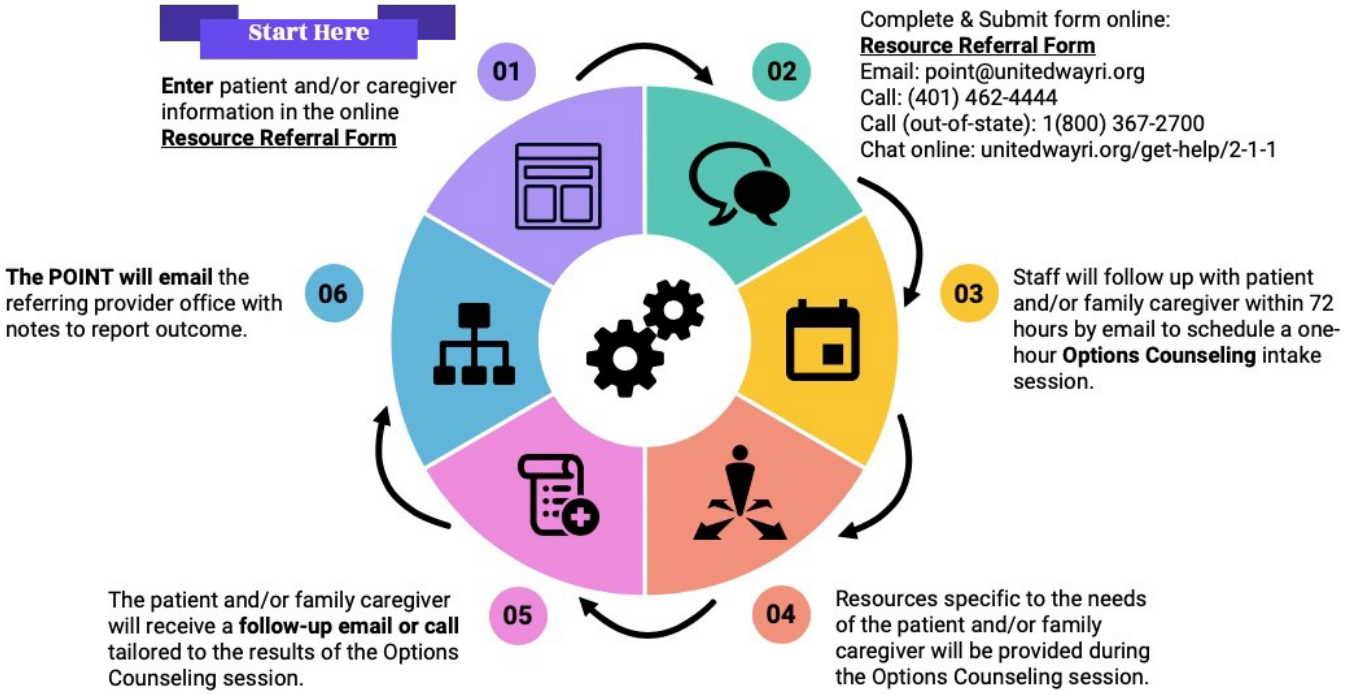
United Way of Rhode Island

alzheimer's association
Rhode Island Chapter

Would you like additional resources for your patients with cognitive impairment and their family caregivers?

Health care providers can access **new care planning and resource referral services** through the healthy aging help desk, the POINT, at United Way of Rhode Island.

How the process works:



Resource Referral Form Online

The Rhode Island Department of Health is encouraging expansion of services for dementia. Your practice can conduct services for Cognitive Assessment and Care Planning. Refer to the attached factsheets, including *CPT Code 99483 Explanatory Guide for Clinicians*.

In addition, to aid eligible providers:

- See the attached Guide to Billing Codes for Dementia Services
- Contact the Rhode Island Department of Health at 401-222-5960 if interested in learning more about strategies to improve dementia services.
- See the attached referral information for Alzheimer's research and clinical trials

These new resources have been developed by the Rhode Island Office of Healthy Aging through a grant from the U.S. Health and Human Services' Administration for Community Living, supported by United Way of Rhode Island The POINT/Healthy Aging Helpdesk

FACTSHEET

ALZHEIMER'S IMPACT MOVEMENT™
alzheimer's association®

MARCH 2020

alzimpact.org

CPT® Code 99483 Explanatory Guide for Clinicians

Since 2017, Medicare and Tricare have reimbursed clinicians for care planning services provided to individuals with cognitive impairment, including Alzheimer's disease.

What is code 99483?

Effective January 1, 2018, under CPT code 99483, clinicians can be reimbursed for providing care planning services to individuals with cognitive impairment, including Alzheimer's disease. This code replaces the temporary code (G0505) that was in place under Medicare and Tricare in 2017.

What clinicians can be reimbursed under this code?

Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives can currently bill under this code.

Who is eligible to receive the services?

All beneficiaries who are cognitively impaired are eligible to receive the services under the code. This includes those who have been diagnosed with Alzheimer's, other dementias, or mild cognitive impairment. But, it also includes those individuals without a clinical diagnosis who, in the judgment of the clinician, are cognitively impaired.

Service elements of CPT® code 99483
Cognition-focused evaluation, including a pertinent history and examination of the patient
Medical decision making of moderate or high complexity (defined by the E/M guidelines)
Functional assessment (for example, Basic and Instrumental Activities of Daily Living), including decision-making capacity
Use of standardized instruments to stage dementia
Medication reconciliation and review for high-risk medications, if applicable
Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized instruments
Evaluation of safety (for example, home safety), including motor vehicle operation, if applicable
Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks
Development, updating or revision, or review of an Advance Care Plan
Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed (for example, adult day programs and support groups); the care plan must be shared with the patient and/or caregiver at the time of initial education and support

How are caregivers included in the care planning billing code?

The code includes specific identification of a caregiver as well as an assessment of that caregiver's knowledge, needs, and ability to provide care. Caregivers may also be included throughout each of the required service elements of 99483, including the creation of a detailed care plan for the person with cognitive impairment.

Can the care planning be provided over the phone?

No. Services under 99483 require a proper history from a corroborating or independent source (such as a family member or caregiver) and must be provided face-to-face with the beneficiary in a physician's office, outpatient setting, home, domiciliary, or rest home.

How often can care planning be provided?

Clinicians can provide and bill for care planning services under 99483 once every 180 days. Experts have noted that care planning for individuals with dementia is an ongoing process and that a formal update to a care plan should occur at least once per year.

Are there other ways to bill for updating a care plan?

