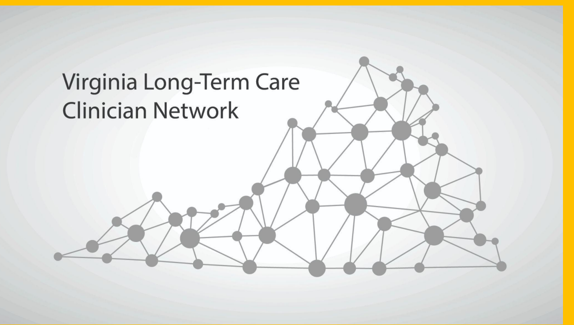
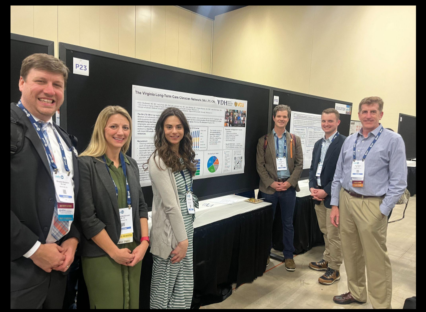
Virginia Long-Term Care Clinician Network

Monthly Forum
June 17, 2026





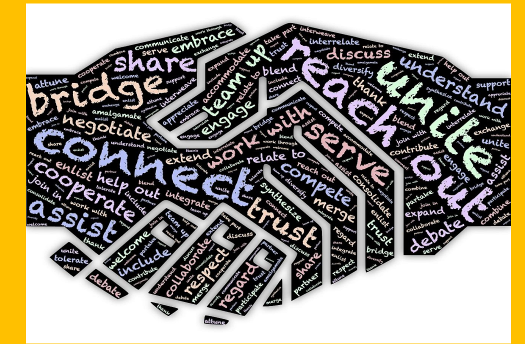
The Virginia Long-Term Care Clinician Network is managed by VCU's Division of Geriatric Medicine, Virginia Center on Aging, and Department of Gerontology.

WE ARE THE UNCOMMON.

Welcome!

As you join, please turn on cameras and mic or unmute your phone and say hello to your Virginia colleagues.

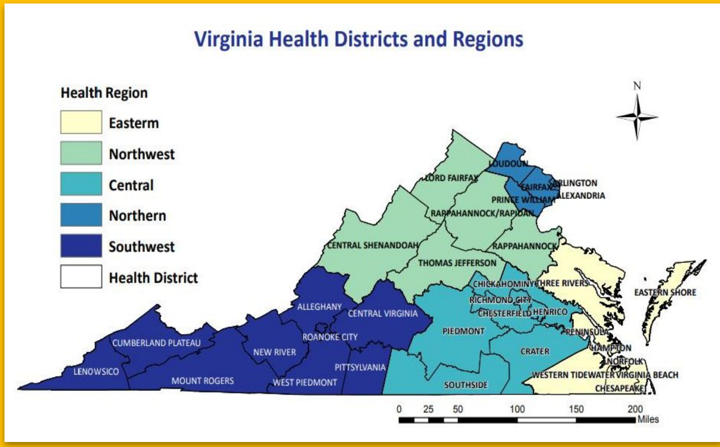
Any updates in the state or with you or your work?



Previous newsletters and other resources for you are at https://ltccn.vcu.edu/resources/

Welcome new members!

- **Julie Beales - Central Region**
- **Laura Kreisa - Central Regions**



There are approximately 287 nursing homes and 580 assisted living facilities operating in Virginia. Within these, there are over 500 clinicians providing care. **We have 334 network members.** The Network provides ongoing learning and communication.

Remind your work colleagues to attend so they can get education, support and CME!

