

Transitional Care Management (TCM)

Transitional Care Management services are provided to Medicare beneficiaries who transition back to their own home, a domiciliary, an assisted living facility, or a rest home from an inpatient/observation hospital stay, acute or rehabilitation hospital, or skilled nursing facility.

- TCM services can be provided to new or established patients whose medical and/or psychosocial problems require moderate to high medical decision-making complexity.
- TCM commences upon the date of discharge and continues for the next 29 days.
- Requires documentation of direct patient contact (can be telephone or electronic) with the patient and/or caregiver within two business days from discharge.
- Medical Decision-Making must be of high or moderate complexity.
- Physicians and the following non-physician practitioners (NP, PA, CNS, CNM), who are legally authorized and qualified to provide services in the state services are furnished may perform TCM.
- A face-to-face visit with the patient must occur within 7 to 14 calendar days from discharge.
- 99495- Submitted as the Evaluation and Management (E/M) code for the face-to-face visit, must occur within 14 calendar days of discharge and requires moderate complexity (Work wRVU 2.11, CMS National Payment Rate \$167).
- 99496- Submitted as the E/M code for the face-to-face visit, must occur within seven calendar days of discharge and requires high complexity (Work wRVU 3.05 CMS National Payment Rate \$236).
- Review the Medicare Learning Network source¹ below for a list of the additional non-face-to face and care coordination services that are required when performing transitional care management.

Chronic Care Management (CCM)

Medicare beneficiaries qualify for CCM services if they have two or more chronic conditions expected to last at least 12 months or until death. CCM requires at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. CCM also requires a comprehensive care plan to be created, implemented, monitored, and revised as necessary. Refer to the Medicare Learning Network source² for a complete understanding of CMS guidelines.

- Patient consent (verbal or written) must be obtained before initiating services; consent must be documented along with making patient aware of applicable cost sharing.
- Only one eligible practitioner (Physician, Nurse Practitioner, Physician Assistant, Clinical Nurse Specialists, Certified Nurse Midwives) can furnish and be paid for CCM services during a calendar month.
- For new patients or patients not seen within one year before the commencement of CCM, the consent and initiation of services must occur during a face to face visit with the billing practitioner [Can be Annual Wellness Visit (AWV) or E/M].

- Patients must have two or more qualifying chronic conditions that are documented and treated. Qualifying chronic conditions are expected to last at least 12 months or through the end of life, and place the patient at significant risk of death, acute exacerbation, or functional decline (i.e., Alzheimer's dementia, COPD, Cardiovascular disease).
- Patients enrolled in Chronic Care Management must have an initiating visit, structured recording of patient information using certified EHR technology, 24/7 access and continuity of care, comprehensive care management, comprehensive care plan, management of transitions, home and community-based coordination, and enhanced communication opportunities.
- The comprehensive care plan must include medication management and reconciliation, a complete problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions and identification of responsible individuals, community/social services ordered, description of how referrals or outside services will be coordinated, a schedule for periodic review and revision of the care plan when applicable.
- CPT 99490 - at least 20 minutes of clinical staff time as directed by a physician or qualified health care professional per calendar month (wRVU 0.61 CMS National Payment Amount \$42.84).
- CPT 99487 - Complex chronic care management services, at least 60 minutes of clinical staff time as directed by a physician or qualified health care professional per calendar month (May NOT be reported with 99490, you must choose to report either complex CCM or traditional CCM) (wRVU 1.0 CMS National Payment Amount \$94.68).
- CPT 99489 - Each additional 30 minutes of clinical staff time as directed by the physician or other qualified health care professional (list in addition to the primary procedure code) (wRVU 0.50 CMS National Payment amount \$47.16).

Advance Care Planning (ACP)

Advance Care Planning³ is a face-to-face discussion (with the patient and/or caregiver, family member or surrogate) and explanation of advance directives, such as standard forms with or without completing the forms.

