GROUP VISIT GUIDELINES – Applicable to all payers

Effective Date: July 1, 2011

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<u>Group Visit Scheduling:</u>

All patients involved in the Group Visit must have a scheduled appointment. The scheduled appointment times are typically the same for all patients involved in the Group Visit. Copays will be collected when applicable through the normal collection process.

- New or established shared medical appointments will be scheduled by the clinic prior to the Shared Medical Session.
- Contact CU Medicine Fee Coordination, Systems and Application Department to establish scheduling set up for EMR systems not addressed below:
    - EPIC Group Medical Visits will be scheduled using visit type "GVA" (Group Visit Appointment)
- The approved consent form for these visit types is included in a separate document.

<u>Group Visit Documentation:</u>
Documentation on each patient is required by CU Medicine Providers to support the Group Visit. These providers may include physicians, nurse practitioners, or physician assistants. Normal documentation templates may be utilized to support Group Visits. Providers should contact Fee Coordination Managers to clarify documentation requirements for Group Visits. A face-to-face encounter must be completed by the CU Medicine billing provider with the patient to bill for the service. The provider should include documentation for the theme of the visit.

Group Visits will be billed based on the CU Medicine Provider medical documentation which must support the billed service. This includes an individual HPI/Exam/Medical Decision Making. Billing **<u>may not</u>** be based on time. The following is documentation criteria:

- HPI must include unique patient information documented by a resident, physician, nurse practitioner, or physician assistant involved in the patient care.

- Exam portion must be specific to the patient encounter documented by a resident, physician, nurse practitioner, or physician assistant involved in the patient care. Except when the nurse documents the vital signs, the provider may tie to the nurse for this information only. The exam portion may/may not include an exam room.

- Medical Decision making must be patient specific and documented by a resident, physician, nurse practitioner, or physician assistant involved in the patient care.
    - There should be no documentation of time.

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- A tie to an ancillary provider is not permitted to include registered dietician, pharmacists, RN for education delivered, or by any other non-billable provider.
- The ancillary providers should document their own portion of the visit; however, this documentation may not support the billing provider's charges.
- Documentation for diagnosis management, labs, and risk should be completed in this section.

- Documentation should not include a group visit statement.

- Patient may not have active issues/complaints; however, CU Medicine recommends billing for the visit based on the information that is documented.

- When involving a resident in the patient visit, Teaching Physician requirements must be met.

- Primary Care Exception rule does apply for the below services when performed in a clinic that has met this requirement.

- Medical Student documentation may be incorporated in the documentation, but may only support the Past/Family/Social History and Review of Systems.

- If education is delivered or co-hosted by more than 1 billable provider, either an MD or Non-MD for the Group Visit – Only one provider may bill for the encounter.

  - CU Medicine does not recommend two billable providers sharing the visit encounter.

- Use of a Scribe - An eligible scribe has no active or simultaneous role in clinical care at the time that they are scribing the service. A scribe creates the documented note concurrently with the visit/encounter. Only the billing provider may use the personal services of a scribe. If encounter is documented in an EHR, the scribe must have their own secured individual login to document in the medical record. In addition, the use of Medical students, Residents, or Fellows may **not** act as a "scribe" for another provider.

  - When a nurse, NPP or other employee acts as a scribe for a physician, the medical record must clearly reflect who performed the service, who recorded the service and the qualifications (i.e., professional degree, medical title, etc.) of each individual. The documentation must be **signed by both** the "scribe" and the rendering provider.

Group Visit Billing:

The following Evaluation and Management services may be billed for a Group Visit:

- 99211-99215 Established Outpatient Visit
- Visits should be billed with appropriate modifiers GC if performed with a resident or GE if performed in a primary care exception clinic.

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