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HCCI HOME CENTERED CARE INSTITUTE

Home-Based Medical Care: Advanced Coding Opportunities – 2024

Purpose

A comprehensive resource to assist home-based medical care providers and practice staff with understanding the advanced coding opportunities beyond Evaluation and Management (E/M) Current Procedural Terminology (CPT®) codes that are available for billing and reimbursement based on the high level of complexity of patient needs. These codes align with the care provided and allow providers to maximize Medicare Fee-for-Service reimbursement. All content was gathered utilizing Centers for Medicare & Medicaid Services (CMS) guidelines[1]. Topics included:

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[1] https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

This information is accurate as of the time of publication.
Coding guidelines and policies change year to year, so please be advised of the finalization date.

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Transitional Care Management (TCM)

Transitional Care Management[2] is the oversight and care management of Medicare beneficiaries who transition back to their own home, a domiciliary, an assisted living facility, nursing home (non-skilled long-term care setting only), or a rest home, from an inpatient/observation hospital stay, acute or rehabilitation hospital, or skilled nursing facility discharge. Research has shown practices that offer a TCM model of care significantly reduce unplanned 30-day hospital readmissions. Consider implementing a process to manage your acute discharge patients through TCM to promote timelier follow-up, improve care, and demonstrate positive outcomes.

- TCM services can be provided to new or established patients whose medical and/or psychosocial problems require moderate to high medical decision-making (MDM) complexity.
- TCM commences upon the date of discharge and continues for the next 29 days.
- Requires documentation of interactive patient contact (can be telephone or face-to-face) with the patient and/or caregiver within two business days of discharge.
- Physicians and the following non-physician practitioners (NP, PA, CNS, CNM), who are legally authorized and qualified to provide services in the state in which services are furnished to the patient, may perform TCM.
- A face-to-face or telehealth 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 post-discharge face-to-face visit, must occur within 14 calendar days of discharge and requires moderate MDM complexity (2024 National CMS Non-Facility Payment $203.34; wRVU 2.78).
- 99496 - Submitted as the E/M code for post-discharge face-to-face visit, must occur within seven calendar days of discharge and requires high MDM complexity (2024 National CMS Non- Facility Payment $275.05; wRVU 3.79).
- As CMS continues efforts to improve payment for care management and coordination, as well as recognize that TCM utilization is low compared to the number of Medicare beneficiaries with eligible discharges, they've unbundled care management services that was previously considered to be duplicative. TCM can now be billed concurrently (i.e., within the same calendar month) as Care Plan Oversight (G0181, G0182), Chronic Care Management (99490, 99491, 99487, 99489, 99439), Advance Care Planning (99497, 99498), Behavioral Health Integration (BHI) services (99484, 99492, 99493, 99494, and G2214), Cognitive Assessment and Care Planning (99483), Prolonged Services, both face-to-face and non-face-to-face (G0318), Remote Patient Monitoring (99457, 99458), Inter-professional Consultations (99446, 99447, 99448, 99449, 99451, 99452), and Principle Care Management Services (99424-99427). It's important to ensure time is not "double-counted" towards multiple care management activities when billing for TCM and care management services for the same patient within the same month.
- Refer to the following HCCIntelligence Tools[3]: Transitional Care Management (TCM)[4] Face-To-Face Visit Requirements and Transitional Care Management (TCM) Interactive Contact Requirements[5] below for further explanation and a list of of the additional non-face-to-face and care coordination services that are required when performing transitional care management.

Chronic Care Management (CCM)

Chronic Care Management[6] (CCM) is a critical component of primary care medicine that contributes to improved health and care for Medicare beneficiaries. CCM, as defined by CMS, is at least 20 minutes of combined clinical staff and provider time per calendar month. This time is spent on care coordination and the management of the patients' chronic conditions. Medicare beneficiaries qualify for CCM services if they have two or more chronic conditions expected to last at least 12 months or until death. Clinical staff time must be directed by a physician or other qualified health care professional, per calendar month. CCM also requires an electronic comprehensive care plan to be created, implemented, monitored, and revised as necessary.

[2] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

[3] https://www.hccinstitute.org/hccintelligence/tools-and-tip-sheets/

[4] https://education.hccinstitute.org/Public/Catalog/Details.aspx?id=zkjpSbfHfiJys10ybjOsBA%3d%3d

[5] https://education.hccinstitute.org/Public/Catalog/Details.aspx?id=L0IP4KvhJ1OdJ%2f63TsQbSw%3d%3d

[6] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf (Chronic Care Management)