Yes. In revising a care plan, clinicians could utilize one of the E/M codes, such as for chronic care management. Also, Medicare now has an E/M code specifically for non-face-to-face consultations, which means updating a care plan could be done over the phone or internet.

Are there any restrictions in using other billing codes at the same time as 99483?

Some of the service elements under 99483 overlap with services under some E/M codes, advance care planning services, and certain psychological or psychiatric service codes. As a result, 99483 cannot be used along with the following codes: 90785, 90791, 90792, 96103, 96120, 96127, 99201-99215, 99241-99245, 99324-99337, 99341-99350, 99366-99368, 99497, 99498, and 96161.

How much will clinicians be reimbursed under the new code?

Reimbursement rates can vary slightly based on the setting in which the service is provided and geographic location. Given those caveats, it has been estimated that the reimbursement rate for 99483 billed by a physician in a non-facility setting would be about $265 in 2020.

How exactly should clinicians conduct a visit under the code?

The Alzheimer's Association, in consultation with an expert Taskforce, developed a toolkit to educate providers about using this billing code with their patients. The tool kit includes best practices on conducting a visit under 99483. A copy of the toolkit, as well as additional information, is available at alz.org/careplanning.

Where can I get more information?

The American Medical Association's 2018 CPT manual contains a full description of, and detailed instructions for using, code 99483.

FACTSHEET

ALZHEIMER'S IMPACT MOVEMENT™
alzheimer's association®

MARCH 2020

alzimpact.org

Care Planning for People with Cognitive Impairment

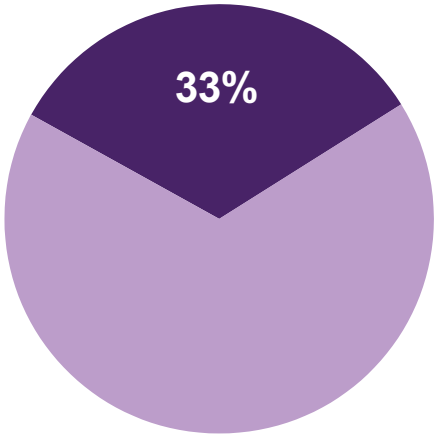
Most people who have been diagnosed with Alzheimer's disease are not aware of their diagnosis.

- As many as half of those with Alzheimer's have been diagnosed.
- Among those seniors who have been diagnosed with Alzheimer's, only 33% are aware they have the disease.
- Even when including caregivers, 45% — less than half — of those diagnosed with Alzheimer's or their caregivers are aware of their diagnosis. For other dementias, the disclosure rate is even lower — only 27%.
- Comparatively, 90% or more of those diagnosed with cancer or cardiovascular disease, or their caregivers, are aware of the diagnosis.

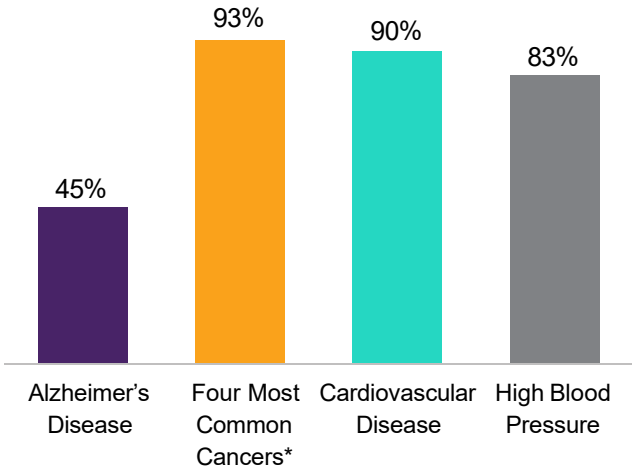
Lack of disclosure is sometimes a result of physicians not having the time or resources to do care planning.

- Following a diagnosis of Alzheimer's disease, individuals and their caregivers need information about the diagnosis and available support services.
- Studies have found one of the reasons physicians do not diagnose Alzheimer's in the first place — or do not disclose a diagnosis once it is made — is because of the lack of time and resources to provide this information and support to patients and caregivers.

Percent of Seniors Diagnosed with Alzheimer's Disease Who Are Aware of the Diagnosis



Percent of Seniors Diagnosed with Condition, or Their Caregivers, Who Are Aware of the Diagnosis



Breast, Lung, Prostate, and Colorectal

A diagnosis — and disclosure of that diagnosis — is necessary before care planning can occur, which is crucial in improving outcomes for the individual.

- Care planning allows diagnosed individuals and their caregivers to learn about medical and non-medical treatments, clinical trials, and support services available in the community — resulting in a higher quality of life for those with the disease.
- Individuals receiving care planning specifically geared toward those with dementia have fewer hospitalizations, fewer emergency room visits, and better medication management.
- Alzheimer's complicates the management of other chronic conditions. Care planning is key to care coordination and managing those other conditions.

The HOPE for Alzheimer's Act

CPT® code 99483 implements the core provision of the Health Outcomes, Planning, and Education (HOPE) for Alzheimer's Act and is consistent with the recommendations of the *National Plan to Address Alzheimer's Disease.*

First introduced in 2009, the bipartisan HOPE for Alzheimer's Act was designed to provide comprehensive care planning services following a dementia diagnosis, with the services available to both the diagnosed individual and his or her caregiver. A total of 12 House members cosponsored the first version of the bill. By 2016, when the Centers for Medicare and Medicaid Services (CMS) proposed the new billing code, support had grown to more than two-thirds of Congress — 310 cosponsors in the House and 57 in the Senate.

CPT® billing code 99483 now allows clinicians to be reimbursed for providing care planning to cognitively impaired individuals.

- Effective January 1, 2018, billing code 99483 is available to clinicians treating those with cognitive impairment, including Alzheimer's disease. This code replaces the temporary G0505 used under Medicare and Tricare in 2017.
- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives can currently be reimbursed under 99483.
- With this code, clinicians will have the time and resources to provide a comprehensive set of care planning services to people with cognitive impairment and their caregivers.

To recieve reimbursement, 99483 requires clinicians to provide detailed, person-centered care planning.

- The new code requires clinicians to provide several services, including:
    - evaluating cognition and function
    - measuring neuropsychiatric symptoms
    - evaluating safety (including driving ability)
    - identifying and assessing a primary caregiver
    - helping develop advance care directives
    - planning for palliative care needs.
- All of these services are ultimately used under the code to develop a detailed care plan — including referrals to community resources — that is shared with both the beneficiary and his or her caregiver.

