Department of
ELDER AFFAIRS
STATE OF FLORIDA

Ron DeSantis
*Governor*

Richard Prudom
*Secretary*

December 6, 2019

Re: Reimbursement Under CPT® Code 99483

Governor Ron DeSantis and Lieutenant Governor Jeanette Nuñez envision a Florida where *ALL* Floridians are not just living – but living well. To make this vision a reality, Governor DeSantis has taken significant steps to support Floridians with Alzheimer's Disease and Related Dementias (ADRD) and their caregivers. One initiative was creating a new priority area in the State Health Improvement Plan (SHIP) focusing solely on ADRD; Florida is the only state to have prioritized those affected by ADRD in this way.

This new priority area of the SHIP requires all licensed hospitals in Florida receive a summary of CPT® code 99483. Currently, data shows that less than 1% of seniors living with Alzheimer's disease receive the care planning benefit provided in this code. The State of Florida wants to ensure that all eligible Floridians receive this comprehensive care planning service and that providers are using the code.

CPT® code 99483 allows reimbursement for providing care planning services to individuals with cognitive impairment, including Alzheimer's disease. It also includes those without a clinical diagnosis who, in the judgment of the clinician, are cognitively impaired. Currently, doctors of medicine, doctors of osteopathic medicine, physician assistants, nurse practitioners, and clinical nurse specialists may bill under this code. Additional details are provided in the two documents enclosed with this notice.

It is our sincere hope that you will disseminate this information and encourage eligible clinicians to avail themselves of this opportunity to provide care planning services to individuals with cognitive impairment.

Sincerely,

Richard Prudom
Secretary

Enclosures:

- *Alzheimer's Impact Movement - Fact Sheet: CPT® Code 99483 Explanatory Guide for Clinicians, March 2018.*
- *Alzheimer's Association – Cognitive Assessment and Care Planning Services: Alzheimer's Association Expert Task Force Recommendations and Tools for Implementation*

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# 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 $241 in 2018.

## 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.

# Cognitive Assessment and Care Planning Services:
*Alzheimer's Association Expert Task Force Recommendations and Tools for Implementation*

## 1. Background and introduction to CPT® code 99483

The Alzheimer's Association® has long advocated for Medicare reimbursement for services aimed at improving detection, diagnosis, and care planning and coordination for patients with Alzheimer's disease and related dementias (ADRD) and their caregivers (Attea, Johns, 2010). These efforts, embodied in the Health Outcomes, Planning, and Education for Alzheimer's (HOPE) Act and aided by support from physician groups involved in developing new Current Procedural Terminology (CPT) codes, culminated in approval of a Medicare procedure code, G0505, which took effect January 1, 2017. In January 2018, G0505 was replaced by CPT code 99483. Code 99483 provides reimbursement to physicians and other eligible billing practitioners for a comprehensive clinical visit that results in a written care plan. Code 99483 requires an independent historian; a multidimensional assessment that includes cognition, function, and safety; evaluation of neuropsychiatric and behavioral symptoms; review and reconciliation of medications; and assessment of the needs of the patient's caregiver. (See the CPT 2018 manual for full details.) These components are central to informing, designing and delivering a care plan suitable for patients with cognitive impairment (Anonymous. Fed Register 2016).

The Alzheimer's Association Expert Task Force provided information and suggestions on the content and use of Code G0505 (now 99483) to the Centers for Medicare & Medicaid (CMS) during the comment phase (Alzheimer's Association Task Force, 2016), and reconvened in November 2016 to make recommendations about how to conduct the required assessments. Its recommendations derive from a broad consensus about good clinical practice, informed by intervention trials and emphasizing validated assessment tools that can be implemented in routine clinical care across the United States. The multidisciplinary task force was comprised of geographically dispersed experts in the United States who provide ongoing clinical care for individuals with ADRD and/or have published recognized works in the field.

## 2. Who is eligible to receive this comprehensive care planning service?

Cognitive assessment and care plan services are provided when a comprehensive evaluation of a new or existing patient, who exhibits signs and/or symptoms of cognitive impairment, is required to establish or confirm a diagnosis, etiology and severity for the condition.

Do not report cognitive assessment and care plan services if any of the required elements are not performed or are deemed unnecessary for the patient's condition. For these services, see the appropriate evaluation and management (E/M) code. (American Medical Association, CPT 2018).

## 3. Who can provide this service?

Any practitioner eligible to report E/M services can provide this service. Eligible providers include physicians (MD and DO), nurse practitioners, clinical nurse specialists, and physician assistants. Eligible practitioners must provide documentation that supports a moderate-to-high level of complexity in medical decision making, as defined by E/M guidelines (with application as appropriate of the usual "incident-to" rules, consistent with other E/M services) (Anonymous. Fed Register 2016). The provider must also document the detailed care plan developed as a result of each required element covered by 99483.

