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NDCC National Dementia Care Collaborative

The John A. Hartford Foundation

National Dementia Care Collaborative

Getting to Yes for Launch: GUIDE Participants Overcoming Challenges to Implement Comprehensive Dementia Care

Billing for Dementia and GUIDE Services

May 19, 2025

Agenda

- National Dementia Care Collaborative Overview
- Content
  - Billing for Dementia Care – UCLA
  - Billing for GUIDE Services - Emory
- Questions and Answers
- Announcements and upcoming events

Alzheimer's and Dementia Care (ADC) Program

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Date: May 19, 2025

ADC Alzheimer's and Dementia Care PROGRAM

UCLA Health

The John A. Hartford Foundation

Disclaimers about this presentation

- CMS Calendar Year 2025 Medicare Physician Fee Schedule (MPFS) Final Rule.
  - Dollar values based on national rates, varies regionally
- Please check with your local billing and compliance department
- Time-based coding
- Non-GUIDE billing
- The billing codes in this section will be appropriate for Physicians (MDs), Nurse Practitioners (NPs), Physician Associates (PAs), and Clinical Nurse Specialists (CNSs)

Billing codes to be covered

99483

Evaluation & Management Codes and Prolonged Visit Code G2212

Chronic Care Management (CCM)

Time-Based Coding

- Physician face-to-face and non-face-to-face time (note that time spent by clinical staff, such as MA, nurse, LVN, etc. cannot be included)
  - Preparing to see the patient (e.g., review of tests)
  - Obtaining and or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Referring and communicating with other healthcare professionals (when not separately reported)
  - Documenting clinical information in the EHR
  - Independently interpreting results and communicating results to patient/ family/caregiver
- Time documented should only be time spent on the date of the encounter

99483: Comprehensive Assessment and Care Planning

- Permanently added to Medicare Telehealth list
  - https://www.cms.gov/cognitive (updated 4/02/2025)
- Who can perform?
  - MD and DO, NPs, CNSs, and PAs
- Locations
    - Office or outpatient setting
    - Private residence
    - Care facility
    - Via telehealth

99483: What's included in a cognitive assessment?

- Cognition-focused evaluation including a pertinent history and examination
- Functional assessment: ADLs and IADLs (including decision-making capacity)
- Staging: FAST or CDR
- Medication reconciliation (including high-risk medications)
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s)

99483: What's included in a cognitive assessment? (continued)

Safety evaluation (home and motor vehicle operation)

Identify social support (caregivers)

- Caregiver knowledge, needs, and willingness of caregiver

Advance Care Planning

Care Plan:

- Neuropsychiatric symptoms
- Cognitive symptoms
- Functional limitations
- Referrals to community resources

Billing 99483

- Covers 60 minutes: $266.21
- Once every 180 days
- Use G2212 for prolonged visits
- Cannot bill on same day
  - Office/outpatient visits (99201-99215)
  - Home visit codes (99431-99350)
  - Advance care planning (99497-99498)

Evaluation & Management (E & M) Codes

New Patient	2025	Natl. Reimbursement	**Established Patient**	2025	Natl. Reimbursement
99202	15-29 mins	$69.87	**99212**	10-19 mins	$54.99
99203	30-44 mins	$109.01	**99213**	20-29 mins	$88.95
99204	45-59 mins	$163.35	**99214**	30-39 mins	$125.18
99205	60-74 mins	$215.75	**99215**	40-54 mins	$175.64
***99205 and 99215 are used the most for ADC patient appointments					

Prolonged services

- Medicare: G2212 ($31.05)
- For extended office visits, time beyond the primary visit code (99483, 99205, 99215, 99350)
- Must document total time on date of encounter
- To be reported for each all 15 mins beyond max range for 99205 and 99215. A full 15 mins must be spent to qualify for G2212.