Guide to Billing Codes for Dementia Services

ACL
Administration for Community Living

NADRC
National Alzheimer's and Dementia Resource Center

RTI
INTERNATIONAL

Guide to Billing Codes for Dementia Services

September 2020

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Acknowledgements

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Introduction

Dementia services and supports play an important role in helping people who are living with dementia to remain in the community. Although providers have expanded the range of dementia services they offer, identifying means of reimbursement to sustain these services remains an ongoing challenge. Billing third-party payers, such as fee-for-service Medicare and private insurance, can provide one sustainable source of funding. Several Administration for Community Living (ACL) Alzheimer's Disease Program grantees are successfully billing third-party payers. This guide is designed to share the knowledge they have gained.

This guide is intended primarily for organizations that have medical billing systems in place and want to understand how to bill for dementia services. It may also be useful for organizations that are considering developing a medical billing system for services. Instituting a billing process to meet the many requirements of third-party payers, which vary depending on the state and insurer, requires extensive time and resources. Carefully weigh the costs versus benefits. Typically, billing revenues do not cover the entire cost of the services provided; however, they can serve as one significant and relatively stable source of funding. Billing for services may also be attractive to other funders, who want to see that all possible sources of revenue are maximized before contributing private funds.

The guide includes codes that select ACL grantees have used successfully. It is not intended as a comprehensive review of all possible billing codes that organizations might use to bill for dementia services. Links to additional resources are provided throughout the guide.

The guide includes three sections:

1. Key Components of the Billing Process
2. Tables of Billing Codes Used by Current ACL Grantees
3. Elements of Developing a Billing Infrastructure

A Note on Methodology

Two approaches were used to gather information for this guide. First, a group of six ACL grantees experienced in billing third-party payers for dementia services served as subject matter experts throughout the development of the guide. They generously shared their experience and recommendations through group meetings, individual interviews, and review of the draft guide. Much of the information in this guide was gleaned from these

meetings and interviews. Without their collective guidance and support, this guide would not have been possible.

Second, information was gathered through online resources and references cited throughout the guide. We would like to acknowledge the Centers for Medicare & Medicaid Services (CMS) website as a primary source of information.

Key Components of the Billing Process

Patients

The billing codes included in this guide relate to specific services provided to a "patient." Most commonly, the patient is the person living with dementia, but in some cases, the patient may be the caregiver. For example, caregivers may seek psychotherapy to cope with the stress of caregiving. When the patient is the caregiver, it is their insurance that is being billed.

Clinicians

All billed services are either provided directly by a qualified clinician (such as a physician or nurse practitioner) or under supervision of a qualified clinician. For example, a nurse might provide case management under the supervision of a physician. The rules about who can provide a service and who can supervise the provision of service depend on the service and also vary by state and by payer. The clinician (or supervising clinician) is responsible for assigning the appropriate CPT® and ICD-10-CM code(s).

Third-Party Payers

Third-party payers are government agencies, private insurance companies, and employers who pay the medical expenses of the first party (the patient) to the second party (the physician or other health care provider). Medicare and private insurance companies such as Blue Cross Blue Shield are examples of third-party payers.

Medicare Administrative Contractor (MAC) Regions

Medicare services are billed through a MAC—a private health care insurer that has been awarded a contract to process medical claims for Medicare fee-for-service beneficiaries in a specific multistate MAC jurisdiction.

The roles of the MAC are the following:

1. Enroll providers in the Medicare program

2. Process Medicare claims
3. Respond to provider inquiries
4. Educate providers about Medicare billing requirements

CMS establishes national policies regarding services that must be covered, but most decisions about coverage are determined by the regional MAC. The criteria for what is considered medically necessary and covered (known as Local Coverage Determinations) vary by MAC (HHS, 2014). It is important to keep informed of the frequent changes in codes and new or updated Local Coverage Determinations and maintain regular communication with the MAC and other insurers.

CPT® and HCPCS Billing Codes

CPT® codes are created by the American Medical Association (AMA) to provide health care professionals a uniform language for coding medical services and procedures. These codes are used by third-party payers to determine the amount that will be paid for each service.

The Healthcare Common Procedural Coding System (HCPCS; often pronounced by its acronym as "hicpics") is developed by CMS and is divided into Level I (service codes, consistent with CPT®) and Level II (health care equipment and supplies codes). The tables in this guide include CPT® codes that are also HCPCS Level I codes used for billing Medicare.

Each provider should be aware of the specific elements required to choose the correct CPT® code and the documentation requirements. The components that must be addressed to define the level of the CPT® code are medical history, examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time spent with the patient. Greater detail of these requirements is found in the AMA CPT® code book and in a variety of other AMA CPT® coding resources.

ICD-10-CM Diagnostic Codes

For each CPT® procedure code billed, one or more diagnostic codes must be provided to justify the service(s). The International Classification of Diseases (ICD)-10-CM provides a system of diagnostic codes for classifying diseases. Every claim submitted for reimbursement includes both a CPT® code and one or more associated ICD-10-CM diagnostic codes that indicate the medical necessity of the service.

Approved diagnostic codes vary by location; consult your MAC and individual insurers to determine which diagnostic codes are approved for use in your area. Some commonly used diagnostic codes are included at the end of each billing code table.

COVID-19 Telehealth

COVID-19 has necessitated that many in-person services including initial assessments, care planning, and individual education or counseling sessions be delivered remotely. During the COVID-19 pandemic, CMS made the decision to allow the use of in-person billing codes for telehealth visits and will pay the same rate. CMS has provided a list of billing codes approved for telehealth (CMS, March 2020a).

These changes and requirements are still evolving at the time of this guide's publication.

CPT® Billing Code Tables

CPT® codes are organized in sets by the types of services that can be reimbursed. The five tables in this section list billing codes that some ACL grantees use or plan to use to bill for services. Links go directly to each table in this document.

- **Cognitive Assessment and Care Planning and Advance Care Planning**
  These codes are used for a comprehensive cognitive assessment, creation of a care plan, and development or update of advance directives.

- **Counseling/Psychotherapy**
  These codes can be used by providers such as licensed clinical social workers or clinical psychologists to provide counseling to the caregiver or person living with dementia.

- **Evaluation and Management (E&M)**
  These codes are used in a clinic setting and cover initial and ongoing assessment, diagnosis, care planning, and follow-up support.

- **Evaluation, Services and Cognitive Testing for Rehabilitative Medicine**
  These codes are used for occupational therapy services, including initial evaluation, individual sessions, and cognitive assessment.

