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2023 Here We Come! Billing & Coding Impacts You Need To Know

HCCIntelligence™ – February 8th, 2022

Presenters

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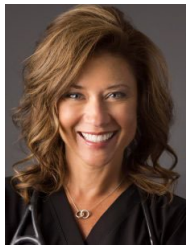

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Objectives

- Review the coding, reimbursement, and policy impacts resulting from the CY 2023 Medicare Physician Fee Schedule Final Rule (MPFS) and how to best respond to these changes.
- Identify and apply correct CPT codes for care management services.
- Discuss documentation requirements to ensure coding compliance.

Agenda

- Evaluation & Management (E/M) & Payment Impacts
  - Place of service (eliminate DOM codes)
  - Documentation Requirements
  - Prolonged Services
  - Telehealth
  - Advance Care Planning
- Case Reviews and Coding Examples
- Chronic Care Management (CCM) Care Plan Requirements
- Transitional Care Management (TCM) Care Plan Requirements
  - Face-To-Face
- Ask the Experts: Q&A

Evaluation & Management (E/M) Impacts

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Key E/M Requirement Changes

- **Domiciliary codes have been deleted**
  - Domiciliary (ALF), rest home, or custodial care services are billed with home and residence services codes.

- **Only "Home and Residence Services" E/M CPT Codes**
  - New patient: 99341, 99342, 99344, 99345
  - Established Patient: 99347, 99348, 99349, 99350
  - Eliminated: 99343 and 99326

- **Documentation no longer requires specific history and examination elements**
  - A "medically appropriate" history and exam is still required.

- **Medical Decision Making (MDM) or total time is the sole requirement for code selection for 99341-99350**
  - Time includes services pre-, during-, and post-encounter and does not require >50% of the time be in counseling and coordination of care.

E/M Requirements

New Patient Codes				
CPT Codes	**MDM**	**Time**	**2023 wRVU**	**+ / - 2022**
99341	Straightforward	15 minutes	1.00	- .01
99342	Low	30 minutes	1.65	+ .13
99344	Moderate	60 minutes	2.87	- .51
99345	High	75 minutes	3.88	- .21

- ***CPT Code 99343 Deleted***

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E/M Requirements

Established Patient Codes				
CPT Codes	**MDM**	**Time**	**2023 wRVU**	**+ / - 2022**
99347	Straightforward	20 minutes	0.90	- .10
99348	Low	30 minutes	1.50	- .06
99349	Moderate	40 minutes	2.44	- .11
99350	High	60 minutes	3.60	+ .32

E/M Requirements

- ***Level of decision-making is based on two out of the three elements: 1) number and complexity of problems addressed at the encounter; 2) amount and/or complexity of data to be reviewed and analyzed; 3) risk of complications and/or morbidity or mortality of patient management.***

Code	Level of MDM 2 of 3	Typical Time Range	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99341 (New) 99347 (Established)	Straightforward	99341 (15 minutes) 99347 (20 minutes)	Minimal 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

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E/M Requirements

Code	Level of MDM 2 of 3	Typical Time Range	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99342 (New) 99348 (Established)	Low	99342 (15 minutes) 99348 (20 minutes)	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury • 1 stable acute illness • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited (Must meet the requirements of at least 1 of the 2 categories) • Category 1: Any combination of 2 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test OR • Category 2: Assessment requiring an independent historian(s)	Low risk of morbidity from additional diagnostic testing or treatment

E/M Requirements

Code	Level of MDM 2 of 3	Typical Time Range	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99344 (New) 99349 (Established)	Moderate	99344 (60 minutes) 99349 (40 minutes)	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate (Must meet the requirements of at least 1 out of 3 categories) • Category 1: Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring independent historian(s); or • Category 2: Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or • Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

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E/M Requirements

Code	Level of MDM 2 of 3	Typical Time Range	Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management
99345 (New) 99350 (Established)	High	99345 (75 minutes) 99350 (60 minutes)	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive (Must meet the requirements of at least 2 out of 3 categories) • Category 1: Any combination of 3 from the following: • Review of prior external note(s) from each unique source • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring independent historian(s); or • Category 2: Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or • Category 3: Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major procedure with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

E/M Prolong Services

Required Time Thresholds to Report E/M Prolonged Services			
Primary E/M Services	**Prolonged Code ****	**Time Threshold to Report Prolonged**	**Count physician/NPP time spent within this time period (surveyed timeframe)**
Home/Residence Visit New Pt (99345)	G0318	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estb. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after

- Time must be used to select visit level.
- Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe and includes time with or without direct patient contact by the physician or NPP.
- Consistent with CPT's approach, there is no assigned frequency limitation.