- ACP must be voluntary and must document patient consent to participate in the discussion after being made aware of applicable cost sharing.
- ACP must be face-to-face and only include the time spent discussing advance directives and wishes, time spent on other aspects of the visit cannot be counted towards this service element.
- Examples of standard forms include: living will, power of attorney for healthcare, POLST (physician's orders for life-sustaining treatment), POST (physician's orders for scope of treatment).
- ACP may be billed in conjunction with AWW, E/M, TCM and/or CCM.
- The documentation must include the conversation details and the exact amount of time spent discussing advance directives.
- CPT code 99497 - Advance care planning, first 30 minutes (at least 16 minutes to bill) wRVU- 1.50, CMS National Payment amount \$86.04.
- CPT code 99498 - Advance care planning, each additional 30 minutes (billed in addition to 99497, at least 46 minutes to bill) (wRVU-1.40, CMS National Payment Amount \$75.96).

Prolonged Services Without Direct Patient Contact

Medicare will reimburse for non -prolonged face-to-face services⁴ provided in relation to an E/M encounter. This enables providers to be paid for time spent reviewing extensive medical records or elongated telephone time discussing history or the patient's medical condition in advance or after the visit.

- CPT 99358 - Prolonged evaluation and management service before and/or after direct patient care, first hour. A minimum of 31 minutes is required to bill. (wRVU 2.10 CMS National Payment Amount \$113.52)
- CPT 99359 - Prolonged service, each additional 30 minutes. List CPT code 99359 separately in addition to 99358, requires a minimum of 76 minutes to bill. (wRVU 1.00 CMS National Payment Amount \$54.78)
- Must be beyond the usual service time a physician or qualified health care professional would spend and document why the service went beyond the normal time and effort.
- Cannot be reported for services that can be described with more specific codes that have no upper time limit, such as care plan oversight, team conferences, online medical evaluations.
- The time spent can be before, on, or after the date of the face-to-face visit; however, services must be related to an E/M encounter. Documentation must describe what was reviewed or how the time was spent.
- Cannot be reported during the same service period as complex chronic care management or transitional care management.
- The exact amount of time spent must be documented in the medical record; the time does not need to be continuous; however, it must occur on the same date (time cannot be added from various days).
- CMS published guidance advising "while the typical CPT threshold time is not required to bill E/M, CMS would expect that only time spent in excess of these times would be reported under 99358 or 99359". Check with your local MAC for additional documentation requirements. Since these are time-based codes, you may consider documenting the time spent during the face-to-face encounter, in addition to the total time for the non-face-to-face services.

Prolonged Services With Direct Patient Contact

Medicare will reimburse for prolonged services⁵ with direct patient contact (face-to-face) that goes beyond the usual service in the outpatient or inpatient setting. This is used to report the total face-to-face time spent by the physician or other qualified health care professional when time exceeds the typical time assigned to the base E/M code by at least 30 minutes.

- Prolonged services are add-on codes and must be reported with their companion E/M code.
- Time-based service; therefore, the total amount of time spent face-to-face with the patient and/or caregiver must be documented in the medical record.
- Time does not need to be continuous; however, it must occur on the same calendar date. It must be direct face-to-face contact that is beyond the typical/average visit time of the code billed.
- Documentation must explain why the encounter went beyond the usual service time.
- CPT 99354 - Prolonged evaluation and management or psychotherapy services beyond the typical primary procedure service time, first hour, wRVU 2.33, CMS National Payment Amount \$132.84.
- CPT 99355 - Prolonged evaluation and management or psychotherapy, each additional 30 minutes (listed separately in addition to 99354) wRVU 1.77, CMS National Payment Amount \$100.44.

Cognitive Assessment and Care Plan Services

Medicare reimburses physicians and other qualified health care professionals for an evaluation of a patient with cognitive impairment. This comprehensive evaluation would be for a new or established patient who exhibits signs and/or symptoms of cognitive impairment, and for whom diagnosis, etiology, or severity of their condition needs to be established or confirmed. For additional information, please refer to the Alzheimer's Association⁶ Guide or Coding Intel article⁷.