Medicare prolonged visit code: G2212

99205	New Pt. Codes
60-74 minutes	G2212 Not reported separately
89-103 minutes	99205 x 1 and G2212 x 1
104-118 minutes	99205 x 1 and G2212 x 2
119 minutes or more	99205 x 1 and G2212 x 3 or more for each additional 15 minutes

99215	Est. Pt Codes
40-54 minutes	G2212 Not reported separately
69-83 minutes	99215 x 1 and G2212 x 1
84-98 minutes	99215 x 1 and G2212 x 2
99 minutes or more	99215 x 1 and G2212 x 3 or more for each additional 15 minutes

Chronic Care Management (CCM)

- Non-face-to-face services provided by Qualified Health Care Personnel (QHCP) and clinical staff
  - Staff can bill 99487, 99489, and 99490. QHCP does not need to be physically present when service is provided.
  - Monthly billing for at least 20 minutes of work (non-face-to-face)
- Services
  - Structured patient health information
  - Comprehensive electronic care plans
  - Care transitions and care management
  - Coordinating and sharing patient information within and outside of practice

CCM

- Who can bill
  - MDs, NPs, PAs, CNSs, and Certified nurse midwives
- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan

Example of Chronic Conditions

- Alcohol abuse
- Alzheimer's disease & related dementia
- Arthritis
- Asthma
- Atrial fibrillation
- Autism spectrum disorder
- Cancer
- Cardiovascular disease
- Chronic kidney disease
- COPD
- Depression
- Diabetes
- Heart failure
- HIV and AIDS
- Hyperlipidemia
- Hypertension & CVA
- Osteoporosis
- Schizophrenia & other psychotic disorders
- Substance use disorders

CCM Requirements

- Patient consent (verbal or written)
- Electronic recording of PHI
  - Demographics, problem list, medications, and allergies
- Comprehensive Care Plan (next slide)
  - Patient-centered: Covers physical, mental, cognitive, psychosocial, functional, and environmental assessment with resources and support
  - Patient and family have copy
- Access to Care & Community
  - 24/7 access to physicians or other QHCP
  - Designated team member that can routinely follow up
  - Patient/caregiver needs to have ability to communicate with provider

Comprehensive Care Plan

- Problem list
- Expected outcomes and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental assessment
- Caregiver assessment
- Interaction & coordination with outside resources and other providers
- When applicable, revision of care plan

Concurrent Billing: No double dipping!

- Cannot report
  - Complex CCM (i.e. 99491) and non-complex CCM (i.e. 99490) in same calendar month
  - Same service period by same provider for home health or hospice supervision and certain ESRD services
  - Complex CCM and prolonged E/M services in same calendar month
  - Time toward the CCM service code for any other billed code
  - CCM cannot be billed by multiple providers

CCM Codes

- Clinical Staff
  - CCM
    - 99490: 1st 20 mins
    - 99439 (add-on): each addl 20 mins
  - Complex CCM
    - 99487: 1st 60 mins
    - 99489 (add-on): each addl 30 mins
- QHCP
  - CCM
    - 99491: 1st 30 mins
    - 99437 (add-on): each addl 30 mins

Chronic Care Management Codes & Payment Rates

CPT	Description	2025 RVUs	2025 Payment Rate	Staff Type	Unit Duration
99490	CCM clinical staff first 20 mins	1.0	$60.49	Clinical Staff	20 Minutes (20-39 mins)
99439	CCM clinical staff each addl 20 mins	0.7	$45.93	Clinical Staff	40-59 mins (x1) 60 or more mins (x2)
99491	CCM QHCP first 30 mins	1.5	$82.16	Physician or other QHCP	30 mins (30-59 mins)
99437	CCM QHCP each addl 30 mins	1.0	$57.58	Physician or other QHCP	30 mins (x1) 60 or more mins (x2)

Advance Care Planning: 99497 & 99498

- Time-based discussions, with or without completion of any forms
- Face-to-face with the patient, family, and/or surrogate
- If E&M and ACP are billed on same date, add modifier 25 to indicate separate and significant service

99497	99498
• 1st 30 minutes • $79.58	• Each additional 30 minutes • $68.90 • No limit on the # of times 99498. If billed multiple times, CMS expects to see a documented change in patient's health status and/or wishes regarding his or her end-of-life care.