Disclosure of Financial Relationships

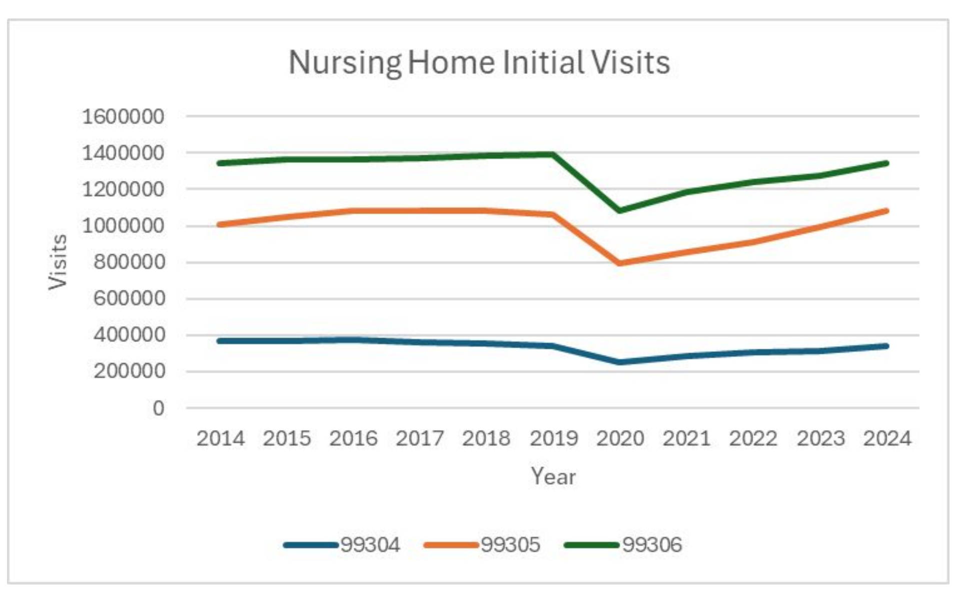
Disclosure of Commercial Support:

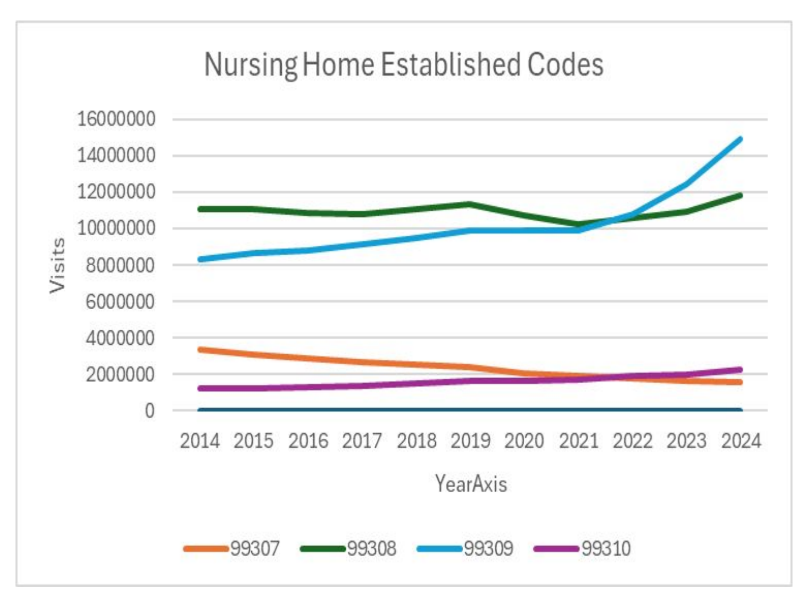
We acknowledge that no commercial or in-kind support was provided for this activity.

E&M Billing and Coding for Nursing Home and Assisted Living

Christian Bergman, MD, CMD, FACP, AGSF
Charles Crecelius, MD, PhD, FACP, CMD
Dallas L. Nelson, MD, FACP, CMD
Jamie Smith, FNP, CPMA

Nursing Home Coding Trends





Subsequent Visits by Provider Type 2024

9000000
8000000
7000000
6000000
5000000
4000000
3000000
2000000
1000000
0

99307 99308 99309 99310

NP PA IM FM PMR GER HM

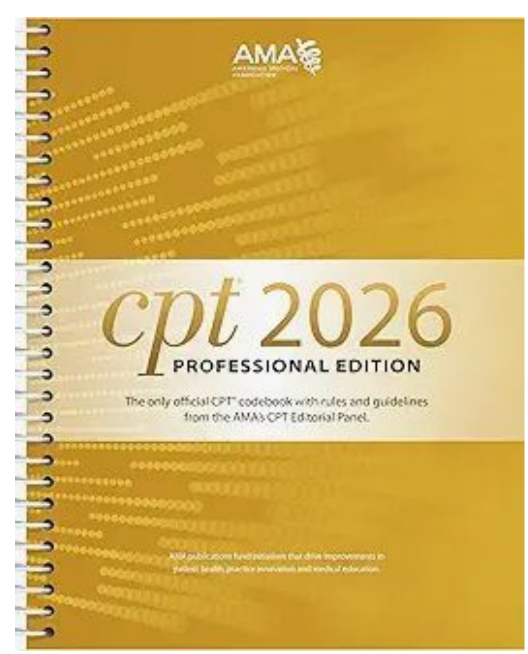
G2211 now in Home/Residence E/M Services