Non Face-to-Face Prolonged Service

- total duration of non-face-to-face time spent by a provider on a given date providing prolonged service
- time spent by the provider on that date does not have to be continuous
  - 99358 - Prolonged service before and/or after direct patient care, first 60 minutes
  - 99359 - Each additional 30 minutes (list separately in addition to code for prolonged service)
- ***Codes remain active; however, CMS will not reimburse for them, and individual payers may make their own reimbursement determinations.***

Telehealth

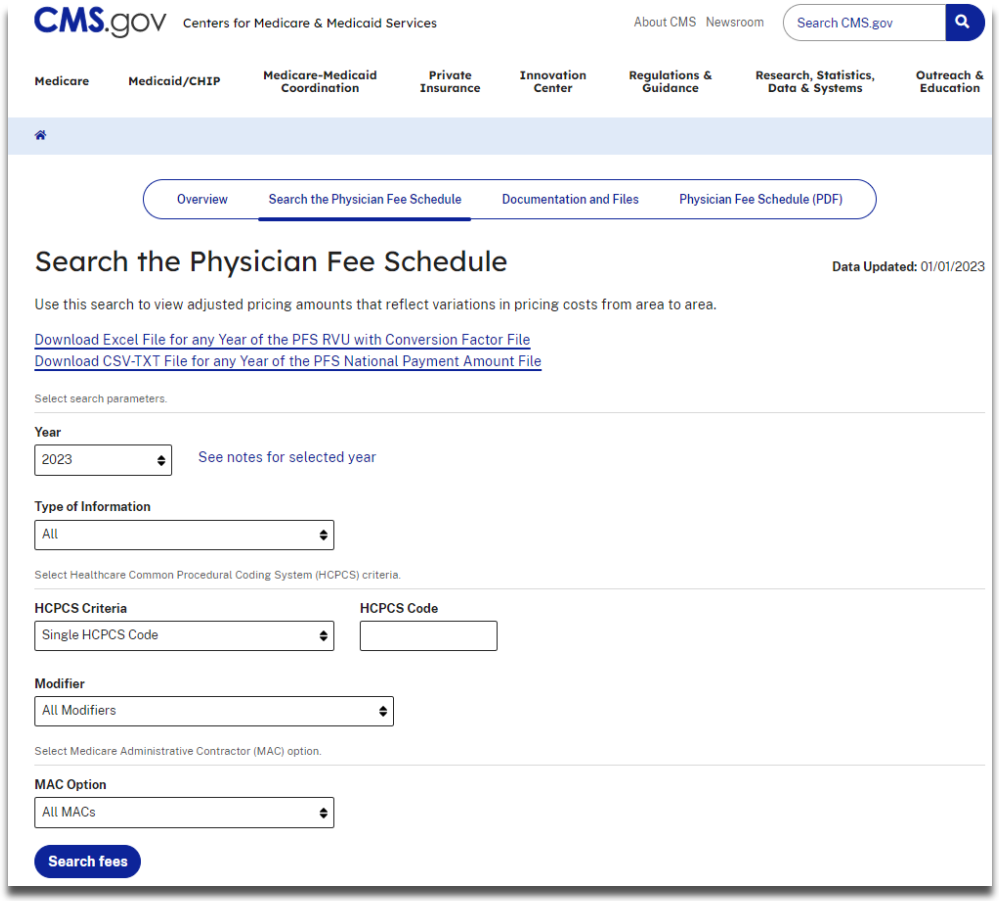
- ***set to expire at the end of the Public Health Emergency; however, the Omnibus bill extends telehealth flexibilities for Medicare beneficiaries through December 31, 2024***
  - Domiciliary (ALF), rest home, or custodial care services are billed with home and residence services codes.
  - Extension of the waiver for the originating site requirement, enabling beneficiaries to receive telehealth services at home
  - Expansion of practitioners eligible to furnish telehealth services
  - Extension of flexibilities that allow federally qualified health centers and rural health clinics to serve as originating or distant sites for the delivery of telehealth services
  - Delay of the in-person requirement for mental health services furnished through telehealth
  - Continued coverage of audio-only telehealth services