2025 Medicare Physician Fee Schedule

https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

Emory's Integrated Memory Care (IMC)

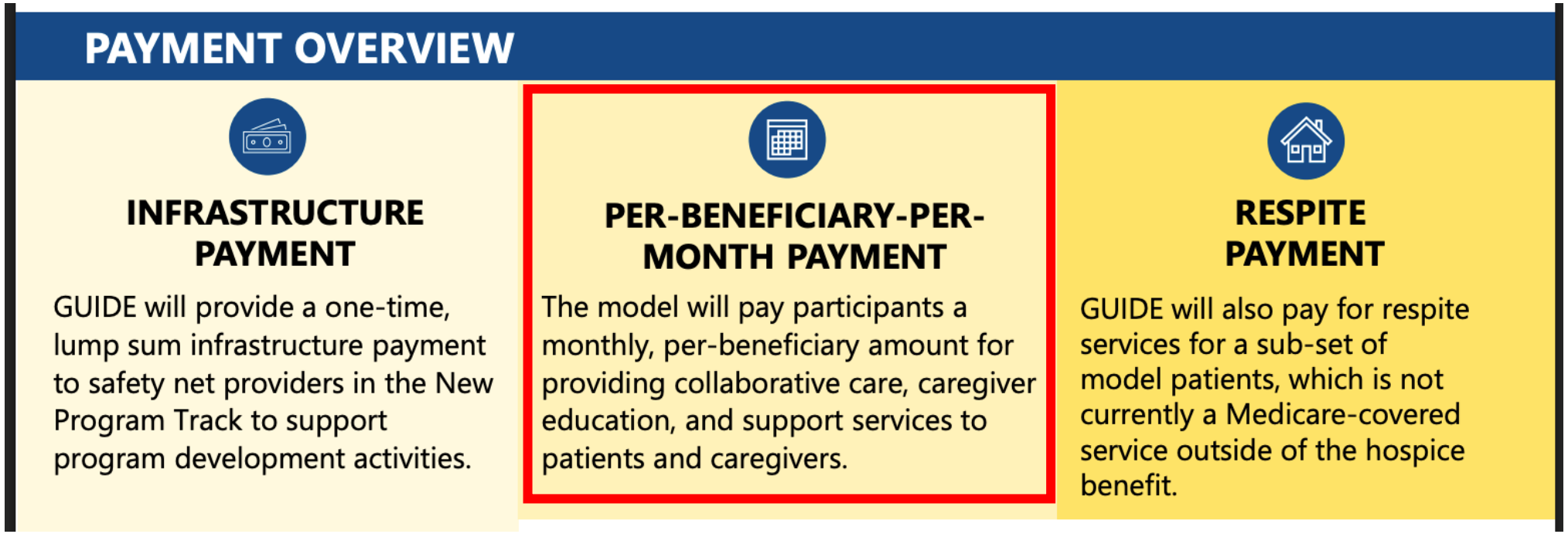
Billing for GUIDE Services

Carolyn Clevenger, DNP, GNP
Gerontological Nurse Practitioner

imc

Where Dementia is Primary

Payment Types



https://www.cms.gov/files/document/guide-model-overview-fs.pdf

DEMENTIA CARE MONTHLY PAYMENT

Model Tiers

Beneficiaries who align to model participants will be assigned to one of five "tiers," based on a combination of their disease stage and caregiver status. Beneficiary needs, and correspondingly, care intensity and payment, will increase by tier.

	TIER	CRITERIA
 **Beneficiaries with a caregiver**	Low complexity	Mild dementia
	Moderate complexity	Moderate or severe dementia and low to moderate caregiver strain
	High complexity	Moderate or severe dementia and high caregiver strain
 **Beneficiaries without a caregiver**	Low complexity	Mild dementia
	Moderate to high complexity	Moderate or severe dementia

Tier Definitions

	Tier	Criteria	Corresponding Assessment Tool Scores
Beneficiaries with a caregiver	Low complexity dyad tier	Mild dementia	CDR= 1, FAST= 4
	Moderate complexity dyad tier	Moderate or severe dementia *AND* Low to moderate caregiver strain	CDR= 2-3, FAST= 5-7 *AND* ZBI= 0-60
	High complexity dyad tier	Moderate or severe dementia *AND* High caregiver strain	CDR= 2-3, FAST= 5-7 *AND* ZBI= 61-88
Beneficiaries without a caregiver	Low complexity individual tier	Mild dementia	CDR= 1, FAST= 4
	Moderate to high complexity individual tier	Moderate or severe dementia	CDR= 2-3, FAST= 5-7

Payment Amounts

Model participants will use a set of new G-Codes created for the GUIDE model in order submit claims for the monthly Dementia Care Monthly Payment (DCMP). The DCMP is intended to cover the model's required care delivery activities.