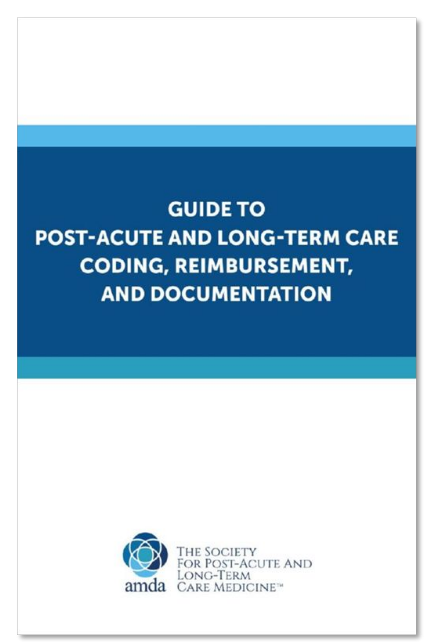
- Created by CMS and effective January 1, 2024.
- G2211 recognizes additional complexities associated with primary care or ongoing medical care of a patient with a single serious or complex condition—longitudinal relationship
- Most likely use in primary care, but may also be used by specialists with longitudinal relationship with patient
- **Effective 2026** - This add-on code may be reported with Home/Residence services 99341-99350 along with Office/Outpatient evaluation and management (E/M) services 99202-99215; cannot be reported in skilled nursing facility/nursing facility (SNF/NF)
- Cannot be reported when services requiring modifier -25 reported
- CMS will pay an additional $17.37 for services reported with G2211, RVU 0.52

Billing/Coding Updates

Christian Bergman, MD, CMD, FACP, AGSF

Resources for Accurate Coding





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SNF/NF 2026 RVU

Code	Total SNF/NF 2025 RVU	Total 2026 SNF RVU (Facility)	Total 2026 NF RVU (non-Facility)	SNF Non APM	SNF APM	NF Non APM	NF APM
99304	2.4	2.13	2.43	$71.14	$71.50	$81.16	$81.57
99305	3.97	3.59	4.22	$119.91	$120.51	$140.95	$141.65
99306	5.44	4.89	5.78	$163.33	$164.15	$193.06	$194.02
99307	1.19	1.11	1.26	$37.07	$37.26	$42.09	$42.30
99308	2.22	2.03	2.36	$67.80	$68.14	$78.83	$79.22
99309	3.22	2.95	3.43	$98.53	$99.02	$114.57	$115.14
99310	4.6	4.2	4.89	$140.28	$140.98	$163.33	$164.15
99315	2.43	2.19	2.57	$73.15	$73.51	$85.84	$86.27
99316	3.9	3.52	4.14	$117.57	$118.16	$138.28	$138.97
G3017	0.9	0.81	1.01	$27.05	$27.19	$33.73	$33.90
			CF non APM	$ 33.4009		CF APM	$ 33.5675

Home/Residential 2026 RVU

Code	Total 2025 RVU	Total 2026 RVU	2026 non-APM	2026 APM
99341	1.47	1.47	$ 49.10	$49.34
99342	2.34	2.36	$ 78.83	$79.22
99344	4.23	4.39	$146.63	$147.36
99345	5.99	6.29	$210.09	$211.14
99347	1.35	1.38	$ 46.09	$46.32
99348	2.3	2.36	$ 78.83	$79.22
99349	3.79	3.96	$132.27	$132.93
99350	5.5	5.78	$193.06	$194.02
	CF non APM	$ 33.4009	CF APM	$ 33.5675

How to Avoid Financial Clawbacks (or Worse): Place of Service (POS) Codes 31 vs 32 Made Simple

1. Know the Difference Between POS 31 and POS 32

2. Improve Communication with Facility Staff

3. Create an Internal "POS Status Notification System"

4. Determine Where Part A Status Lives in the Facility's EHR

31
Patients under Medicare Part A Skilled Nursing Facility (SNF)

32
Patients in custodial long-term care Nursing Facility (NF)

https://paltmed.org/sites/default/files/2025-12/PALTmed_POS%20Made%20Simple%20One-Pager_2025.pdf