## 4. What must the clinician do to meet the required elements for code 99483?

Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home, domiciliary or rest home setting with all of the following required elements:

- Cognition-focused evaluation including a pertinent history and examination;
- Medical decision making of moderate or high complexity;
- Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity;
- Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]);
- Medication reconciliation and review for high-risk medications;
- Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s);
- Evaluation of safety (eg, home), including motor vehicle operation;
- 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 written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support.

Typically, 50 minutes are spent face to face with the patient and/or family or caregiver.

***See the 2018 CPT manual for the full description and detailed instructions for code 99483.***

## 5. When, where and by whom can the required elements be assessed?

The nine assessment elements of 99483 can be evaluated within the care planning visit or in one or more visits that precede it, using appropriate billing codes (most often an E/M code). Patients with complex medical, behavioral, psychosocial and/or caregiving needs may require a series of assessment visits, while those with well-defined or less complex problems may be fully assessed during the care plan visit. Results of assessments conducted prior to the care plan visit are allowed in care planning documentation provided they remain valid or are updated with any changes at the time of care planning.

A single physician or other qualified health care professional should not report 99483 more than once every 180 days.

Many of the required assessment elements can be completed by appropriately trained members of the clinical team working with the eligible provider. Assessments that require the direct participation of a knowledgeable care partner or caregiver, such as a structured assessment of the patient's functioning at home or a caregiver stress measure, may be completed prior to the clinical visit and provided to the clinician for inclusion in care planning. Care planning visits can be conducted in the office or other outpatient, home, domiciliary or rest home settings.

## 6. What measurement tools should be used to support the care planning process and its documentation?

Standardized, validated tools are preferred whenever possible and are required for some elements (see Table 1 for suggested tools). Such tools offer a basic framework on which to build a nuanced clinical understanding of care needs through ongoing clinical contact with the patient and caregiver. Though all required elements must be represented, the choice of assessment tools should be customized for differing clinician styles and practice composition, workflows and overall clinical goals. For example, primary care providers and dementia specialists may prefer different tools.

For several domains of care planning, simple, validated tools do not yet exist, and where they do, not all have been formally tested for validity and uptake in actual primary care practices. In the table below, those that have been tested in primary care are marked with an asterisk; those untested in primary care have either high face validity (e.g., Safety Assessment checklist) or published validation data that support further use. Ideally, tools should be:

- **Practical:** Time and effort to complete them fit the primary care clinical setting.
- **Parsimonious:** Provide enough information to support a meaningful care plan.
- **Scorable:** Results depicted in a single number.
- **Retrievable:** Easily incorporated into electronic health record fields and searchable at the point of care.

**Table 1: Suggested Measures to Support the Care-Planning Process**
The table below provides examples of simpler and more complex tools acceptable for assessing each domain. In some settings, a simple tool might be sufficient; in others, it could be used to trigger a more complex assessment or be replaced by a more detailed measure.

| Domain | Suggested measures | Comments |
|---|---|---|
| **Cognition** | Mini-Cog | ≤ 3 min, validated in primary care |
| | GPCOG | Patient/informant components |
| | Short MoCA | ~ 5 min, needs testing in primary care |
| **Function** | Katz (ADL), Lawton-Brody (IADL) | Caregiver rated |
| **Stage of cognitive impairment** | Dementia Severity Rating Scale | Caregiver rated, correlates with Clinical Dementia Rating |
| **Decision-making** | 3-level rating: able to make own decisions, not able, uncertain/needs more evaluation | Global clinician judgment |
| **Neuropsychiatric symptoms** | NPI-Q | 10 items |
| **Depression** | BEHAVE 5+ | 6 high-impact items |
| | PHQ-2 | Depression identification |
| **Medication review and reconciliation** | Med list + name of person overseeing home meds | Identify/reconsider high-risk meds; assess for reliable administration by self or other |
| **Safety** | Safety Assessment Guide | 7 questions (patient/caregiver) |
| **Caregiver identification and needs assessment** | Caregiver Profile Checklist | Ability/willingness to care, needs for information, education, and support |
| | Single-Item Stress Thermometer | Rapid identification of stress |
| | PHQ-2 | Depression |
| **Advance care planning** | End-of-Life Checklist | Screen for preferences and legal needs |

## 7. The written care plan

**Preparing the plan**

The care plan should reflect a synthesis of the information acquired as part of the assessment. It should be written in language that is easily understood, indicate who has responsibility for carrying out each recommended action step and specify an initial follow-up schedule.

Some clinicians find it useful to organize the care plan into broad components, such as:

- Specific characteristics of the cognitive disorder (e.g., type and severity of cognitive impairment; special hazards such as falls or orthostatic hypotension in Lewy body dementia; or referral to a dementia specialist for further diagnostic assessment or complex management).
- Management of any neuropsychiatric symptoms, including referrals for caregiver stress and behavior management training or psychiatric care for the patient as indicated.
- Comorbid medical conditions and safety management, including any changes needed to accommodate the effects of cognitive impairment.
- Caregiver stress and support needs, including primary care counseling and, as indicated, referrals to community-based education and support, specialized individual or family counseling, or in-home care, legal or financial assistance.