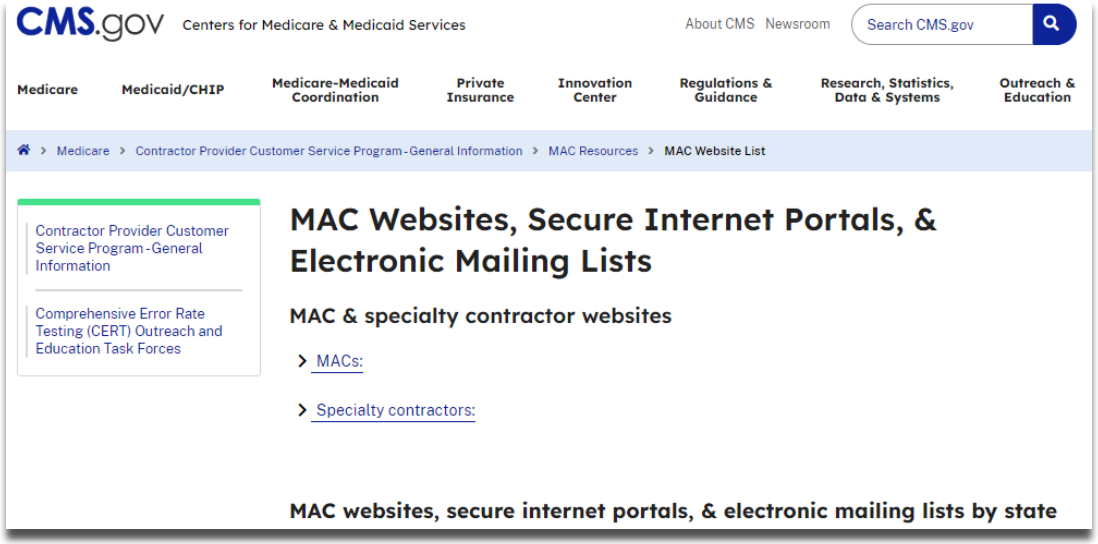
Advanced Care Planning (ACP)

- face-to-face time a physician or other qualified health care professional spends with a patient, family member, or surrogate to explain and discuss advance directives
  - 99497 - First 30 minutes (minimum of 16 minutes)
    - ***2023: $83.02 **** versus 2022: $85.48
  - 99498 - Add-on for additional 30 minutes
    - ***2023: $71.84 **** versus 2022: $74.06

* *Reflects 2023 Medicare National Fee Schedule Payment.*

How to Verify Fee Schedule Rates in Your Region





Go HERE to find your Medicare Administrative Contractors (MAC) website by state

Go HERE to search Physician Fee Schedule
https://www.cms.gov/medicare/physician-fee-schedule/search