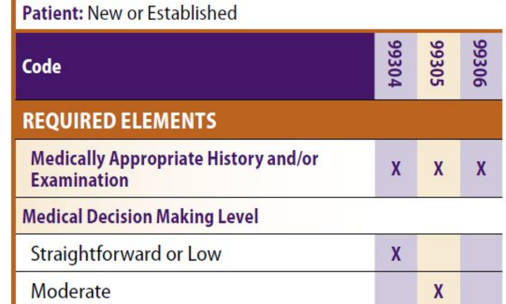
How to Avoid Financial Clawbacks (or Worse): Place of Service (POS) Codes 31 vs 32 Made Simple

PALTmed is actively advocating to ensure that the lower reimbursement for SNF POS 31 services is not permanent. Efforts are underway to reverse or mitigate the adjustment and to restore parity in facility-based care in nursing homes.

https://paltmed.org/sites/default/files/2025-12/PALTmed_POS%20Made%20Simple%20One-Pager_2025.pdf

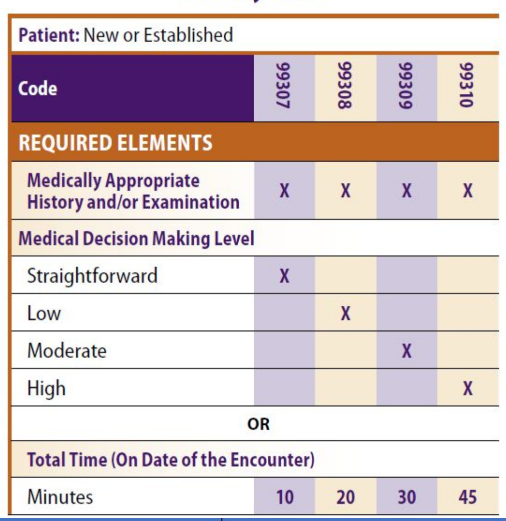
Nursing Facility Care Services

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

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Home or Residence Services

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

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

Home or Residence Services includes:

- private residence, temporary lodging, or short-term accommodations (hotel, campground, hostel, or cruise ship).
- Assisted living, group home, custodial care facilities, or residential substance abuse treatment facility.

Of note, for services in an intermediate care facility (ICF) for individuals with intellectual disabilities and services provided in a psychiatric residential treatment center, please see Nursing Facility Services.

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Billing / Coding Basics

- E/M codes that have levels of services include a medically appropriate history and/or physical exam.
- The final CPT code selection based on the **level of MDM** – or – **total time** for E/M service on the date of the encounter.
- To qualify for a particular level of MDM, **2 of the 3** elements for that level of MDM must be met or exceeded.

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Time-Based Billing

- Total time on the date of the encounter
- Includes face-to-face time with patient/family/caregiver and non-face-to-face time personally spent by physician
- Includes time regardless of location
- Do not count:
  - Travel, general teaching, other services reported separately

- Examples:
  - Preparing to see pt (e.g., review of tests)
  - Obtaining/reviewing prior history
  - Physical exam
  - Counseling/educating pt/family
  - Ordering meds, tests, procedures
  - Referring/Communicating with other physicians
  - Documentation
  - Independently interpreting results
  - Care coordination

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Total Time = Time Spent on Day of Service

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." Document briefly what activities were performed*

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Discharge Service Codes – 99315/6

- 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.

Code	Total SNF/NF 2025 RVU	Total 2026 SNF RVU (Facility)	Total 2026 NF RVU (non-Facility)	SNF Non APM	SNF APM	NF Non APM	NF APM
99315	2.43	2.19	2.57	$73.15	$73.51	$85.84	$86.27
99316	3.9	3.52	4.14	$117.57	$118.16	$138.28	$138.97

Medicare Claims Policy Manual, Chapter 12, Section 30.6.13

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Prolonged Services – A Tale of Two Cities

- Prior to 2024, prolonged services were reported using CPT Codes 99417/99418 (-17 home, AL; -18 nursing home, hospital)
- Starting in 2024, CMS determined that these codes may use incorrect times and modified them into site specific prolonged service codes with new time elements ("G" codes)
  - Base codes contain pre-and post-service times that were not included in time requirement calculations for CPT 99417 & 99418
  - CPT 99417/99418 are ineligible for Medicare patients – the G codes must be used instead
- Commercial insurers do not necessarily follow use of G codes, and depending on the insurer they may use CPT 99417/99418
- Persons in large groups academic centers may have the coders change to a "correct" code to fit the insurer needs

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Why Were These Changes Made?