- CPT 99483 (wRVU 3.44 CMS National Payment amount \$241.92) - Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient setting (home, rest home), which can be billed once every 180 days per provider.
- This code requires the following ten specific service elements to be provided and documented:
 - Cognitive focused evaluation including pertinent history and examination
 - Medical decision-making of moderate or high complexity
 - Functional assessment (i.e., basic and instrumental activities of daily living), must include decision-making capacity
 - Use of standardized instruments for staging dementia (i.e., functional assessment staging test or clinical dementia rating)
 - Medication reconciliation and review for high-risk medications
 - Evaluation for neuropsychiatric and behavioral symptoms, including depression, using a standardized screening instrument
 - Evaluation of safety (i.e., home), including motor vehicle operation
 - Identification of caregivers and the caregiver's knowledge, needs, social supports, and willingness to take on caregiving tasks
 - Development, updating, revision, or review of an advance care plan
 - Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (i.e., adult day programs, rehabilitation services, support groups). The written care plan must be shared with the patient and/ or caregiver with initial education and support.
- This code may NOT be billed in conjunction with an E/M code, TCM or CCM. The typical face-to-face time spent with the patient and/or caregiver is 50 minutes.

Smoking Cessation Counseling Services

Medicare and most private insurers will reimburse physicians and other qualified health care professionals for counseling patients about stopping tobacco use. The provider must document and report a diagnosis of tobacco use and may report two individual cessation visits per 12-month period. (Each attempt may include a maximum of 4 intermediate or intensive sessions, with a total benefit of 8 annually.) For additional information, please refer to the CMS Preventative Services Guide⁸ ⁹. Documentation must include the following elements:

- The exact amount of time spent on cessation counseling (minimum 4 minutes to bill).
- Briefly describe the nature of the counseling visit and the patient's readiness to stop using tobacco products.
- If reported with another service (such as E/M) must describe how this was distinct from the other service provided.
- Identify any barriers to changing behavior, if any, and provide specific resources (i.e., 1-800-784-8669- Quit Now) or other specific action suggestions determined by the provider.
- CPT 99406 (wRVU 0.24 CMS National Payment rate \$14.76) - Smoking and tobacco use cessation counseling visit, intermediate, greater than 3 minutes up to 10 minutes.
- CPT 99407 (wRVU 0.50 CMS National Payment rate \$28.44) - Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes.

Anticoagulation Management

Medicare reimburses physicians and other qualified health care professionals for home and outpatient International Normalized Ratio (INR) monitoring services in the management of warfarin therapy. For full details, please refer to the Medicare Learning Network source^{10 11}. The two new services available are as follows:

- CPT 93792 (There is no wRVU value for this service and National Payment Rate \$55.08) Patient and/or caregiver training for initial set up when a patient is placed on a home INR monitoring regimen. This service can be provided under the direction of a physician or qualified health care professional and billed in conjunction with a separate office visit by appending Modifier -25 to the E/M code. Documentation requirements are as follows:
 - Must be face-to-face
 - Include education on use and care for the INR monitor, obtaining a blood sample, and instructions for reporting home INR test results
 - Documentation of the patient's and/or caregiver's ability to perform testing and report results
- CPT 93793 (wRVU 0.18 CMS National Payment rate \$12.24) Review and subsequent management of a new home, office, or lab test once per day regardless of the number of tests reviewed. Code 93793 is not billable with an E/M service. Documentation requirements are as follows:
 - Review and interpretation of results
 - Include test results with patient instructions and dosage adjustment if necessary
 - Scheduling of additional test(s) when performed
- Neither 93792 nor 93793 is billable with chronic care management and/or transitional care management services because INR monitoring is considered included in those services.

General Behavioral Health Integration Care Management

CPT code 99484 (wRVU 0.61 CMS National Payment Amount \$48.65) is used to report at least 20 minutes of care management services for a behavioral health condition in a calendar month. It can be combined work done by billing practitioner and clinical staff. Medicare assumes 15 minutes is spent by the billing practitioner. Please refer to the Medicare Learning Network¹² for full details.