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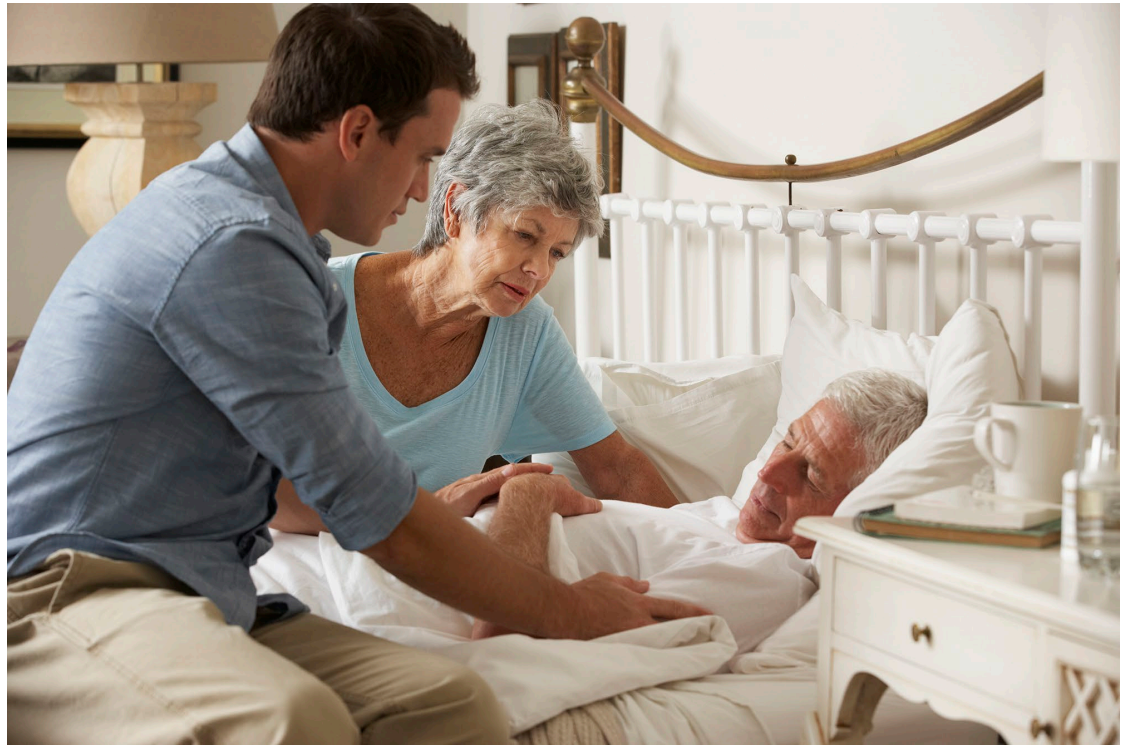
Coding Example:

You’re visiting a new patient, and an extensive amount of time has been spent on a pre-chart review of past medical records. Ears were cleaned during the visit.



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Coding Example:

You're conducting a follow-up home visit with an established patient. The patient presents with stable COPD and five other chronic medical conditions. You continue all medications with no changes. Smoking cessation counseling was discussed and documented.

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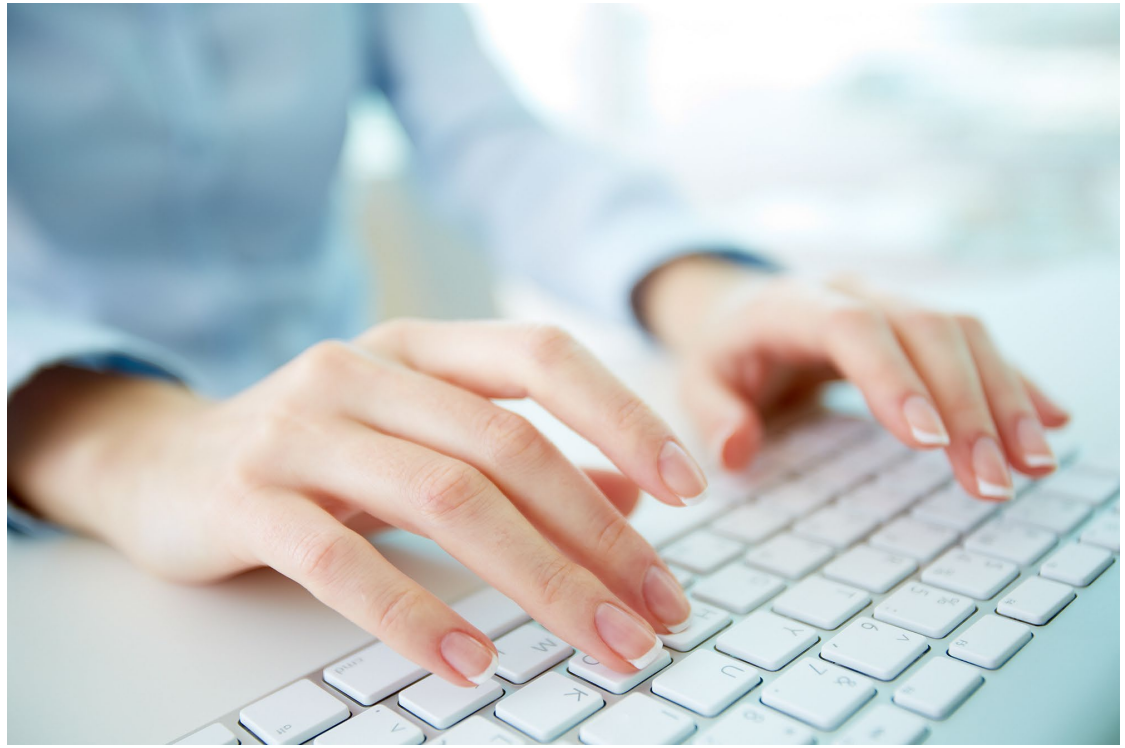
Coding Example:

You’re answering messages in the car in-between visits and review a rash sent via the patient portal. You review history, medications, image, provide diagnosis and treatment care plan back to daughter DTR via the patient portal, and send an RX. Total time 7 minutes.