Per Beneficiary Per Month Payment Rates

	Monthly payment rates for beneficiaries with caregiver			Monthly payment rates for beneficiaries without caregiver	
	Low complexity dyad tier	Moderate complexity dyad tier	High complexity dyad tier	Low complexity individual tier	Moderate to high complexity individual tier
First 6 months (New Beneficiary Payment Rate)	$150 G0519	$275 G0520	$360 G0521	$230 G0522	$390 G0523
After first 6 months (Established Beneficiary Payment Rate)	$65 G0524	$120 G0525	$220 G0526	$120 G0527	$215 G0528

In order to support accurate billing, CMS will provide each participant with a monthly beneficiary alignment file that lists all beneficiaries aligned to that participant, their model tier assignment, and the length of their alignment to the participant.

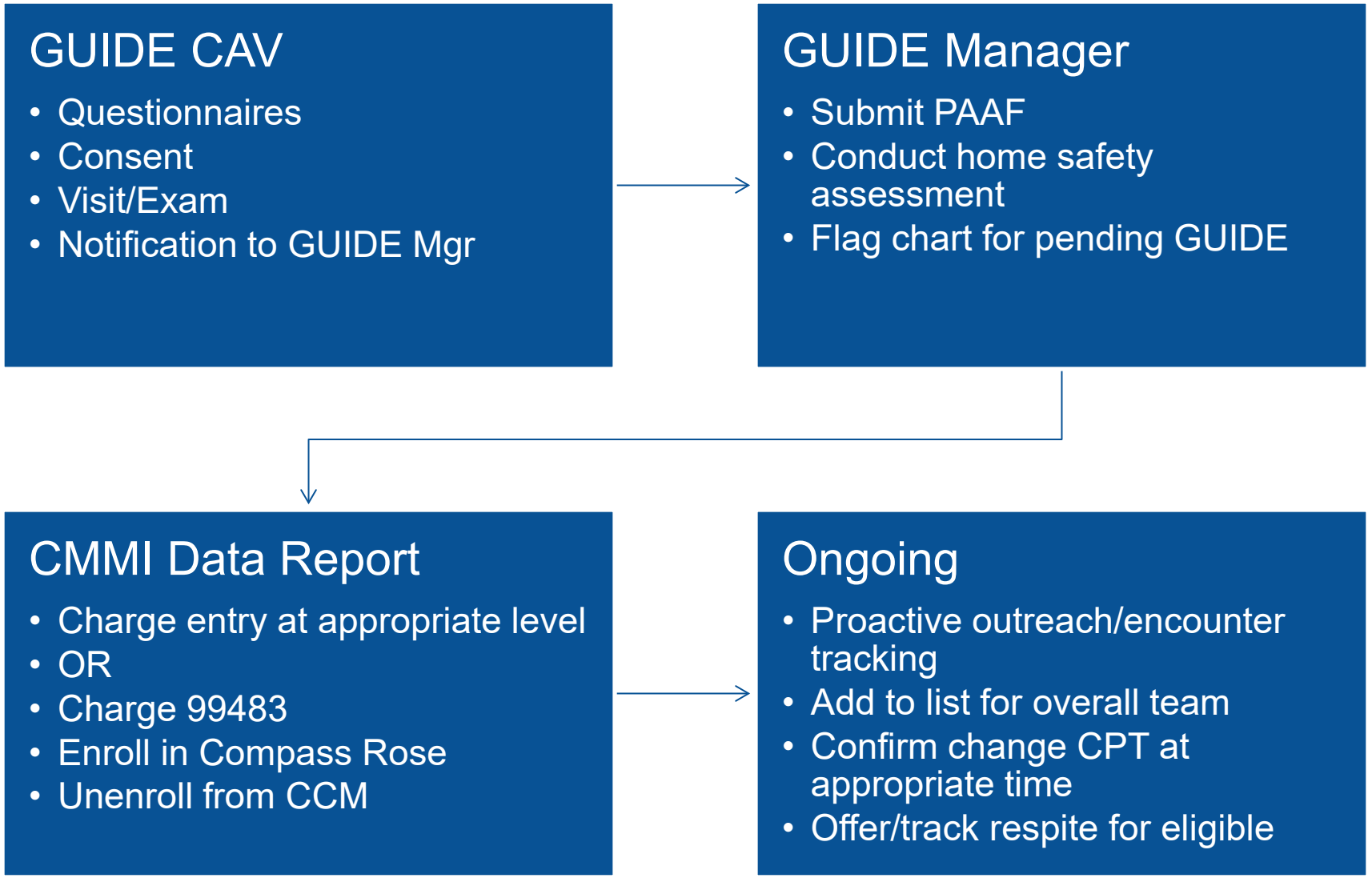
New CPT Codes versus Old CPT Codes

- G0159-G0528

- G0529: Home Care Respite (4-hour)
- G0530: Adult Day Center (8-hour)
- G0531: Facility-based Respite (24-hour)

Service Type	HCPCS Codes
Advance care planning	99497, 99498
Welcome to Medicare and Annual Wellness Visits	G0402, G0438, G0439
Home Health Care Plan Oversight	G0181
Hospice Care Plan Oversight	G0182
Cognitive Assessment and Planning	99483