Service elements include:

- Systematic assessment and monitoring with the use of applicable validated rating scale; if initial assessment is required may be billed separately.
- Care planning with the primary care team and the patient, with revision if the condition is not improving.
- Continuous relationship with a designated member of the care team.
- Facilitation and coordination of behavioral health treatment.
- Advance patient consent, either verbal or written, is required and must be documented in the medical record to ensure the patient is aware of applicable cost sharing.
- Service and documentation requirements include assessing or monitoring the patient, developing and revising the care plan, coordinating treatment with the patient and affected parties, and maintaining a continuous relationship with a member of the care team.
- 99484 (General BHI) and traditional chronic care management services (CPT 99492) may, in some instances, may be reported by the same provider in the same month if distinct care management services are performed. Time and effort may only be counted once towards either activity to prevent double counting time for the same efforts.
- You may also want to explore Psychiatric Collaborative Care Services (CoCM) if your practice has access to a psychiatric consultant and behavioral health care manager. CoCM services are reported with CPT codes 99492-99494. For additional information, please visit the Medicare Learning Network link below or contact HCCI.

2019 Medicare Physician Fee Schedule Changes

With the release of the 2019 Medicare Physician Fee Schedule brings policy changes and new billing opportunities, your practice needs to be aware of. For additional information, please refer to the following sources¹³. Below is a summary of the changes:

As of 01/01/19, CMS removed the requirement for providers to document and justify why a patient is being seen in the home as opposed to the office if the encounter is medically necessary. This means providers no longer need to document in their progress note why a patient was seen in the home in lieu of the office, and the decision to be seen in the home is left to the provider and/or patient.

As of 01/01/19 Medicare will now pay for interprofessional internet consultation codes, two new CPT codes we're also added to the existing consult services. Interprofessional internet consultation services must be formally requested by the attending or treating provider. Consultations are only payable to providers who are permitted to bill E/M services, and the consulting provider must be of a different specialty than the requesting provider.

Existing consult codes which now have an active payment status:

Interprofessional telephone/ internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting provider:

- 99446- 5-10 minutes of medical consultative discussion and review (wRVU 0.35 CMS National Payment Amount \$18.38).
- 99447- 11-20 minutes of medical consultative discussion and review (wRVU 0.70 CMS National Payment Amount \$36.40).
- 99448-21-30 minutes of medical consultative discussion and review (wRVU 1.05 CMS National Payment Amount \$54.78).
- 99449-31 minutes or more of medical consultative discussion and review (wRVU 1.40 CMS National Payment Amount \$72.80).

New as of 01/01/19

CPT 99451: Interprofessional telephone/internet/ electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/ requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time (i.e., verbal or internet discussion with the requesting provider).

CPT 99452: Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating or requesting physician or other qualified health care professional, 30 minutes. May be reported for 16 to 30 minutes of time spent preparing the referral and/or communicating with the consulting provider).

- CPT codes 99451-99452 differ from the other interprofessional consults because the report may be written only and do not require a written and verbal report.
- CPT 99451 wRVU 0.70 CMS National Payment Amount \$37.48.
- CPT 99452 wRVU 0.70 CMS National Payment Amount \$37.48.

Brief Communication Technology-Based Virtual Check-ins

HCPCS G2010- Remote evaluation of recorded video and/or images submitted by an established patient (prerecorded patient information still or video) including interpretation with follow up to the patient/ caregiver within 24 business hours. May not be related to an E/M visit within past seven days and may not result in E/M visit within the next 24 hours or next available appointment. (wRVU 0.18 CMS National Payment Amount \$12.61)

- Pre-recorded patient-generated information that may be still images or video images sent by the patient/caregiver
- Intended to substitute an E/M visit or determine if a face-to-face visit is warranted.
- May not be billed if related to an E/M encounter within the previous seven days and cannot result in an E/M visit within 24 hours or the next available appointment.
- Must be an established patient.
- Includes interpretation with follow up to the patient/caregiver within 24 business hours. Follow up may be a phone call, audio/video, secure text message, secure email, or patient portal communication.
- Patient's verbal consent is required, must be documented in the medical record to ensure they're aware of potential cost sharing.