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Coding Example:

You’re seeing a patient who is currently on hospice and has active lung cancer. You’re primarily managing their HTN and DM.

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Coding Example:

You add a patient to the end of your schedule because you're in the area, but you only perform a knee injection.

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Coding Example (Audio-Only):

You receive a message to address the following concerns:

- Patient with mental status changes
- Suspect and order testing to confirm UTI
- You prescribe an antibiotic
- Spent 8 minutes on the phone discussing and addressing needs with DTR

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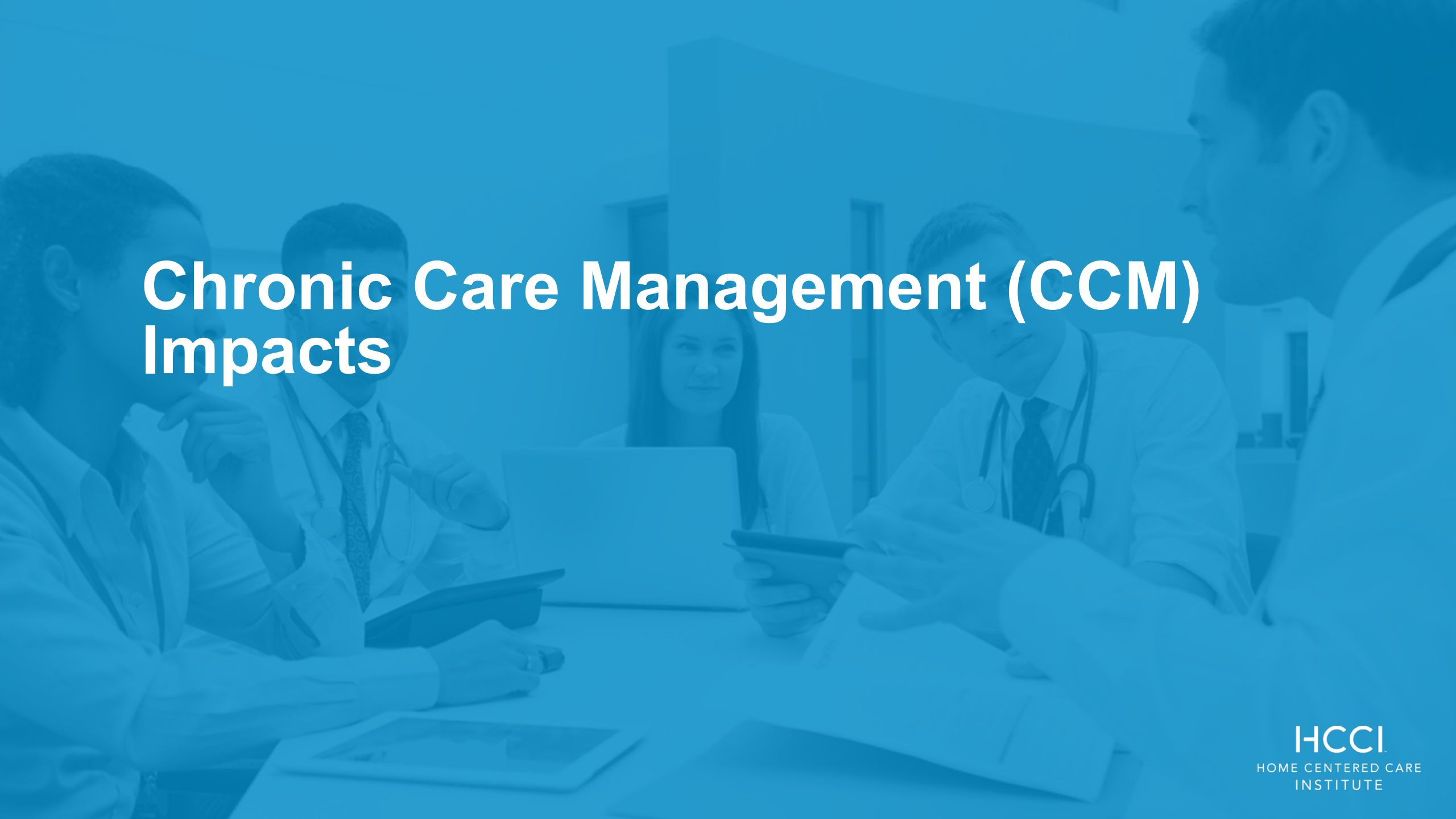
Coding Example (Telehealth Visit):