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- Patient consent (verbal or written) must be obtained before initiating services. Documentation of advance consent before initiating CCM services includes informing the patient of the availability of CCM services and potential applicable cost-sharing (i.e., copay), that only one practitioner may provide/bill for CCM services during the calendar month, and the patient's right to stop CCM services at any time. CMS only requires informed consent to be obtained once prior to billing for services unless there is a billing practitioner change. Refer to the Care Management webpage[7] for additional information.
- Only one eligible practitioner (Physician, Nurse Practitioner, Physician Assistant, Clinical Nurse Specialist, Certified Nurse-Midwife) 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 (e.g., Alzheimer's dementia, COPD, Cardiovascular disease).
- CCM requirements that must be offered to patient's enrolled in CCM include the following:
  - Initiating visit (when required for new patients or patients not seen within 12 months).
  - Structured recording of patient information using Certified Electronic Health Record (EHR) Technology (CEHRT).
  - 24/7 Access and Continuity of Care (i.e., after-hours on-call access and relationship with a designated member of the care team with whom the patient can schedule successive routine appointments).
  - Comprehensive Care Management for chronic conditions including systematic assessment of the patient's medical, functional, and psychosocial needs.
  - Electronic Person-Centered Care Plan. The separate and formal care plan must be created, revised, and/or monitored, as appropriate. A copy of the comprehensive care plan must be given to the patient/caregiver.
  - Management of Care Transitions.
  - Home and Community Based Care Coordination.
  - Enhanced Communication Opportunities (i.e., access to means of electronic communication other than telephones such as patient portal, secure messaging, or other asynchronous non-face-to-face consultation methods).
  - Complex CCM (99487, 99489) requires Medical Decision Making (MDM) of moderate to high complexity demonstrated by the billing practitioner.
- CMS describes the CCM comprehensive care plan as a person-centered electronic care plan based on the physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources for all health issues, with a particular focus on the chronic conditions being managed. A copy of the care plan must be provided to the patient/caregiver initially upon creation. The electronic separate and formal CCM care plan must be available within the medical record. It should be shared in a timely manner with care team members, internal and external, involved in the patient's care. Per CMS, the comprehensive care plan typically includes, but is not limited to the following elements:
  - Problem list.
  - Expected outcome and prognosis.
  - Measurable treatment goals.
  - Symptom management.
  - Planned interventions and identification of individuals responsible for each intervention.
  - Medication management.
  - Community & social services ordered.
  - A description of how services, agencies, and specialists outside of the practice are coordinated/directed.
  - Requires a schedule for periodic review, and when applicable, revisions (consider reviewing and updating the CCM care plan annually as part of Annual Wellness Visits).

[7] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management

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- CPT 99490 - At least 20 minutes of clinical staff time as directed by a physician or qualified health care professional per calendar month (2024 National CMS Non- Facility Payment $61.56; wRVU 1.00).
- CPT 99439 - Add-on code, can only be billed in conjunction with traditional CCM (99490). CCM each additional 20 minutes of clinical staff time directed by a provider per calendar month. Maximum of 2 billable units per calendar month, may require a modifier if billing multiple units due to Medically Unlikely Edit, check with your local Medicare Administrative Contractor (2024 National CMS Non- Facility Payment $47.15; wRVU 0.70).
- CPT 99491 - At least 30 minutes of time personally performed by the physician or other qualified healthcare professional per calendar month (2024 National CMS Non- Facility Payment $83.17; wRVU 1.50).
- CPT 99437 - Provider CCM Add-on Code: Each additional 30 minutes of CCM time personally spent by the billing practitioner. Can only be billed in conjunction with CPT 99491 (2024 National CMS Non- Facility Payment $58.61; wRVU 1.00).
- 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. Requires moderate to high medical decision making complexity; for patients with multiple illnesses, coordination of specialty services, require assistance with ADLs or cognitive impairment, psychiatric or other comorbidities including social needs (May NOT be reported with 99490, you must choose to report either complex CCM or traditional CCM) (2024 National CMS Non- Facility Payment $131.96; wRVU 1.81).
- CPT 99489 - Complex CCM Add-on Code; 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) (2024 National CMS Non- Facility Payment $71.06; wRVU 1.00).
- HCPCS G0506 - Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services. Billed separately from monthly care management services. Add-on code, list separately in addition to primary E/M service. G0506 is reportable once per patient in conjunction with CCM initiation. This code is only reported for new patients during which an initiating face-to-face visit, the billing practitioner personally spends direct face-to-face time developing and discussing the CCM care plan with the patient/caregiver (2024 National CMS Non- Facility Payment $61.56; wRVU 0.87).
- CCM is bundled, meaning it cannot be reported within the same calendar month as the following services: Care Plan Oversight (G0181 & G0182), ESRD Services (90951-90970), Prolonged Services Non-Face-to-Face (99358, 99359), home and outpatient INR monitoring (93792, 93793), telephone E/M services (99441-99443), and analysis of physiologic data (99091).
- Do not report CPT codes 99490, 99491, 99487, or 99489 within the same calendar month; instead, the provider must select one type of CCM services that best represents their time and efforts.
- As a result of 2020, Medicare Physician Fee Schedule Final Rule, TCM and CCM services were unbundled and may be reported within the same calendar month for traditional Medicare purposes. However, CPT still lists these services as bundled, so commercial payor policies may vary.
- In CY 2022 CMS increased the payment and wRVU's for CCM services enhancing the value of providing CCM services to promote practice sustainability.

Principle Care Management (PCM)

PCM Services[8] are similar to CCM. However, they are focused on comprehensive care management for a single high-risk disease of sufficient severity to place the patient at risk of hospitalization or have been the cause of a recent hospitalization, which resulted in the development or revision of a disease-specific care plan.