Technology-based check-in services	G2012, G2252
Transitional Care Management	99495-99496
Chronic Care Management	99487, 99489-99491, 99437, 99439, G0506
Principal Care Management	99424–99427
Administration of patient-focused health risk assessment (HRA)	96160
Administration of caregiver-focused HRA	96161
Depression screening	G0444
Group Caregiver Behavior Management/ Modification Training Services*	96202, 96203
Caregiver Training Services under a Therapy Plan of Care established by a PT, OT, SLP*	97550, 97551, and 97552
Community Health Integration Services*	G0019, G0022
Principal Illness Navigation Services*	G0023, G0024, G0140, and G0146
Administration of a Standardized, Evidence-based Social Determinants of Health Risk Assessment*	G0136

IMC Process for GUIDE Enrollment and Alignment



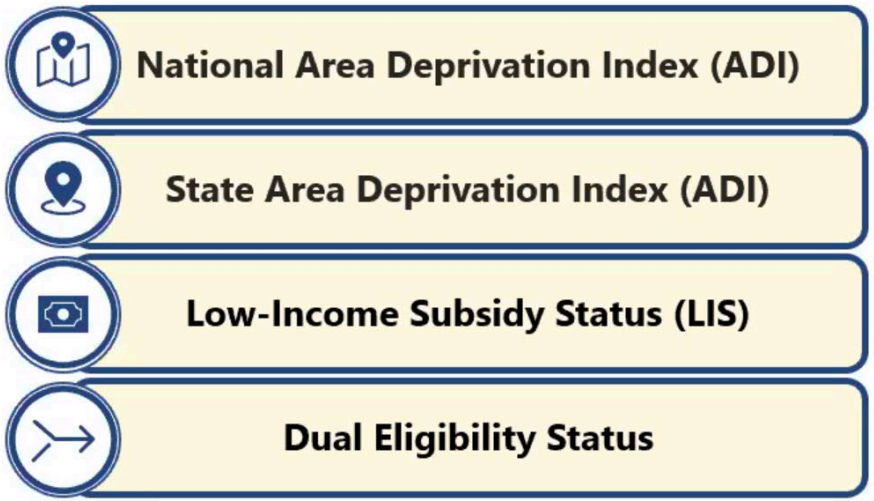
Payment Adjustments

When participants bill the per beneficiary per month Dementia Care Management Payment (DCMP), the DCMP will be adjusted by a Performance-Based Adjustment (PBA), as well as a Health Equity Adjustment (HEA).

The Health Equity Adjustment (HEA) is designed to decrease the resource gaps in serving historically disadvantaged communities.