You're conducting a telehealth E/M visit (40 minutes) using video for a patient who is COVID positive. 77 year old patient with DM, COPD tested positive for COVID yesterday. Patient does a fever and shortness of breath and is feeling weak. Review of past history, labs, medications done. Antiviral medication prescribed

Chronic Care Management (CCM) Impacts



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Chronic Care Management (CCM) Care Plan

- Practices providing CCM services must utilize structured recording of patient health information using certified Electronic Health Record (EHR) technology, inclusive of maintaining a comprehensive electronic care plan, managing transitions, coordinating and sharing of patient health information promptly both inside and outside of the practice and other care management services.
- CMS recommends that the comprehensive care plan for all health issues include but is not limited to the following elements:
    - Problem list.
    - Expected outcome and prognosis.
    - Measurable treatment goals.
    - Cognitive and functional assessment.
    - Symptom management
    - Planned interventions
    - Environmental evaluation
    - Caregiver assessment
    - Interaction and coordination with outside resources and practitioners and providers.
    - Requirements for periodic review
    - When applicable, revision of the care plan

Chronic Care Management (CCM) Care Plan

- ***CCM codes require patients to have two or more chronic conditions expected to last 12 months or until their death.***
- Document verbal consent, defined as informing the patient/caregiver of the availability of the service, that only one practitioner can bill per month, the patient's right to stop services at the end of any service period, and make the patient aware of applicable cost-sharing.
- Initiating visit, which is required for new patients or patients not seen within the past twelve months. This service is separately payable.
- 24/7 access to care, defined as offering on-call services including after-hours coverage, so the patient has access to clinical advice and guidance
- Relationship with a designated care team member to promote continuity of care
- Comprehensive Care Management, defined as systematic needs assessment (medical and psychosocial), ensure receipt of preventative services, and medication reconciliation including management and oversight of self-management

Chronic Care Management (CCM) Care Plan

- Comprehensive electronic care plan, requirements described earlier in this resource. CMS also requires the care plan is timely available within and outside of the practice (e.g., fax), a copy of the care plan provided to the patient/caregiver (format not prescribed), and that the care plan is established, implemented, monitored, and revised, as appropriate.
- Management of care transitions (e.g., follow up post-discharge and ED visits) and referrals, defined as creating
- and exchanging care documents in a timely manner. Following up on the need and execution of referrals for other services.
- Home and community-based care coordination, defined as coordination with any home and community-based clinical service-based providers, and documenting communication with those professionals regarding psychosocial and functional deficits.
- Enhanced communication opportunities, defined as offering non-face-to-face methods other than telephones, such as secure email or patient portals.

Chronic Care Management (CCM) Care Plan

Available CCM CPT Codes

CPT Code	Descriptor
99487	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of comprehensive care plan, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.
99489	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or significant revision of comprehensive care plan, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month (List separately in addition to code for primary procedure).
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.
99491	Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of a physician or other qualified healthcare professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored.

Chronic Care Management (CCM) Care Plan

New CCM CPT Codes

- A new code was created for physicians and qualified providers, reimbursing for an additional 30 minutes of provider-delivered CCM services. This code is an add-on to the original 99491 code.

CPT Code	Descriptor
99437 (add-on) to 99491)	Additional 30 minutes of a physician or qualified professional time each month for patients with two or more chronic conditions.