**Documenting and sharing the plan**

Though not required by 99483, a standardized care plan template customized to the provider or health care system simplifies communication and tracking of patient care and outcomes over time. The written plan must be discussed with and given to the patient and and/or family or caregiver; this face-to-face conversation must be documented in the clinical note for all encounters reported using 99483. The care plan must be filed in the patient's medical record where it can be easily retrieved and updated. Sharing the plan with other providers caring for the patient, including clinicians, care managers, caseworkers, and others who assist the patient and caregiver, both within and outside the primary care environment will help ensure continuity and coordination of care. When such sharing requires explicit consent of the patient, family caregiver or legally designated decision-maker (DPOA holder), that permission should be sought and documented.

## 8. How often can 99483 be used?

Qualified health care professionals may report 99483 as frequently as once per 180 days, per CPT. However, payer policy may say otherwise and should be consulted. Care plans should be revised at intervals and whenever there is a change in the patient's clinical or caregiving status. Medicare intermediaries may audit the frequency of use.

## 9. How does 99483 relate to Chronic Care Management (CPT 99490)?

CPT code 99490 is an appropriate service to use for monthly care management of a patient with dementia plus at least one other chronic condition, after a cognitive impairment care plan has been developed and documented.

## 10. Identifying proper coding

CPT code 99483 was developed to provide reimbursement for comprehensive evaluation of a new or existing patient, who exhibits signs and/or symptoms of cognitive impairment, is required to establish or confirm a diagnosis, etiology and severity for the condition. This service includes a thorough evaluation of medical and psychosocial factors, potentially contributing to increased morbidity. Do not report cognitive assessment and care plan services if any of the required elements are not performed or are deemed unnecessary for the patient's condition. For these services, see the appropriate evaluation and management code.

**Table 2: Commonly used ICD-10 codes for dementia and mild cognitive impairment**

| Code | Description |
|---|---|
| G300 | Dementia Alzheimer's disease with early-onset |
| G301 | Dementia Alzheimer's disease with late-onset |
| G309 | Dementia Alzheimer's disease, unspecified |
| F01.50 | Vascular dementia without behavioral disturbance |
| F01.51 | Vascular dementia with behavioral disturbance |
| F02.80 | Dementia in other diseases classified elsewhere without behavioral disturbance |
| F02.81 | Dementia in other diseases classified elsewhere with behavioral disturbance |
| F03.90 | Unspecified dementia without behavioral disturbance |
| F03.91 | Unspecified dementia with behavioral disturbance |
| G31.01 | Pick's disease |
| G31.09 | Other frontotemporal dementia |
| G31.85 | Corticobasal degeneration |
| G31.83 | Dementia with Lewy bodies |
| G31.84 | Mild cognitive impairment, so stated |

**Table 3: CPT codes that cannot be reported in conjunction with 99483**
Because many 99483 elements overlap with other CPT codes, CMS provides specific guidelines on which CPT codes cannot be reported together with 99483 on the same date of service. It is important to note that Medicare Advantage Plans and Accountable Care Organizations may have different reimbursement criteria. Payer policy should be consulted.

| Code | Description |
|---|---|
| 90785 | Psychotherapy complex interactive |
| 90791 | Psychiatric diagnostic evaluation |
| 90792 | Psychiatric diagnostic evaluation with medical services |
| 96103 | Psychological testing administered by a computer |
| 96120 | Neuropsychological testing administered with a computer |
| 96127 | Brief emotional/behavioral assessment |
| 96160-96161 | Health risk assessment administration |
| 99201 – 99215 | Office/outpatient visits new |
| 99241-99245 | New or established patient office or outpatient consultation services |
| 99324 – 99337 | Domicile/rest home visits new patient |
| 99341 – 99350 | Home visits new patient |
| 99366 – 99368 | Team conference with patient by healthcare professional |
| 99497 | Advanced care plan 30 min |
| 99498 | Advanced care plan additional 30 min |
| 99605-99607 | Medication therapy management services |
| G0506 | Comprehensive assessment of and care planning by the billing practitioner for patients requiring CCM services |
| G0181, G0182 | Home health care and hospice supervision |

**Table 4: CPT codes that can be reported with 99483 on the same date of service**
CMS does not believe the services described in 99483 would significantly overlap with the following codes.

| Code | Description |
|---|---|
| 99358, 99359 | Non-face-to-face prolonged services |
| 99487, 99489, 99490 | Chronic care management (CCM) services |
| 99495, 99496 | Transitional care management (TCM) services |

## References (partial)

Alzheimer's Association Expert Task Force. Alzheimer's Association Expert Task Force Consensus Statement on CMS Proposed Billing Code for the Assessment and Care Planning for Individuals with Cognitive Impairment. Release September 6, 2016. Available at: http://act.alz.org/site/DocServer/Taskforce_Consensus_Statement_FINAL.pdf?docID=51841. Accessed November 29, 2016.

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