- **Health Behavior Assessment and Intervention (HBAI)**
  These codes are used for services and interventions that address the behavioral, psychosocial, and other factors that impact the management of a physical health

condition. They are NOT used for providing medical treatment or providing mental health services.

Cognitive Assessment and Care Planning, and Advance Care Planning

Clinicians' time spent conducting cognitive assessments, including care planning services for individuals who are cognitively impaired, is reimbursable. The code 99483 is used to perform a cognitive assessment that includes a patient history, medical examination, functional assessment, medication reconciliation, evaluation for behavioral symptoms, safety evaluation, identification of caregivers, creation of a care plan, and development or update of advance directives. Physicians, nurse practitioners, and staff supervised by the eligible clinician can use these codes.

If advance care planning occurs at a separate visit solely for the purpose of discussing the individual's health care wishes, this can be billed as a separate service using code 99497.

Examples of services and interventions that have been billed using these codes:

- Time spent with a neurologist or nurse practitioner as part of the Care EcoSystems intervention;
- Advance care planning with a physician (or under the supervision of a physician if insurer allows)

Cognitive Assessment and Care Planning, and Advance Care Planning

Billing Code	Procedure	Time/ Complexity	Notes	Clinicians Who can Use this Code (May Vary by State and Payer)
99483	Cognitive assessment and care planning	Untimed (flat fee for service)	Face-to-face contact with a patient. There are many required components of the cognitive assessment and care planning process—see link below.	Physician (Phys), nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA)
99497	Advance care planning	First 30 minutes	Face-to-face contact with a patient, family member(s), or surrogate. Includes the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed).	Phys, NP, CNS, PA
99498	Advance care planning	Additional 30 minutes	This code is billed along with 99497 when the advance care planning session lasts an hour	Phys, NP, CNS, PA

Examples of ICD-10-CM Diagnostic Codes and Modifiers
F01.50 F02.80, F02.81, F03.90, F03.91, G11.8, G20, G23.1,G23.9, G30.0, G30.9, G31.01, G31.09, G31.83, G31.85

Resources
Cognitive Assessment and Care Planning:
Alzheimer's Association Expert Task Force Recommendations and Tools
Advance Care Planning:
Medicare Learning Network Fact Sheet
Living with Dementia: Advance Planning Guides for Persons with Dementia and Caregivers
Evidence-Based Intervention Resources:
Best Practice Caregiving
Grantee-Implemented Evidence-Based and Evidence-Informed Interventions

Counseling/Psychotherapy for Caregivers and Persons Living with Dementia

These are traditional counseling and psychotherapy codes. The patient may be the person living with dementia or the caregiver. If the caregiver is the patient, it is their insurer that is billed for the service. Psychotherapy or counseling services may only be covered for persons living with early dementia; check with the MAC or private insurer for specific limitations.

These codes can be used by a licensed clinical social worker, psychologist, or another approved clinician (as determined by insurer). The diagnostic code(s) (ICD-10-CM codes) used with these CPT® codes will relate to mental health diagnoses such as depression.

Examples of services and interventions that have been billed using these codes:

- REACH II intervention
- Care of Persons with Dementia in Their Environments (COPE) intervention
- Family counseling, with or without the person with dementia

Counseling/Psychotherapy

Billing Code	Procedure	Time/ Complexity	Notes	Clinicians Who can Use this Code (May Vary by State and Payer)
90791 90792	Psychotherapy diagnostic evaluation	Untimed	With patient	Licensed clinical social workers or clinical psychologist (90791); psychiatrist or other physician (90792)
90832	Psychotherapy treatment	30 minutes	With patient	Psychiatrist (Psych MD), other physician (Phys), nurse practitioner (NP), physician assistant (PA), clinical nurse specialist (CNS), clinical psychologist (CP), licensed clinical social worker (LCSW) *Not currently covered by Medicare but may be covered by private insurance:* Licensed professional counselors (LPC) Licensed mental health counselors (LMHC) Licensed marriage family therapists (LMFT)
90833	Psychotherapy treatment	30 minutes	With patient performed with an evaluation	Psych MD, other Phys, NP, PA, CNS, CP, LCSW *Not currently covered by Medicare but may be covered by private insurance:* LPC, LMHC, LMFT
90834	Psychotherapy treatment	45 minutes	With patient	Psych MD, other Phys, NP, PA, CNS, CP, LCSW *Not currently covered by Medicare but may be covered by private insurance:* LPC, LMHC, LMFT
90836	Psychotherapy treatment	45 minutes	With patient when performed with an office visit	Psych MD, other Phys, NP, PA, CNS, CP, LCSW *Not currently covered by Medicare but may be covered by private insurance:* LPC, LMHC, LMFT

(continued)

Counseling/Psychotherapy (continued)

Billing Code	Procedure	Time/ Complexity	Notes	Clinicians Who can Use this Code (May Vary by State and Payer)
90837	Psychotherapy treatment	60 minutes	With patient	Psych MD, other Phys, NP, PA, CNS, CP, LCSW *Not currently covered by Medicare but may be covered by private insurance:* LPC, LMHC, LMFT
90838	Psychotherapy treatment	60 minutes	With patient when performed with an office visit	Psych MD, other Phys, NP, PA, CNS, CP, LCSW *Not currently covered by Medicare but may be covered by private insurance:* LPC, LMHC, LMFT
90846	Family psychotherapy treatment	50 minutes	Without patient	Psych MD, other Phys, NP, PA, CNS, CP, LCSW *Not currently covered by Medicare but may be covered by private insurance:* LPC, LMHC, LMFT
90847	Family psychotherapy treatment	50 minutes	With patient	Psych MD, other Phys, NP, PA, CNS, CP, LCSW *Not currently covered by Medicare but may be covered by private insurance:* LPC, LMHC, LMFT

Examples of ICD-10-CM Diagnostic Codes and Modifiers
F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33, F33.0,F33.1, F33.2, F33.3, F33.41, F33.42, F33.9, F41.1, F41.9, F43.20, F43.21, F43.22, F43.23, F43.24, F43.25, F43.20

Resources
Evidence-Based Intervention Resources:
Best Practice Caregiving
Grantee-Implemented Evidence-Based and Evidence-Informed Interventions

Evaluation and Management (E&M)

E&M codes are used by primary care and memory clinics to bill for assessment, diagnosis, care planning, and follow-up. An advantage of these billing codes is that services can be billed by time, which often increases overall reimbursement. Examples of services and interventions that have been billed using these codes:

- Memory clinic cognitive assessment, diagnosis, care planning, and follow-up
- Care EcoSystems intervention initial cognitive assessment, diagnosis, care planning, and follow-up