- CMS felt there was overlap and potential double billing with CCM, ACP, prolonged service, non face to face codes and other services
- Time elements for codes are based off intraservice time (“typical times”) when the codes do contain times for pre and post services (1 and 3 days got nursing home, 3 and 7 days for AL/HC). A prolonged service then could occur over several days. (Times are based off surveys of providers).
- Changes were made to form G codes that include the total times of the service
- CMS-ineligible code time elements are only based off intraservice time but are limited in days covered

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G codes for Prolonged Services & Older Codes

- "G" codes for prolonged services are now in place
  - G0316 Prolonged Hospital or Observation Services
  - **G0317 Prolonged Nursing Home Services**
  - **G0318 Prolonged Home or Residence Services**
  - G2212 Prolonged Office/outpatient
- Converted not only face to face prolonged service codes 99417/99418 but also previously non-face-to-face prolonged service codes 99358-99359 to status "I," i.e. "Not valid for Medicare purposes" or "Ineligible."
- While CPT Codes for Prolonged Services (F2F and non-F2F) are not reimbursed by CMS, they may be paid by commercial, Medicaid or some Medicare Advantage payers
- Medicare does not limit the frequency of prolonged service codes, but reimbursement is capped at 4 units (60 minutes) per day. Additional units require an appeal with detailed justification.
- *Always check payer-specific rules, as private insurers may have different limits*.

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

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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)*

HCPCS Level II codes published by CMS.

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, AND the pre and post time of 30 minutes must be met or exceeded, making the threshold of 15 minutes beyond the base code now ***equals 95 minutes to report G0317 X 1***
  - **99310 Subsequent nursing facility care**, per day, 45 minutes must be met or exceeded, AND the per and post time of 25 minutes must be met or exceeded, making the threshold of 15 minutes beyond the base code now **equal to *85 minutes to report G0317 X 1***
- **May be reported for prolonged time within the surveyed time frame:**
  - **One day before, the day of and 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

Medicare Claims Processing Manual

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).*

HCPCS Level II codes published by CMS.

Prolonged Service G0317, G0318 CMS Eligible, Commercial May Pay

Setting of Care	Primary Code	Intra-service Time	Threshold for 1st unit	CPT Code	Threshold for 2nd unit
Nursing Facility, new	99306	50 min	>95 min	G0317	>110 min
Nursing Facility, est	99310	45 min	>85 min	G0317	>100 min
Home/Residence, new	99345	75 min	>140 min	G0318	>155 min
Home/Residence, est	99350	60 min	>110 min	G0318	>125 min

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Time-Based Billing / Prolonged Service Codes

- Remember – time spent on day of service determines correct CPT code.
- **Example 1: New pt to SNF – phone call not on DOS**

Date	Time Spent	Activity
Monday 12/8	15 min	Pre-visit, reviewed chart, phone call from hospital d/c provider
Tuesday 12/9 (DOS)	42 min	Date of Service, pt examined / spoke to staff / coordinated care / documentation / tried to call daughter – left voicemail
Wednesday 12/10	35 min	Phone call in evening from daughter
Total Time	92 min	99305 – time on DOS did not meet threshold for 99306 thus additional time not on DOS cannot be counted

Time-Based Billing / Prolonged Service Codes

- Remember – time spent on day of service determines correct CPT code.
- **Example 2: New pt to SNF – phone call on DOS**

Date	Time Spent	Activity
Monday 12/8	15 min	Pre-visit, reviewed chart, phone call from hospital d/c provider
Tuesday 12/9 (DOS)	60 min	Date of Service, pt examined / spoke to staff / coordinated care / documentation / **spoke to daughter on phone (18 minutes)**
Wednesday 12/10	10 min	Daughter called to ask a follow up question.
Total Time	85 min	99306 – time on DOS meets threshold for 99306; however, criteria not met for G0317 – needs to be more than 95 minutes

Time-Based Billing / Prolonged Service Codes

- Remember – time spent on day of service determines correct CPT code.
- **Example 3: New pt to SNF – 2 phone calls**

Date	Time Spent	Activity
Monday 12/8	15 min	Pre-visit, reviewed chart, phone call from hospital d/c provider
Tuesday 12/9 (DOS)	60 min	Date of Service, pt examined / spoke to staff / coordinated care / documentation / **spoke to daughter on phone (18 minutes)**
Wednesday 12/10	25 min	Daughter called to ask a follow up question.
Total Time	100 min	99306 + G0317 – time on DOS meets threshold for 99306; criteria met for 1 unit of G0317; next threshold for report 2nd unit is 110 minutes.

