GROUP VISIT (SHARED MEDICAL APPOINTMENT) GUIDELINES

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Description

A group visit, also known as a shared medical appointment, is when multiple patients are seen as a group for follow-up or routine care. These visits are voluntary for patients and provide a secure but interactive setting in which patients have improved access to their physicians, the benefit of counseling with additional members of a health care team (for example, a behaviorist, nutritionist, nurse, or health educator), and can share experiences and advice with one another.

Group visits (shared medical appointments) can be satisfying to both the physician and the patient. They can offer an increase in the productivity of the health care team and can provide patients with an alternate to an individual visit. Group visits offer a holistic and therapeutic approach designed to improve patient access to and quality of care through enhanced education and support.

Three general models for the group visit exist: 1) the cooperative health care clinic (CHCC), created for older patients requiring frequent, broad-spectrum care; 2) the disease-specific CHCC, a diagnostically exclusive group that aids patients with chronic-disease management; and 3) the drop-in group medical appointment (DIGMA), intended for established patients needing a more comprehensive approach to their follow-up care.

These three types of group visits have some common features. These group visits are:

- Voluntary
- Interactive
- Care delivery systems - NOT classes
- Intended to enlist and validate patients as their own caregivers
- Efficient and effective

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) will provide coverage for group visits (shared medical appointments) when the criteria outlined in this policy are met.

Reimbursement Guidelines

Group visits (shared medical appointments) are covered if the following criteria are met:

1. The patient is an established patient already enrolled in the practice
2. The group visit is disease or condition specific; however, this does not preclude coverage of group visits that are designed to address aspects of multiple chronic conditions for patients with co-morbid conditions.

3. Patient attendance is completely voluntary; patients are entitled to have individual appointments as needed
4. Adequate facilities and time are provided for group visits
5. Appropriate staff members are maintained to facilitate the group discussion and coordinate the meeting
6. Individual as well as group interaction must be documented in the patient's medical record

Group visits (shared medical appointments) are not covered under the following circumstances:

1. The patient is new to the practice
2. The physician is not in attendance during the group visit
3. Inadequate time, staffing or facilities are not provided during the group visit
4. The patient is not allowed to have one-to-one time with the physician during the group visit, at the patient's request

Rationale

No official payment or coding rules have been published by Medicare regarding group visits. The American Academy of Family Physicians (AAFP) sent a request to the Centers for Medicare and Medicaid Services (CMS) to ask the question "What is the most appropriate CPT code to submit when billing for a documented face-to-face evaluation and management (E/M) service performed in the course of a shared medical appointment, the context of which is educational. "The request from AAFP further clarified, "In other words, is Medicare payment for CPT code 99213, or other similar evaluation and management codes, dependent upon the service being provided in a private exam room or can these codes be billed if the identical service is provided in front of other patients in the course of a shared medical appointment?"

According to the AAFP website, the response from CMS was, "...under existing CPT codes and Medicare rules, a physician could furnish a medically necessary face-to-face E & M visit (CPT code 99213 or similar code depending on level of complexity) to a patient that is observed by other patients. From a payment perspective, there is no prohibition on group members observing while a physician provides a service to another beneficiary." The letter went on to state that any activities of the group including group counseling activities should not impact the level of code reported for the individual patient.

Group visits or shared medical appointments should be documented in each participating patient's medical record. That documentation should reflect the individual services provided to each patient as well as the services provided to the group as a whole at each encounter.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross NC web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Group visits for individual members should be billed using the Evaluation and Management code applicable to the level of service provided to the individual patient during the group visit. The details of that individual encounter should be appropriately documented in the patient's medical record.

CPT® Code	Description
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Related policy

n/a

References

American Academy of Family Physicians (AAFP). Coding for Group Visits. Retrieved on July 9, 2014 from http://www.aafp.org/practice-management/payment/coding/group-visits.html

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Sidorsky T, Huang Z, Dinulos JH. A Business Case for Shared Medical Appointments in Dermatology: Improving Access and the Bottom Line. Arch Dermatol. 2010;146(4):374-381. doi:10.1001/archdermatol.2010.32.

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Palaniappan, LP, Muzaffar AL, Wang EJ, et al. Shared Medical Appointments: Promoting Weight Loss in a Clinical Setting. Journal of the American Board of Family Medicine. 2011;24(3):326-328. Doi:10.3122/jabfm.2011.03.100220

History

1/4/11	New policy implemented. Group visits (shared medical appointments) may be covered if the following criteria are met: 1) The patient is an established patient already enrolled in the practice, 2) The group visit is disease or condition specific, however, this does not preclude coverage of group visits that are designed to address aspects of multiple chronic conditions for patients with co-morbid conditions. 3) Patient attendance is completely voluntary; patients are entitled to have individual appointments as needed, 4)Adequate facilities and time are provided for group visits, 5)Appropriate staff members are maintained (mco)
8/13/13	Reviewed by Medical Director. No change to current policy. (adn)
5/13/14	Policy category changed from "Corporate Medical Policy" to "Corporate Reimbursement Policy". No changes to policy content. (adn)
7/29/14	Updated link to reference for American Academy of Family Physicians (AAFP). Coding for Group Visits. (adn)
10/30/15	Routine policy review. No change to current policy. (adn)
12/30/16	Routine policy review. No change to current policy. (an)
12/29/17	Routine policy review. No change to current policy. (an)
12/14/18	Routine policy review. No change to current policy. (an)
1/14/20	Routine policy review. Senior Medical Director approved 12/2019. No changes to policy statement. (an)
12/31/20	Routine policy review. Medical Director approved 12/2020. No changes to policy statement. (eel)
4/20/21	Policy format update. No changes to policy statement. (eel)
12/30/21	Routine policy review. Medical Director approved. (eel)

Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.

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