Evaluation and Management (E&M)

Billing Code	Procedure	Time/ Complexity	Notes	Clinicians Who can Use this Code (May Vary by State and Payer)
99201–99205	Office/outpatient visit, new patient	99201–10 min 99202–20 min 99203–30 min 99204–45 min 99205–60 min Complexity increases with code number	Standard codes used by clinics to bill for **new** patient clinic visits. Billing by time for complex patients may result in greater reimbursement—see codes 99354–99358.	Physicians (Phys), nurse practitioners (NP), clinical nurse specialists (CNS), physician assistants (PA)
99211–99215	Office/outpatient visit, established patient	99211–5 min 99212–10 min 99213–15 min 99214–25 min 99215–40 min Complexity increases with code number	Standard codes used by clinics to bill for established patient clinic visits. Billing by time for complex patients may result in greater reimbursement—see codes 99354–99358.	Phys, NP, CNS, PA
99341–99345	Home visit	99341–20 min 99342–30 min 99343–45 min 99344–60 min 99345–75 min Problem severity increases with code number	New patient	Phys, NP, CNS, PA
99347–99350	Home visit	99347–15 min 99348–25 min 99349–40 min 99350–60 min Problem severity increases with code number	Established patient Self-limited or minor problem	Phys, NP, CNS, PA
99348	Home visit	25 minutes Low to moderate problem	Established patient	Phys, NP, CNS, PA
99349	Home visit	40 minutes Moderate to high problem	Established patient	Phys, NP, CNS, PA
99350	Home visit	60 minutes	Established patient Patient unstable or significant new problem requiring immediate attention Place of Service (POS) Code 12—Home	Phys, NP, CNS, PA

(continued)

Evaluation and Management (E&M) (continued)

Billing Code	Procedure	Time/ Complexity	Notes	Clinicians Who can Use this Code (May Vary by State and Payer)
99354	Prolonged face-to-face contact with the patient visit	Minimum 30–74 minutes beyond the office visit	Grantees use these codes to bill for new patient visits, follow-up, home visits, cognitive evaluation, and care planning. 99354 can only be billed when there is face-to-face contact with a patient, including a psychotherapy visit. These codes are billed in addition to an office visit code.	Phys, NP, CNS, PA
99355	Prolonged in-person visit	Each additional 30 minutes	Grantees use these codes to bill for new patient visits, follow-up, home visits, cognitive evaluation, and care planning. 99355 can only be billed when there is face-to-face contact with a patient, including a psychotherapy visit. These codes are billed in addition to an office visit code.	Phys, NP, CNS, PA
99358	Prolonged service without direct patient contact	Minimum 30–74 minutes	Grantees use these codes to bill for new patient visits, follow-up, home visits, cognitive evaluation, and care planning. 99358 can be billed for a different date of service from the face-to-face contact with a patient. These codes can be billed when doing research, making phone calls to other providers, or phone calls to family members to gather information.	Phys, NP, CNS, PA
99359	Prolonged service without direct patient contact	Each additional 30 minutes	Grantees use these codes to bill for new patient visits, follow-up, home visits, cognitive evaluation, and care planning. 99359 can be billed for a different date of service from the face-to-face contact with a patient. These codes can be billed when doing research, making phone calls to other providers, or phone calls to family members to gather information.	Phys, NP, CNS, PA
99421	Online digital evaluation and management service	5–10 minutes cumulatively, over a period of up to 7 days	Patient-initiated follow-up or check-in contacts with an established patient.	Phys, NP, CNS, PA

(continued)

Evaluation and Management (E&M) (continued)

Billing Code	Procedure	Time/ Complexity	Notes	Clinicians Who can Use this Code (May Vary by State and Payer)
99422	Online digital evaluation and management service	11–20 minutes cumulatively, over a period of up to 7 days	Patient-initiated follow-up or check-in contacts with an established patient	Phys, NP, CNS, PA
99423	Online digital evaluation and management service	21 or more minutes cumulatively, over a period of up to 7 days	Patient-initiated follow-up or check-in contacts with an established patient	Phys, NP, CNS, PA
99487	Non–face-to-face contact with a patient chronic care management	60 minutes	Revise or establish a comprehensive care plan with moderate- to high-complexity medical decision making	Phys, NP, CNS, PA
99489	Non–face-to-face chronic contact with a patient care management	Additional 30 minutes		Phys, NP, CNS, PA
99490	Non–face-to-face contact with a patient chronic care management	20 minutes over the period of a month	Coordination of care across providers Monthly follow-up Around-the-clock access to a qualified health care professional who has access to necessary health information to address any urgent needs after hours	Registered nurses, social workers, non-credentialed community health workers (e.g., Care Ecosystems intervention)

Examples of ICD-10-CM Diagnostic Codes and Modifiers
99205, 99212, and 99215: G31.84, F41.1, F43.23, F43.22, F41.9

Resources
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Prolonged Services
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CMS Chronic Care Management Toolkit
American Academy of Family Physicians Chronic Care Management
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Best Practice Caregiving
Grantee-Implemented Evidence-Based and Evidence-Informed Interventions

Evaluation, Services, and Cognitive Testing for Rehabilitative Medicine

ACL grantees have used the billing codes for Occupational Therapy (OT) Evaluation, Services, and Cognitive testing to bill for services delivered by OTs. ACL grantees that provide OT services often do so in the home rather than in a clinic setting. However, the reimbursed rate often does not cover the full cost of services in the home.

Dementia services are billed for the patient, who is the person living with dementia. Caregiver education is an integral part of providing OT services to people with cognitive impairment and may be billed using these service codes, even though the patient is the person living with dementia.

