SHARED MEDICAL APPOINTMENTS (SMAs):

GROUP VISITS FOR CARE AND ONGOING FOLLOW-UP OF A CHRONIC OR BEHAVIORAL CONDITION

OVERVIEW:

Shared medical appointments (SMAs) are an alternative to the standard individual medical appointment. They typically include an E/M visit with each patient as well as an educational/counseling component done as a group. SMAs can be used for care and ongoing follow-up of a chronic or behavioral condition and would be an effective, efficient way to deliver diabetes self-management education (DSME) in primary care. Outpatient fee-for-service clinics, FQHCs, and RHCs are potential settings for SMAs to take place. SMAs usually consist of staff-formed groups of 10-12 patients who have a common condition, such as type 2 diabetes, depression, or COPD. Newer Medicare-covered services that may be appropriate to offer as SMAs include alcohol misuse counseling, smoking/tobacco cessation counseling, cardiac risk reduction counseling, and intensive behavioral counseling for obesity.

BENEFITS OF SMAs:

- Provider/Practice Benefits
    - Cost-effective, efficient way to deliver quality care
    - Improved provider satisfaction
    - Increased provider capacity and revenue
- Patient Benefits
    - A provider visit and a health education intervention in one trip
    - Longer and possibly more frequent access to providers
    - Improved patient satisfaction
    - Interactive learning and support from the healthcare team and peers
    - Enhanced self-management skills
    - Improved health outcomes

STAFF:

Examples of eligible rendering providers for SMAs include: MDs, DOs, NPs, PAs, and CNSs. However, the primary care practitioner, psychologist, or other billing provider must be present in the room throughout the medical component (CMS). Clinical and administrative staff supports the provider's tasks as needed. If a provider and allied health professional are supplying two separately billable services, there should be two separate chart notes to reflect this, completed during the visit if possible, but may need to be finished afterward (AAFP).

FREQUENCY AND DURATION:

These are determined by the practice. SMAs are typically one to two hours in duration, including the provider-patient E/M visit and the educational/counseling component. The frequency and number of visits should be based on the standards of care for the condition being treated and the payors' listed frequency and timeframe for initial and follow-up visits for each condition.

PRIVACY:

To ensure privacy, the patients have the option to do their individual provider-patient E/M visits in the group setting or in a private room away from the group. The provider also should accommodate patient requests for one-to-one time during the SMA or in a separate visit.

BILLING:

No additional CMS code exists to denote the medical visit was done in a group format. Generally, performing these services in a group format does not affect the coding, billing, or reimbursement per patient.

The table below provides information for billing Medicare for SMAs.

BILLING	• For FQHCs or RHCs, CMS does not reimburse via Medicare Part B for DSMT done as a group (G0109) • FQHCs and RHCs can account for each patient seen in each group visit on their annual cost report • In fee-for-service programs, billing is under the physician or mid-level's NPI# for the E/M code • The DSMT component, either DSMT program's NPI or DSMT individual provider's NPI is billable under separate NPI
ICD-10 DIAGNOSIS CODES	• Use individualized ICD-10 codes that correspond to each patient
HCPCS/CPT PROCEDURE CODES	• For Medicare E/M codes to be charted per patient, choose 99213, 99214, or 99215 for each patient based on complexity level. Any applicable, existing E/M code in Current Procedural Terminology may be used (for more information, see references 2 and 3 below) • For other insurers, identify procedure codes for each covered benefit being billed
BENEFICIARY DEDUCTIBLE AND COINSURANCE/ COPAYMENT	• Medical visits would count toward deductible and copay related to provider's E/M and HCPCS code assigned to each patient • The educational/counseling component, if billed, would count toward deductible and copay related to that service (DSMT, for example) • This excludes medical and educational/counseling services where deductible and copay are waived, such as alcohol screening and counseling or tobacco screening and counseling

ADDITIONAL RESOURCES:

1. Shared Medical Appointments: A Recipe for Success (Cleveland Clinic)
   - https://www.youtube.com/watch?v=9_4T-Z6tWNk
2. Group Visit Coding (American Academy of Family Physicians)
   - http://www.aafp.org/practice-management/payment/coding/group-visits.html
3. Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (CMS)
   - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf or search for FQHC PPS 4-26-16
4. Medicare Benefit Policy Manual , Chapter 13 - Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services (CMS)
   - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf or search for Medicare Benefit Policy Manual, Chapter 13, 1-15-16

** The information in this handout is based on suggested practices by the American Academy of Family Physicians (AAFP) and providers who have successfully used SMAs. Coding and billing tips were consistent with CMS guidelines at the time this was written.*

For further details and/or assistance, contact your QIN-QIO.

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