Pre-recorded information must be of sufficient quality for the provider to be able to review and interpret the image or video.

HCPCS G2012- Virtual check-in, by a physician or other qualified health care professional who can report E/M services, provided to an established patient, may not originate from a related E/M visit nor may it lead to an E/M visit or procedure within the next 24 hours or next available appointment. 5-10 minutes of medical discussion by the provider. (wRVU 0.25 CMS National Payment Amount \$13.33).

- Five to the ten-minute medical discussion by the qualified provider (may not be clinical staff) that assesses the patient's condition to determine if an office or outpatient visit is needed can be audio or two-way video.
- May not be billed if related to an E/M (Face-to-Face) visit within seven days prior and cannot result in an E/M visit within 24 hours or the next available appointment.
- Must be an established patient.
- Patient's verbal consent required must be documented in the medical record to ensure they're made aware of potential cost sharing.
- Virtual Brief Check-In is permitted for use as part of a treatment regimen for opioid use disorders
- Payable only to providers who are permitted to bill E/M services.
- Documentation required to include: consent, date, time, duration of the service, along with a brief summary of what topic(s) were discussed.

Sources:

- ¹ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf> (MLN Transitional Care fact sheet)
- ² <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf> (Chronic Care Management)
- ³ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf> (Advance Care Planning)
- ⁴ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9905.pdf> (Non-face-to-face prolonged services)
- ⁵ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5972.pdf> (Prolonged Services face-to-face)
- ⁶ <https://www.alz.org/careplanning/downloads/cms-consensus.pdf> (Cognitive Assessment Care Planning Services)
- ⁷ <https://www.codingintel.com/cpt-code-99483-cognitive-assessment-care-plan-services/> (Cognitive Assessment Care Planning Services)
- ⁸ <https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#TOBACCO> (Smoking Cessation Counseling Services)
- ⁹ <https://www.codingintel.com/a2-smoking-cessation/> (Smoking Cessation Counseling Services)
- ¹⁰ <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6313.pdf> (Anticoagulation Management)
- ¹¹ <https://www.codingintel.com/new-cpt-codes-2017-anticoagulation-management-education-for-home-inr-monitoring/> (Additional source Anticoagulation management)
- ¹² <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf> (Behavioral Health Integration Services)
- ¹³ <https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year> (All below 2019 sources)
https://www.ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/news-alerts/news-articles/news-detail/whats%20changed%20as%20a%20result%20of%20cms%20final%20rule%202019!/ut/p/z1/xZLfbolwFMzFXsActrCoF4WYaIOUTeG9MYULNhM_gQNxrdfNctMtjgv15uT0_P16--0BzsigNeiV6U4qKYWO52n3F5bbOxjPETTiAYIsanHLDYbmTTG8A6pB2lcbvvoCMk9NddldGMxBJN7Ao1DunAYIsBbcdgaqi4aWNXlvpIblYtOagR-MblCmBFFzHp2PW8xN0cu-RL8cUuq23ButoExJL2SR4jrpqv0G72eHZNhuF7E_IKf3Yte5k3zoeTZKd9J0V3TI8iFdC66w4OOS380jmZ6Wxu0udpAimzyRLAsjIGiGFIDjUEoQPDOWJAsswqNg6B4C6i-d-lkx-f8GsSEv97ajiGtqpPBs_sJT2-MRZUa88NGZMZPZWPn0RdwmU!/dz/d5/L2dBISEvZ0FBIS9nQSEh/?clearcookie=&savecookie=&LOB=Part%20B®ION=https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24170.pdf (CMS Physician Fee Schedule Final Rule)

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