Examples of services and interventions that have been billed using these codes:

- Care of Persons with Dementia in Their Environments (COPE) intervention
- Skills2Care® intervention
- Medication management

Evaluation, Services, and Cognitive Testing for Rehabilitative Medicine

Billing Code	Procedure	Time/ Complexity	Notes	Clinicians Who can Use this Code (May Vary by State and Payer)
97110	Therapeutic procedure/ Therapeutic exercise	15-minute units		Occupational therapist (OT), physical therapist (PT), speech language pathologist (SLP)
97112	Neuromuscular reeducation	15-minute units		OT, PT, SLP
96125	Cognitive performance testing	Untimed	Requires interpretation of results and written report Check with the insurer to confirm it will cover this service	OT, PT, SLP,
97129	Cognitive function intervention	Initial 15 minutes	Multiple units of 97130 can follow the initial use of 97129	Physicians (Phys), nurse practitioners (NP) psychologists (CP), physician assistants (PA), clinical nurse specialists (CNS), OT, SLP, PT

(continued)

Evaluation, Services, and Cognitive Testing for Rehabilitative Medicine (continued)

Billing Code	Procedure	Time/ Complexity	Notes	Clinicians Who can Use this Code (May Vary by State and Payer)
97130	Cognitive function intervention	Additional 15 minutes	Multiple units of 97130 can follow the initial use of 97129	OT, Phys, NP, CP, SLP, PT, PA, CNS
97165	OT evaluation	Untimed (typically 30 minutes) Low complexity	The OT evaluation level of complexity is determined by the occupational therapist	OT
97166	OT evaluation	Untimed (typically 45 minutes) Moderate complexity	The OT evaluation level of complexity is determined by the occupational therapist	OT
97167	OT Evaluation	Untimed (typically 60 minutes) High complexity	The occupational therapist must determine if the complexity of the evaluation warrants this code. The CPT Code Book provides guidance on each complexity level. Also refer to the American Occupational Therapy Association	OT
97168	OT reevaluation	Untimed		OT
97530	Therapeutic activities	15-minute units		OT, PT, SLP
97533	Sensory integration	15-minute units	When completing interventions for persons living with moderate cognitive impairment who are supported by their caregiver, sensory diets may become part of a care approach to mitigate behaviors.	OT, PT, SLP
97535	Self-care/Home management training	15-minute units		OT, PT, SLP
97755	Assistive technology assessment	15-minute units	Requires interpretation of results and written report.	OT, PT, SLP

Examples of ICD-10-CM Diagnostic Codes and Modifiers
Medical diagnoses: G31.83, G30.8, G30.9, F03.9, G30.1, F03.91, F01.5, F01.51, G21.4
Treatment diagnoses: Z74.1, Z74.8, Z74.3

Resources
Evidence-Based Intervention Resources:
Best Practice Caregiving
Grantee-Implemented Evidence-Based and Evidence-Informed Interventions

Health Behavior Assessment and Intervention (HBAI)

HBAI codes are used to bill for services provided by or under the supervision of a clinical psychologist that address symptom management, unsafe behaviors, or other "cognitive, emotional, or psychosocial factors that affect the treatment or management of one or more physical health conditions" (National Council on Aging, 2018). For example, a chronic disease self-management education program could be billed using these codes. Dementia services may be provided to a person living with dementia, their family, or a group. If these same services are provided by a physician, nurse practitioner, or physician assistant, they are billed using E&M codes rather than HBAI codes.

Note: These are medical codes, not mental health codes; there must be a medical diagnosis, not a psychiatric/mental health diagnosis. Some insurers classify Alzheimer's disease and other dementias as a psychiatric or mental health condition (American Psychological Association, 2018).

One ACL grantee will begin using these codes shortly and several others are exploring their use for services such as REACH Community and Savvy Caregiver Program™ interventions.

Health Behavior Assessment and Intervention (HBAI)

Billing Code	Procedure	Time/ Complexity	Notes	Clinicians Who can Use this Code (May Vary by State and Payer)
96156	Health behavior assessment or reassessment (i.e., health-focused clinical interview, observations, clinical decision making)	Untimed	Dementia must not be severe enough for the intervention to be ineffective (as defined by the insurer)	Clinical psychologist or auxiliary staff directly supervised by a clinical psychologist, such as licensed clinical social worker. Verify approved auxiliary staff providers with the MAC and insurers.
96158	Health behavior intervention, individual	Initial 30 minutes	Individual, face-to-face contact with a patient	See explanation in 96156 above
96159	Health behavior intervention, individual	Each additional 15 minutes	Individual, face-to-face contact with a patient	See explanation in 96156 above
96164	Health behavior intervention, group	Initial 30 minutes	Group of two or more patients, face-to-face contact with a patient	See explanation in 96156 above
96165	Health behavior intervention, group	Each additional 15 minutes	Group of two or more patients, face-to-face contact with a patient	See explanation in 96156 above

(continued)

Health Behavior Assessment and Intervention (HBAI) (continued)

Billing Code	Procedure	Time/ Complexity	Notes	Clinicians Who can Use this Code (May Vary by State and Payer)
96167	Health behavior intervention, family with patient	Initial 30 minutes	Family (with the patient present), face-to-face contact with a patient	See explanation in 96156 above
96168	Health behavior intervention, family with patient	Each additional 15 minutes	Family (with the patient present), face-to-face contact with a patient	See explanation in 96156 above
96170	Health behavior intervention, family without patient	Initial 30 minutes	Family (without the patient present), face-to-face contact with patient	See explanation in 96156 above
96171	Health behavior intervention, family without patient	Each additional 15 minutes, up to 1 hour	Family (without the patient present), face-to-face contact with patient	See explanation in 96156 above

Examples of ICD-10-CM Diagnostic Codes and Modifiers
None at this time, several grantees will begin billing to these codes soon.

Resources
National Council on Aging: Health and Behavior Assessment / Intervention (HBAI)
Evidence-Based Intervention Resources:
Best Practice Caregiving
Grantee-Implemented Evidence-Based and Evidence-Informed Interventions

Elements of Developing a Billing Infrastructure

Successful billing requires a robust operational structure. The process to institute billing is complex and requires substantial time. It is important to understand that some services and service components cannot be billed, and that reimbursement typically does not cover the full cost of services.

This section outlines key elements for organizations to understand and establish. The items are not listed in a chronological order; your organization will need to consider many of these elements simultaneously.

Third-Party Payer Enrollment

Individual clinicians or providers must be enrolled with each payer. Once credentialing is approved, payment can be made retroactively within time limits.

- **Medicare provider enrollment**—To bill services to Medicare, the organization must enroll as a Medicare provider:

  - Providers must obtain a National Provider Identifier (NPI) before enrolling in Medicare. Providers obtain an NPI online via the National Plan & Provider Enumeration System.
  - Enroll as a Medicare **fee-for-service** provider:
    - Medicare provider enrollment is managed in the PECOS system. There is an annual cost to enroll as a Medicare provider both for your agency and each of your individual providers.

Payment for billed services will be assigned to your agency.

This CMS PowerPoint provides a tutorial covering all the steps to provider enrollment.

    - CMS hosts a National Provider Enrollment Conference.
  - Connect to Your Regional MAC:
    - When you enroll as a Medicare provider in PECOS, your MAC will be identified, and an analyst at your MAC will be assigned to assist in the completion of the enrollment process.
    - You may also enroll as a Medicare provider through your MAC, but the process generally takes longer.