Time-Based Billing / Prolonged Service Codes

- Remember – time spent on day of service determines correct CPT code.
- **Example 4: NF Visit – Phone call not on DOS**

Date	Time Spent	Activity
Monday 12/8	10 min	Pre-visit, reviewed chart
Tuesday 12/9 (DOS)	35 min	Date of Service, pt examined / spoke to staff / coordinated care / documentation
Wednesday 12/10	42 min	Daughter called back, long discussion regarding preferences and recent changes
Total Time	87 min	99309 – time on DOS did not meet threshold for 99310 thus additional time not on DOS cannot be counted

Time-Based Billing / Prolonged Service Codes

- Remember – time spent on day of service determines correct CPT code.
- **Example 5: NF Visit – Phone call on DOS**

Date	Time Spent	Activity
Monday 12/8	10 min	Pre-visit, reviewed chart
Tuesday 12/9 (DOS)	77 min	Date of Service, pt examined / spoke to staff / coordinated care / documentation / long discussion in evening with daughter 42 minutes
Wednesday 12/10	5 min	Updated nursing facility staff, changed orders
Total Time	92 min	99310 + G0317 – time on DOS meets threshold for 99310; criteria met for 1 unit of G0317; next threshold for report 2nd unit is 110 minutes.

Time-Based Billing / Prolonged Service Codes

- **Advise: Perform all services on DOS**
- If subsequent activities are needed and there is a medical necessity – better to turn into new E&M encounter. Daughter calls back 1 day after wants to talk about GOC – schedule time later in week and bill for ACP visit.

Ex	Code	Time	RVU	Total RVU	Reimbursement (CF non APM 33.4009)
1	99305	92 min	3.59 (SNF)	3.59	$119.91
2	99306	85 min	4.89 (SNF)	4.89	$163.33
3	99306 + G0317	100 min	4.89 + 0.81 (SNF)	5.70	$190.39
4	99309	87 min	3.43 (NF)	3.43	$114.57
5	99310 + G0317	92 min	4.89 + 1.01 (NF)	5.90	$197.07

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

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Elements of the MDM Table

- Examples in the table may be more or less applicable to specific care settings.
- Level of Medical Decision-Making is determined by the highest level in 2 of the 3 elements
- The details and examples of Medical Decision-Making are described in the 2026 CPT Manual.

- Tip: If leveling the MDM doesn’t seem to add up, try free online resources as decision-support tools.
- Example: AAPC E/M Calculator, MAC Websites (e.g., E/M Interactive Score Sheet).
- Keep in mind, payers may interpret MDM elements differently

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AMA CPT Manual

Gold standard reference for E/M and CPT coding guidance

▶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**

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MDM – Problems Addressed

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

- **Minimal**
  - 1 self-limited or minor problem
- **Low**
  - 2 or more self-limited/minor problems, OR
  - 1 stable acute or chronic illness, OR
  - 1 acute, uncomplicated illness/injury
- **Moderate**
  - 2 or more stable chronic illnesses, OR
  - 1 or more chronic illnesses with an exacerbation/progression
  - 1 undiagnosed problem w/ uncertain prognosis
  - 1 acute illness w/ systemic symptoms
  - 1 acute, complicated injury
- **High**
  - 1 or more chronic illnesses with a severe exacerbation/progression
  - 1 acute or chronic illness or injury that poses threat to life/bodily function
  - Multiple morbidities requiring intensive management
    - **specific to initial nursing facility by the principal physician or QHCP (pg 29)

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MDM – Complexity of Data

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

- **Minimal or None**
- **Limited** (Meet 1 out of 2 categories)
  - Category 1: Any combo of 2 (ext notes, review test, order test)
  - Category 2: Assessment requiring independent historian*
- **Moderate** (Meet 1 of 3 categories)
  - Category 1: Any combo of 3 (ext notes, review test, order test, independent historian)
  - Category 2: Independent interpretation of tests performed by another physician
  - Category 3: Discussion with external physician
- **Extensive** (Meet 2 of 3 categories)
  - Category 1: Any combo of 3 (ext notes, review test, order test, independent historian)
  - Category 2: Independent interpretation of tests performed by another physician
  - Category 3: Discussion with external physician

