

Effective for dates of service on or after March 1, 2008, group clinical visits will be a benefit of the Texas Medicaid Program and may be reimbursed using procedure code 1-99078. The reimbursement rate for procedure code 1-99078 will be established through the rate hearing process and will be published in a future provider notification.

Reminder: Providers are responsible for meeting the initial 95-day filing deadline when submitting claims with procedure codes that are awaiting a rate hearing. After the initial 95-day filing deadline is met, no further action on the part of the provider is necessary. The affected procedure code(s) will be denied as pending a rate hearing, and TMHP will automatically reprocess the claims after the applicable reimbursement rates are implemented. The client cannot be billed for these services.

Group clinical visits will be a benefit for the management of chronic conditions of diabetes and asthma using the following diagnosis codes:

Diagnosis Codes						
25000	25001	25002	25003	25010	25011	25012
25013	25020	25021	25022	25023	25030	25031
25032	25033	25040	25041	25042	25043	25050
25051	25052	25053	25060	25061	25062	25063
25070	25071	25072	25073	25081	25082	25083
25090	25091	25092	25093	49300	49301	49302
49310	49311	49312	49320	49321	49322	49381
49382	49390	49391	49392			

An E/M service (procedure codes 1-99211, 1-99212, 1-99213, 1-99214, or 1-99215) must be performed and billed on the same day by the same provider as the group clinical visit in order to be considered for payment.

Group clinical visits must be provided to established patients only. The client's plan of care must be determined and documented in the medical record by the physician prior to the client's attending group clinical visits.

Participation of established patients in a group clinical visit is optional. Informed consent must be obtained from the client and maintained in the medical record prior to rendering group clinical visit services.

Clients who participate in group clinical visits and who have diseases covered under the Texas Medicaid Enhanced Care program (congestive heart failure, chronic obstructive pulmonary disease, diabetes, coronary artery disease, and asthma) should receive information on the disease management program. Clinical providers are encouraged to coordinate care with the Texas Medicaid Enhanced Care program for clients that are eligible for and choose to participate in the disease management program. Clients and providers may receive additional information on the Texas Medicaid Enhanced Care program by calling 1-800-777-1178.

The physician who leads the group clinical visit is responsible for the effectiveness and content of the information provided during the group clinical visit.

Nationally approved curriculums on asthma and diabetes, such as those available through the American Association of Diabetic Educators and Asthma Education and

Prevention Programs approved by the Centers for Disease Control and Prevention (CDC), must be incorporated into the educational portion of group clinical visits.

Group clinical visits must last at least one hour, have a minimum of 2 and a maximum of 20 clients, and include the following:

- A presentation on clinical issues to promote self-management of chronic disease. The presentation must include topics on prevention of disease exacerbation or complications, proper use of medications and other therapeutic techniques, and/or living with chronic illness.

Diabetes education must include the following:

- What is diabetes?
- Nutrition.
- Exercise and physical activity.
- Prevention of acute complications.
- Prevention of chronic complications.
- Monitoring.
- Medication.

Asthma education must include the following:

- What is asthma?
- What are symptoms of asthma?
- What happens during an episode of asthma?
- What exacerbates asthma?
- How is asthma controlled?
- What can people with asthma do? (physical activities)
- A question-and-answer period.
- A short (approximately 5-15 minutes per client) one-on-one, private, face-to-face encounter with the physician that consists of a physical exam; the gathering, monitoring, and reviewing of laboratory and diagnostic tests; and medical decision-making, including an individual treatment plan. Documentation in the client's medical record must satisfy E/M guidelines determined by the Centers for Medicare & Medicaid Services (CMS) and the Current Procedural Terminology (CPT) manual.

The following components of the individual treatment plan must be maintained in the client's medical record:

- Data collected (physical exam and lab findings).
- Educational services provided.
- Patient participation.
- Referrals to the Health and Human Services Commission (HHSC) disease management program.
- The beginning and ending time of the group visit.

Providers may bill an additional E/M service. A group clinical visit must be billed with one of the E/M services associated with the group visit, and an additional E/M service may be reimbursed on the same day by the same provider when the provider bills for a distinct, separate, identifiable service with modifier 25. (The eligible additional procedure codes are listed in the table below). Documentation must be submitted on appeal when it is medically necessary to render distinct services.

E/M Procedure Codes						
1-99201	1-99202	1-99203	1-99204	1-99205	1-99231	1-99232
1-99233	1-99234	1-99235	1-99236	1-99238	1-99239	3-99241
3-99242	3-99243	3-99244	3-99245	3-99251	3-99252	3-99253
3-99254	3-99255	1-99304	1-99305	1-99306	1-99307	1-99308
1-99309	1-99310	1-99315	1-99316	1-99318	1-99324	1-99325
1-99326	1-99327	1-99328	1-99334	1-99335	1-99336	1-99337
1-99341	1-99342	1-99343	1-99344	1-99345	1-99347	1-99348
1-99349	1-99350	1-99401	1-99402			

Group visits are limited to a maximum of four visits per year.

In addition, the following benefit changes will become effective for dates of services on or after March 1, 2008:

- Only one initial hospital care visit may be reimbursed to the same provider within a 30-day period when billed with the same diagnosis. Additional initial hospital visits with the same diagnosis within the 30 days will be denied.
- One initial inpatient consultation (procedure codes 3-99251, 3-99252, 3-99253, 3-99254, or 3-99255) may be reimbursed for each hospitalization within a 30-day period. Subsequent consultations billed as initial consultations during this time period will be denied.
- Office or outpatient consultations will be limited to one consultation every six months by the same provider for the same diagnosis. Subsequent office or outpatient consultation visits during this time period will be denied.
- Comprehensive initial nursing facility assessments (procedure codes 1-99304, 1-99305, or 1-99306) are limited to one every six months by the same provider for the same diagnosis. Subsequent assessments billed as initial assessments will be denied.
- Charges for inconvenience or after-hours services (1-99050, 1-99056, or 1-99060) by emergency department-based physicians or emergency department-based groups will be denied.
- The following E/M procedure codes may no longer be reimbursed to psychologists:

E/M Procedure Codes						
3-99241	3-99242	3-99243	3-99244	3-99245	3-99251	3-99252
3-99253	3-99254	3-99255				