Billing Guidance for Patient Priorities Care

Patient Priorities Care (PPC) is an approach to clinical decision making for older adults with multiple chronic conditions that aligns care with their health priorities. This worksheet describes: 1) the appropriate Medicare codes to bill for each PPC activity; 2) who is able to perform activities for each code, 3) how many work RVUs are associated with the activity; 4) important considerations (pros, cons, and important FAQ's); 5) documentation issues and tips; and 6) helpful links.

The PPC steps covered here, include:

1. **Introduce Patient health priorities aligned decision making and care** (One-time by primary provider)
2. **Identify Patient health priorities** (Understand how to bill for the work of priorities identification either by the patient's primary care provider, specialist clinician, or by another member of the care team [care manager (CM), registered nurse (RN), physician assistant (PA), nurse, nurse practitioner (NP), social work (SW), other]
3. **Provide Patient health priorities aligned decision making and care** (Ongoing, by primary provider or team member)

Guidance on these billing codes continues to evolve. Providers and health system leaders should advocate for use of all codes. For many components of PPC, there is more than one way to bill. Use the code that you are familiar with and that is appropriate for the way the service is provided.

Code	Patient Priorities Care Activity	Who Performs	MD RVUs*	Important Considerations	Workflow and Documentation Issues and Tips	Helpful Links for Details
Annual Wellness Visit (AWV) **G-code (Medicare only) G0438 (initial) G0439 (subsequent)**	1. Introduce 2. Identify	MD/NP/PA	G0438: 2.60 G039: 1.92	• Establishes preventive care plan • May bill at intervals of at least one year. • All Medicare beneficiaries eligible • Many clinicians, practices and health care systems are billing for AWV • Advanced Care Planning can be provided and billed on the same day if desired	• Requires workflow design and • Requires use of templates and instruments	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/preventive-services/medicare-wellness-visits.html

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				• Clinical staff may perform many components • Good reimbursement • Supports age friendly health system		
Advance Care Planning (ACP) **CPT 99497, 99498**	1. Introduce 2. Identify 3. Provide PPC	MD/NP/PA SW (?)	CPT 99497: 1.50 CPT 9948: 1.40	• Can be billed whenever clinically indicated • Advance directives may be included but are not required • Suitable for priorities identification (see below) • No co-pay if performed on same day as AWV • No explicit frequency limitation	Easily integrated into workflow	Advance Care Planning Services Fact Sheet (PDF)
Evaluation and Management (E/M) **CPT 99213, 99214, 99215**	1. Introduce 2. Elicit 3. Provide PPC	MD/PA/NP	CPT 99213: 1.30 CPT 99214: 1.92 CPT 99215: 2.80	• Can be used for any part of PPC • An in-person office visit service • Billing by time particularly useful when providing PPC this way	• Document time spent (e.g., I spent 20 minutes discussing her desire to reduce her list of medications) • Document clinical content of the interaction (example: Mrs. Jones and I discussed the implications of the progression of her renal failure. She does not want her remaining life to be focused on her disease, instead wishing to maximize the quality and minimize the hassle. She would not want to attend a dialysis center but wants to hear about home peritoneal dialysis • May count all time spent on the day of the service • Evolving rules for telemedicine may allow this to be done remotely for PPC.	AMA Guidance on E/M (up to date but may be more detailed for some)
Chronic Care Management **CPT 99490** This is a legitimate billing code that you should consider	Provide PPC	Clinical staff, e.g. RN/SW	CPT 99490: 0.61	• Patient must have 2 or more significant chronic conditions • CMS has loosened requirements and documentation burden to promote use. • 20 minutes of **clinical staff time** directed by a physician or other qualified health care professional, per calendar month	• Requires verbal permission annually; document in chart • Time may be counted cumulatively over calendar month • Can be done remotely (e.g. telephone) or in person • Establishment or revision of a comprehensive care plan	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-

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using. Persist with your billing people if they are reluctant.				• Recognizes/facilitates contributions of clinical staff working under physician supervision. Supports team-based care. • Care plan requirement consistent with PPC model. • Some practices and health care systems reluctant to use these codes but billing is legitimate and appropriate for these services	• Services that must be documented in the electronic health record include, but are not limited to: Management of chronic conditions; referrals to other providers; management of prescriptions; ongoing review of patient status • Designation of staff responsibility and workflow needed • Many “typical” elements (e.g. patient’s demographics, problems, medications, and medication allergies; physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment) but none are specifically required	Publications-Items/ICN909188

*** Resource-Based Relative Value Scale**

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