- **Medicaid Provider Enrollment**
  - Medicaid reimbursement rates vary by state but are typically much less than those of Medicare and private insurers (Kaiser Family Foundation, 2016).
  - Learn about Medicaid provider enrollment through the Medicaid Provider Enrollment Compendium.
  - Enroll as a Medicaid provider through your State Department of Health. Specific instructions can be found by conducting a web search using the terms “state” + “Medicaid provider enrollment” (replace “state” with the name of the state where you seek to enroll).
  - Additional information on Medicaid provider enrollment is available in this CMS presentation.
  - CMS hosts a National Provider Enrollment Conference.
- **Private Insurance Provider Enrollment**
  - Identify private insurers that you will bill, including Medicare Advantage and Medicaid managed care plans.

  - Each insurer's website will provide directions on their provider enrollment process. Here is a link to Anthem's enrollment webpage as an example.
  - Many insurers use a national credentialing database such as the Council for Affordable Quality Healthcare (CAQH) ProView to enroll their providers. This allows the provider to enroll with a number of private insurers at the same time.
  - Payment processes, coverage, and speed of claims processing vary by insurer. It is important to understand the billing practices of each insurer that you will bill.
  - Determine which clinicians will be enrolled with each insurer and if separate credentialing contracts are necessary (as in private/group practices).

- **Contracting Enrollment Services**
  - Each provider should consider its capacity to effectively execute the enrollment process.
  - Another option is to use the services of a private agency to enroll providers in Medicare, credential clinicians, and update CAQH databases. If you are considering using a third-party agency for billing, it may also assist you with the enrollment process.

Determining Who Will Do the Billing

- **Hire staff with medical billing experience**—Hiring the right staff is critical. Experienced billers will understand the procedure and diagnostic codes and modifiers. They will also be familiar with the reimbursement rates for various insurers and the state Local Coverage Determinations that define what will be covered and how it will be covered in the state(s) that you bill.

  OR

- **Hire a third-party billing agency**—This is strongly suggested by grantees if an agency is new to the billing process. Third-party billers have the expertise to identify and resolve many common billing issues and help you to identify the practices that will ensure the highest return for services provided. As an example, they will know diagnostic code modifiers that enhance your level of reimbursement with the insurers that you bill. To find a quality third-party billing agency in your region, you may want to solicit recommendations from other providers in your area.

Other Billing Structure Components

- **Health Insurance Portability and Accountability Act (HIPAA) Compliance—** There is no certification process for HIPAA compliance. Agencies are required to demonstrate HIPAA compliance by having written policies and procedures in place that protect the privacy of patients and their health care records. CMS provides guidance to achieving and maintaining HIPAA compliance. Check website for updates regularly.
- **Process for Determination of Services to be Billed**
  - Finalize the services you will bill for, and to what payers.
  - Identify CPT® codes for each billable component of care.
  - Identify corresponding diagnostic code(s) and modifiers. Examples are provided at the bottom of each table.
  - Electronic Medical Records (EMR) and Electronic Billing Software may have the billing and diagnostic codes preprogrammed (provided via drop-down list for selection).
- **Proper documentation of care**—Necessary care must be provided and documented in compliance with payer requirements. This includes:
  - Obtaining/documenting prior approval from payer if required.
  - Obtaining a physician's orders for the service, if required.
  - Developing a required care plan or partnering with a physician or qualified health care provider who develops and signs the care plan.
  - Documenting specific elements of care as required, such as medical history, exam, and complexity of provider decision making.
- **Electronic Medical Records—**Maintaining electronic (or handwritten) documentation/patient records:
  - Streamlines patient records and maintains timely documentation, which can reduce delays in treatment and increase accuracy and clarity of records.
  - Maintains documentation needed to justify billing.
  - Provides diagnostic codes and modifiers to optimize billing and CPT® codes for billing.
  - The newest EMR software includes built-in electronic billing software.

  - EMR software varies greatly and is dependent on the type of patients you will be seeing and the services that you will deliver. One grantee tested 20 EMR systems before selecting one based on its flexibility and the ability to support the types of services it was delivering.

- **Electronic Billing Software**

  - Optimally, it may be a built-in component of your EMR software so that the processes operate seamlessly.
  - If not integrated, it is important that the electronic billing software interfaces seamlessly with the EMR software.
  - Provides the billing codes and diagnostic codes and modifiers that generate invoices to optimize payment for services.
  - The billing software connects to one of the approved billing clearinghouses that initiates the payment process with the appropriate third party payer (CMS, 2019).

Denials, Appeals, and Audits

- **Denials**

  - Once a claim is processed, it may be denied for a variety of reasons, including missing information, submission past the required time limit, a service that is not covered, or services that have been billed incorrectly (Marting, 2015).
  - It takes time to determine and understand the billing requirements of different payers. Clinicians may need education on the appropriate CPT® and ICD-10-CM codes and modifiers to use for different types of services to avoid denials.

- **Appeals**

  - Be prepared for many claim denials, especially when instituting a new billing system or billing for a new service.
  - Claims denied by private insurance companies can be appealed, and each insurer will provide information on its appeals process. Visit the Anthem website to view an example of one insurer's appeals process
  - Medicare claims (CMS, 2005)
    - Minor claim errors or omissions may be corrected without going through the appeals process.

    - The Medicare appeals process has five levels, each with its own adjudicating body. The first level of appeal is to the MAC and may be submitted by the patient or the provider.
    - File appeals promptly and in writing.
    - Consolidate similar claims into one appeal.
    - Include copies of all required documentation (decision letter, request for repayment, etc.).

- **Medicare Compliance and Audits**
    - Consider instituting an internal compliance and ethics committee. Such a group can oversee an internal controls process to ensure that new policies and regulations are adhered to.
    - CMS employs multiple programs to educate providers on billing policies and to reduce instances of Medicare overpayment (CMS, 2020c).
    - The federal government contracts with Recovery Audit Contractors that review past claims for evidence of over- or underpayment (CMS, 2020d).
    - Automated reviews are completed using electronic claims data; the provider is notified of an overpayment through a Demand letter (CMS, 2013, 2020b).
    - Complex reviews include a review of medical records, requested from the provider. Most of these audits look at whether the service was medically necessary (CMS, 2013).

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Rhode Island Clinical Trial Opportunities

REGISTRIES are opportunities to connect individuals interested in current and future research studies with researchers at local and national levels to discover what clinical trials may fit their needs and those of their loved ones. Registries also provide information, news, and research updates to its members.