*Assessment requiring independent historian:
Could be family member, caregiver, CNA or other staff members

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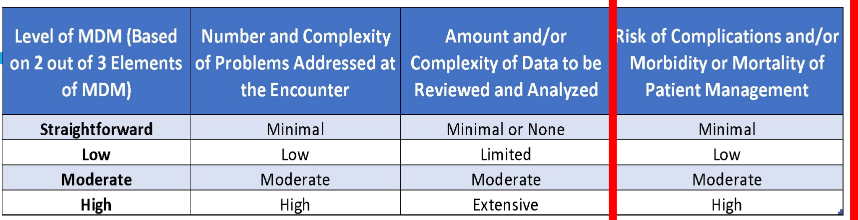
MDM – Risk



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

- **Minimal**
- **Low**
- **Moderate**, examples include:
    - Prescription drug management
    - Decision regarding minor surgery w/ patient/procedure risk factors
    - Decision regarding elective major surgery w/o pt/procedure risk factors
    - Diagnosis or treatment significantly limited by SDOH
- **High**, examples include:
    - Drug therapy requiring intensive monitoring for s/e or toxicity
    - Decision regarding elective major surgery with pt/procedure risk factors
    - Decision regarding emergency major surgery
    - Decision regarding hospitalization or escalation of care to hospital-level
    - Decision not to resuscitate or to de-escalate care d/t poor prognosis
    - Decision regarding parenteral controlled substances

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Key Notes:

- Prescription Drug Management –
  - Remember to connect the dots and show the work and risks involved when managing a prescriptions.
    - “Is the Rx something that could be harmful to the patient’s health?
    - “Will it interact with other drugs the patient is taking?”
    - “Did the pt have a stroke and is there a risk they may sustain a subsequent hemorrhage?”
  - Simply listing current medications is not considered "prescription drug management.“
- MDM Risk –
  - Includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s)
    - Includes the possible management options selected and those considered but not selected after shared decision making with the pt and/or family.

https://med.noridianmedicare.com/web/jfb/article-detail/-/view/10534/evaluation-and-management-prescription-drug-management

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Aligning Documentation With E/M Coding Requirements

- E/M improper payment rate is 10.3% (CMS 2024).
- Most denials are preventable: incorrect coding (49.1%) and insufficient/no documentation (47.2%).
- Coders and auditors cannot infer □ clear documentation must reflect your clinical thought process.
- Strong documentation improves care continuity, reduces after-hours disruptions, and protects revenue.
- **Points**: ensure documentation supports the CPT, HCPCS, & ICD-10 codes reported; document the pts progress, response to treatment, & updated diagnoses; connect the dots in the c/c, HPI, and A/P.

https://www.cms.gov/training-education/medicare-learning-networkr-mln/compliance/medicare-provider-compliance-tips/evaluation-management-services?utm_source

Why Learn MDM when I can use Time?

Code	Short Description	Total Time in Min.	Medical Decision-Making Level	Payment (2026 SNF)
99304	Initial NF Care w/ low MDM	25	Straightforward or Low	$71.14
99305	Initial NF Care w/ mod MDM	35	Moderate	$119.91
99306	Initial NF Care w/ high MDM	50	High	$163.33
99307	Sbsq NF Care w/ sf MDM	10	Straightforward	$37.07
99308	Sbsq NF Care w/ low MDM	20	Low	$67.80
99309	Sbsq NF Care w/ mod MDM	30	Moderate	$98.53
99310	Sbsq NF Care w/ high MDM	45	High	$140.28

https://paltmed.org/news-media/2024-physician-fee-schedule-released

Efficiency (might be able to 99309 level of visit in <30 minutes)

Better rationale for coding in case of audit

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Question and Answer

Claiming CE Credit Through VCU

NEW ACCOUNT NEEDED

Go to vcu.cloud-cme.com to create an account – make sure to add your cell phone number

Text the 5 digit code to (804) 625-4041 within 5 days

If you are driving during the Forum email ksivey@vcu.edu after the meeting for the code.