CCM EHR Template Example:

Type of Contact: In-Person, Telephone
MyChart: Yes or No
Contact Provider:
Contact Date:

Care management for chronic conditions

- Needs assessment:
  - Medical:
  - Functional:
  - Psychosocial:
  - Spiritual:
- Recommended preventive care services:
- Medication reconciliation with review
  - Side Effects:
  - Adherence (compliance):
  - Potential interactions:
- Oversight of patient self-management of medications:

Care plan documentation

- Created New:
- Reviewed Unchanged:
- Updated:

Management of care transitions between and among health care providers and settings

- Referrals to other clinicians:
- Follow-up emergency department:
- Follow-up discharge from a hospital, skilled nursing facility, or other health care facility (Consider TCM Services):

Coordination with home- and community-based clinical service providers

Time Spent in Minutes on this Interaction

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Transitional Care Management (TCM) Face to Face Impacts

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Transitional Care Management (TCM) Face to Face

- **99495 - TCM services with moderate Medical Decision Making complexity**
  - Domiciliary (ALF), rest home, or custodial care services are billed with home and residence services codes.
  - Report this Evaluation and Management (E/M) code for the post-discharge face-to-face visit.
  - The patient must be seen within 14 calendar days of discharge.
  - The visit must require **moderate** Medical Decision Making (MDM).
  - Interactive contact by a clinical staff member must occur within two business days of discharge.
  - 2023 CMS National Payment Amount ***$205.36 ****; wRVU 2.78

- **99496 - TCM services with high Medical Decision Making complexity**
  - Report this Evaluation and Management (E/M) code for the post-discharge face-to-face visit.
  - The patient must be seen within 7 calendar days of discharge.
  - The visit must require **high** Medical Decision Making (MDM).
  - Interactive contact by a clinical staff member must occur within two business days of discharge.
  - 2023 CMS National Payment Amount ***$278.21 ****; wRVU 3.79

* *Reflects 2023 Medicare National Fee Schedule Payment.*

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Transitional Care Management (TCM) Face to Face

- ***Service must meet or exceed two of the three medical decision-making elements to qualify as an established type of medical decision-making.***
- Providers should not report an E/M code in addition to the TCM CPT code. CMS requires, at a minimum, the following information be documented in the beneficiary's medical record:
  - The date on which the patient was discharged.
  - The date on which the provider's office contacted the patient and/or caregiver.
  - The date on which the provider furnished the face-to-face visit.
  - The documentation must support the overall complexity of MDM being moderate or high.

Transitional Care Management (TCM) Face to Face: Elements of Medical Decision Making

Types of Decision Making	Diagnoses & Management Options Possible	Data Amount & Complexity	Significant Complications, Morbidity, & Mortality Risk
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	**Moderate**	**Moderate**	**Moderate**
High Complexity	**Extensive**	**Extensive**	**High**

Transitional Care Management (TCM) Face to Face: Elements of Medical Decision Making

Along with the face-to-face visit, CMS expects the following services to be rendered as part of TCM unless the provider determines they are not medically necessary. The clinical staff may assist with certain non-face-to-face services:

- Obtain and review discharge information, such as the discharge summary or inpatient records.
- Complete a comprehensive medication reconciliation, inclusive of a review of all medications to reconcile discharge medications with home medications, ensure necessity, and to check for interactions. Clinical staff may begin the process during the interactive contact, which occurs within two business days of discharge, however, the provider is responsible for completing the process during the visit.
- Review the need for follow-up on any pending orders such as diagnostic tests or treatments.
- Communicate with other healthcare professionals who also have a responsibility in the patient's care.
- Provide education to the patient and/or caregiver.
- Establish or re-establish referrals to any needed community resources.
- Assist with scheduling required follow-up with community services or providers.

HCCIntelligence™ – Tools and Tip Sheets

- **HCCIntelligence™ Tools and Tip Sheets**
  - Home Visits E/M Guide
  - Chronic Care Management (CCM) Care Plan Requirements
  - Transitional Care Management (TCM) Face-To-Face Visit Requirements
  - Transitional Care Management (TCM) Interactive Contact Requirements
  - Superbill Worksheet – ***HCCIntelligence™ Premier Resource***
  - Advanced Coding Opportunities – ***HCCIntelligence™ Premier Resource***

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HCCIntelligence™ : Ask the Experts

An open forum for questions and answers

HCCIntelligence™ Upcoming Webinar

- Topic: Value-Based Care
- Presenter: Christopher Dodd, MD
- Date / Time: March 22 @ 4:00 PM CT

Questions

education@hccinstitute.org

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