Butler Hospital's Alzheimer's Prevention Registry (The Memory and Aging Program)
- Ages 40-90
- People with normal memory, mild cognitive impairment and mild AD may join.

The Rhode Island Alzheimer's Disease Prevention Registry at Rhode Island Hospital
- Ages 55-90
- Normal memory or mild memory issues. Those with a diagnosis of Alzheimer's disease or dementia are excluded.

OBSERVATIONAL AND INVESTIGATIONAL DRUG STUDIES
Interested individuals will be screened to determine their eligibility for clinical trials participation. Screening generally includes a review of medical conditions and current medications for study safety, physical, cognitive, and neurological testing, blood and urine testing, EKG, and imaging (MRI, tau PET, amyloid PET). These tests will be repeated regularly throughout the course of the study to monitor safety and demonstrate efficacy. Participation in prevention or treatment studies will require use of investigational drugs to be taken orally or by intravenous infusion.

Prevention Studies – Investigational drug studies aimed at preventing, slowing, or stopping Alzheimer's disease.
- generally, ages 50-85
- Normal memory or mild memory issues. Those with a diagnosis of Alzheimer's disease or dementia are excluded.

Treatment Studies - Investigational drug studies aimed at treating the symptoms of Alzheimer's disease or slowing/stopping Alzheimer's disease.
- generally, ages 50-90
- Diagnosis of Mild Cognitive Impairment or mild to moderate Alzheimer's disease

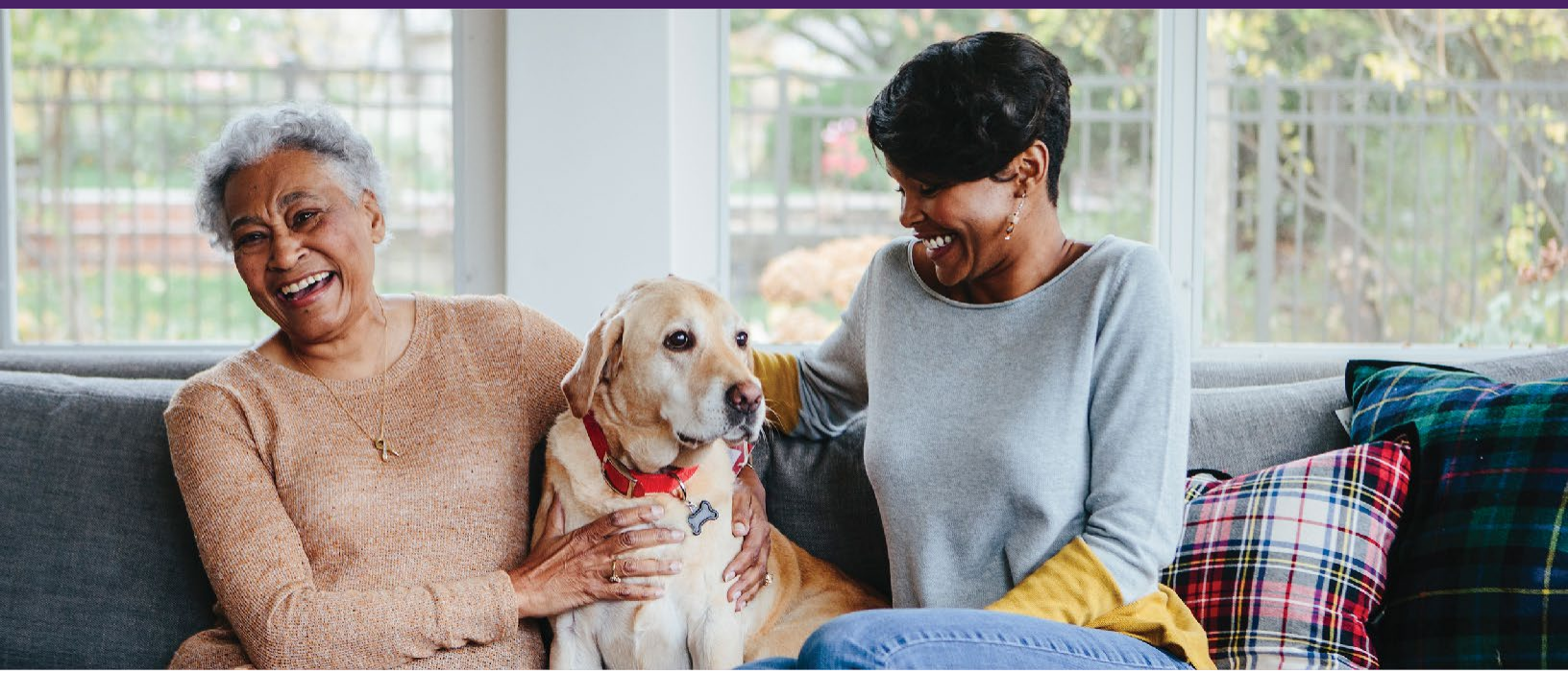
OBSERVATIONAL STUDIES
Research to expand scientific knowledge of Alzheimer's disease with no attempt to affect the outcome and in which no investigational drug is given. These studies may include diagnostic, epidemiology, social science, lifestyle interventions, psychology, or statistics research.
- generally, ages 50-90
- Normal memory or mild memory issues, diagnosis of Mild Cognitive Impairment or mild to moderate Alzheimer's disease, care partners, family members.

Butler Hospital's Memory and Aging Program	**Rhode Island Hospital Alzheimer's Disease and Memory Disorders Center**
Outreach Phone: 401-455-6402	**Community Outreach Coordinator: 401-444-0085**
Email: memory@butler.org	**Email: memory@lifespan.org**
Website: www.butler.org/memory	**Website: www.lifespan.org/memory**
Butler's Alzheimer's Prevention Registry www.butler.org/AlzRegistry	**Rhode Island Alzheimer's Disease Prevention Registry: www.lifespan.org/preventionregistry**
Facebook & Twitter: @MemoryAndAging	

LIVING WITH ALZHEIMER'S

FOR PEOPLE WITH ALZHEIMER'S

An education program presented by the Alzheimer's Association®



A diagnosis of Alzheimer's disease may be life-changing and lead to many questions. What will this mean for me and my family? How do I plan for the future? Where can I get the help I need?

Join us for this three-part program and hear from other individuals living with Alzheimer's on what to expect, how to build a care team and planning for the future.

Visit **alz.org/CRF** to explore additional education programs in your area.

alzheimer's association®

Rhode Island Chapter

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