Complete Evaluation & Claim Credit,

within 60 days of the event and download your certificate of completion

Need help? ceinfo@vcuhealth.org

TEXT **40437** to
804-625-4041

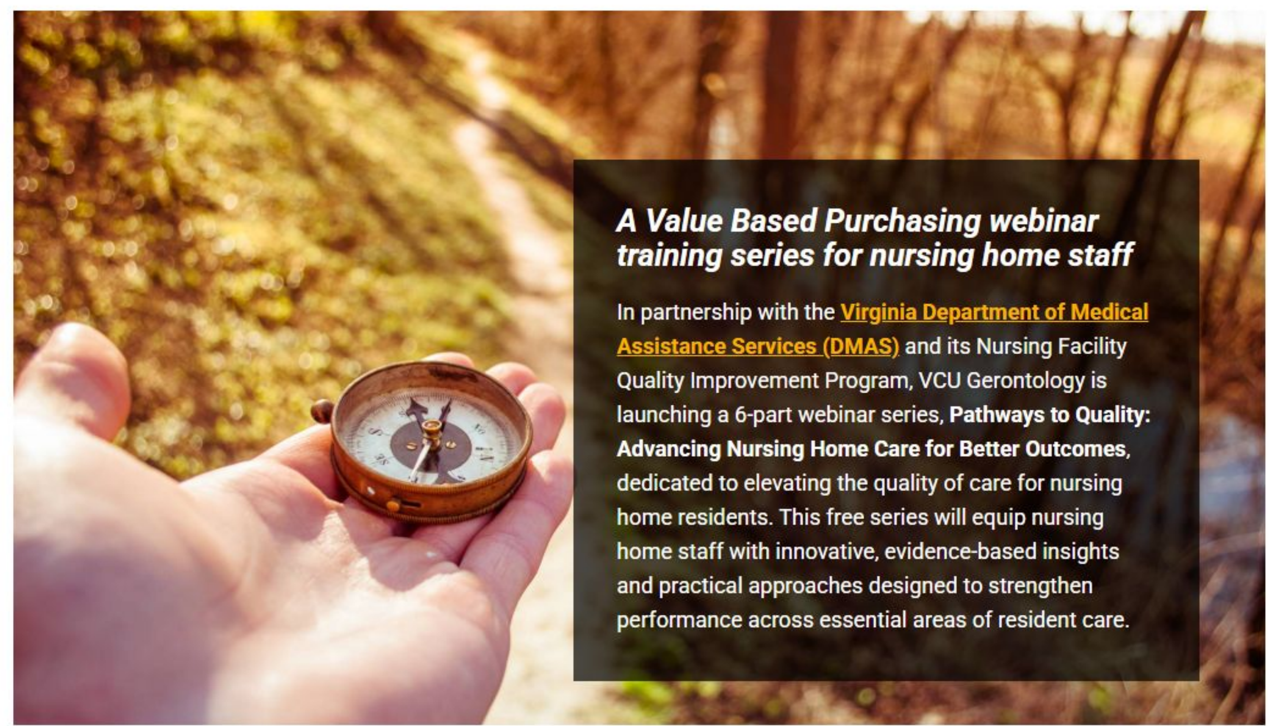
You will receive a text message and an email.

Accreditation

	In support of improving patient care, VCU Health Continuing Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
	VCU Health designates this live activity for a maximum of ***1.00 AMA PRA Category 1 Credits***™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education designates this activity for a maximum of ***1.00 ANCC*** contact hours. Nurses should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for ***1.00 AAPA Category 1 CME credits***. PAs should only claim credit commensurate with the extent of their participation.

WE ARE THE UNCOMMON.

Pathways to Quality: Advancing Nursing Home Care for Better Outcomes



Upcoming Dates:

July 28

Falls with Major Injury Part 1: Risk Factors, Causes, and Care Paths

Register Here

September 22

Falls with Major Injury Part 2: Moving to Prevention

Register Here

Details Here: https://tictoolkit.vcu.edu/learning-center/pathways/

Open Forum

Any questions or ideas from the talk?

Todays CE Code is **40437**

Text this code to 804-625-4041

WE ARE THE UNCOMMON.

Thank you for joining us!

Upcoming Forums:

- **July 15 - Varicella Zoster Virus**
- **August 19 - TBD**

Your Calendar Link - In the email reminder you received, there's a calendar link to update your calendar for future meetings.

On your way out of our meeting today, kindly answer a brief feedback survey.

Invite your colleagues! They can register at ltccn.vcu.edu