The Performance Based Adjustment (PBA) will increase or decrease participants' monthly DCMPs, depending on how they perform during the previous performance year.

HEA will be based on certain social risk factors, which may include:

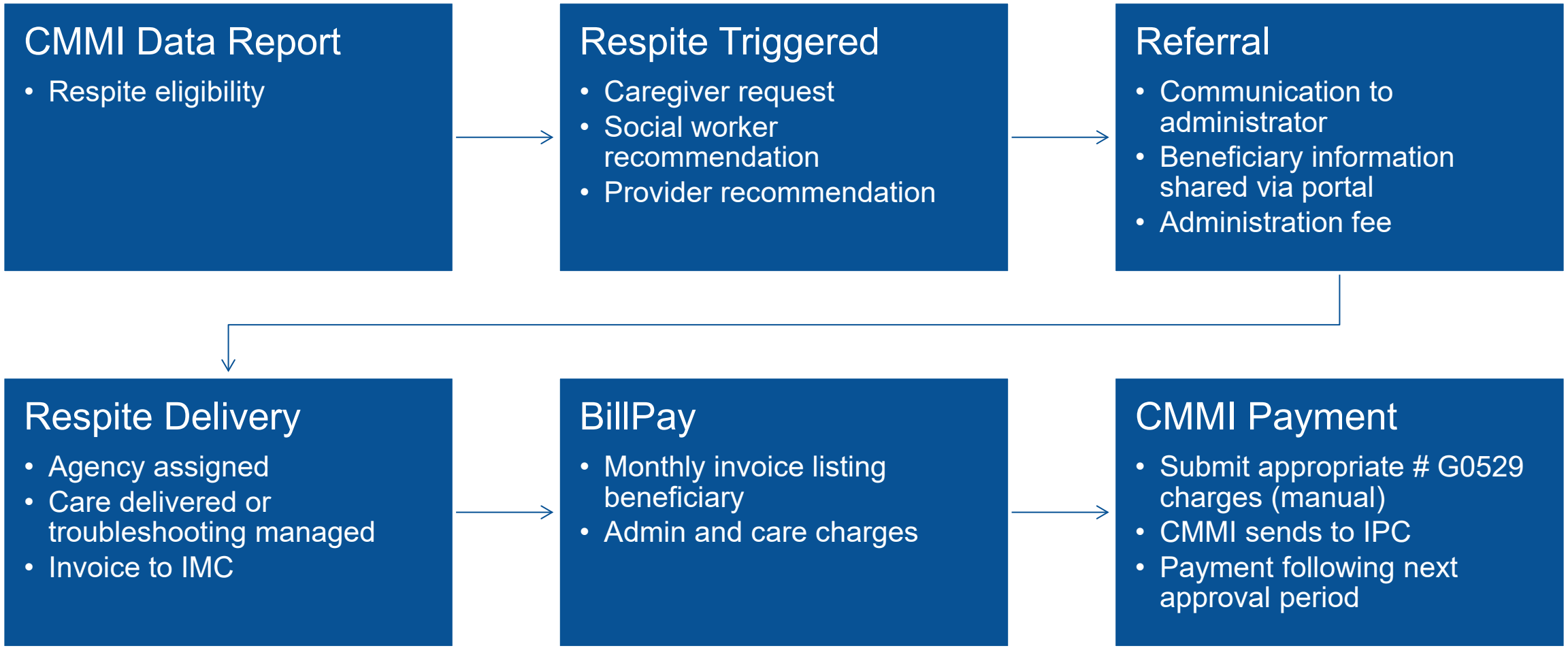


PBA will calculate five model performance metrics across four domains that include:

DOMAIN	METRICS
Care Coordination and Management	High-risk medications (eCQM/CQM)
Beneficiary quality of life	Quality of life outcome (Survey-based)
Caregiver Support	Zarit Burden Interview (Survey-based)
Utilization	Total Per Capita Cost (Claims-based)
	Long-term nursing home stay rate (Claims-based)

RESPITE

IMC Process for Respite



Questions & Answers

Please complete the webinar evaluation

Thank you for attending!

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