- Patient verbal consent must be obtained and documented to make aware of applicable cost-sharing and to inform the patient that only one practitioner can provide and bill for PCM services per calendar month.
- Requires an initiating visit for new patients which is separately billable.

[8] https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other

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- Patients enrolled in PCM require structured recording of patient information using Certified Electronic Health Record (CEHRT) technology, 24/7 access (after-hours on-call), designated care team member, disease-specific care management, a disease-specific electronic care plan, management of transitions and referrals, home and community-based care coordination, and enhanced communication opportunities (e.g., patient portal electronic communications opportunities).
- CPT 99424 - Provider PCM, Minimum of 30 minutes personally spent by the qualified billing practitioner (i.e., NP, PA, MD) per month, single high-risk disease (2024 National CMS Non- Facility Payment $81.21; wRVU 1.45).
- CPT 99425 - Provider PCM Add-on code: Each additional 30 minutes of qualified billing practitioner time per calendar month (2024 National CMS Non- Facility Payment $58.94; wRVU 1.00).
- CPT 99426 - Traditional PCM, 30 minutes of clinical staff & Provider time per calendar month, single high-risk disease (2024 National CMS Non- Facility Payment $60.90; wRVU 1.00).
- CPT 99427 - Traditional PCM Add-on code, each additional 30 minutes of clinical staff and provider time per calendar month, can only be reported with CPT 99426 (2024 National CMS Non- Facility Payment $46.49; wRVU 0.71).

Caregiver Training

Caregiver training codes have been implemented by CMS and effective January 1, 2024. These codes are to be used when practitioners train and involve one or more caregivers to assist patients who have certain diseases (for example dementia) carry out a treatment plan.

CMS will reimburse for these services when provided by a physician or a non-physician practitioner: Nurse Practitioner, physician assistant, or certified nurse specialist or therapist (physical therapist, occupational therapist, or speech language pathologist) under an individualized treatment plan or therapy plan of care, without the patient present[9]. When billing for these services it is important to maintain the following for compliance purposes:

- Consent is required from the patient or the patient's representative, especially because the patient may not be present for the training(s)
- The training should be directly relevant to the person-centered treatment plan for the patient for services to be considered reasonable and necessary under the Medicare program.
- Frequency and volume of the training can be based on the patient's treatment plan, changes in condition, diagnosis, or changing caregivers
- Codes are not included on CMS Telehealth list
- 96202 - Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes) (2024 National CMS Non- Facility Payment $23.25; wRVU 0.43).
- 96203 - each additional 15 minutes; an add on code that must be billed in conjunction with 96202 (2024 National CMS Non- Facility Payment $5.57; wRVU 0.12).
- 97550 - Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face; initial 30 minutes (2024 National CMS Non- Facility Payment $52.06; wRVU 1.00).
- 97551 - each additional 15 minutes (List separately in addition to code for primary service) (Use 97551 in conjunction with 97550) (2024 National CMS Non- Facility Payment $25.87; wRVU 0.54).
- 97552 - Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face-to-face with multiple sets of caregivers (2024 National CMS Non- Facility Payment $21.94; wRVU 0.23).

[9] https://www.cms.gov/files/document/mm13452-medicare-physician-fee-schedule-final-rule-summary-cy-2024.pdf

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Online Digital E/M Services (E-Visits)

The E-visits[10] codes capture time over a 7-day period for communicating and reviewing patient information on a digital communication platform, such as a patient portal or secure email. Communications are intended to evaluate and address an acute symptom or problem that does not result or relate to a recent face-to-face visit.

- The patient must initiate the interaction
- Must be an established patient (Except during the Public Health Emergency).
- The service should be evaluative in nature and requires a clinical decision that would have typically occurred during a face-to-face visit. Do not report for nonevaluative communication, such as reviewing test results or scheduling appointments.
- Verbal consent must be obtained and documented however this can be captured by auxiliary personnel under general supervision. Once annual consent for all Communication Technology Based Services (CTBS) is acceptable, does not need to be service specific consent.
- The service cannot be related to an E/M visit that occurred within the past 7 days or lead to a visit within the following 24 hours or next available appointment.
- Cannot be reported during the global surgery period.
- If within the 7 days of the digital communication you decide a face-to-face visit or separately reportable service is needed, do not report the E-visit.
- The 7-day period begins when the provider personally reviews the patient generated issue and is cumulative over the next 7-days when the problem is addressed. Service time includes review of the initial inquiry, review of patient records or data related to the problem, personal interaction with clinical staff focused on the patient's problem, development of management plans, generation of prescriptions, ordering of tests, and subsequent communication with the patient via online, telephone, email, or other digitally supported communications.
- Do not double count any time for any other care management related activities such as anticoagulation management.
- Document within the medical record the dates and times of the services, a description of the problem or concern from the patient and the provider's clinical judgment and treatment plan or recommendations and/or response to address the patient's concern without resulting in a visit.
- CPT 99421 Online Digital E/M, cumulative 7 days, 5-10 minutes (2024 National CMS Non- Facility Payment $14.74 wRVU 0.25).
- CPT 99422 Online Digital E/M, cumulative 7days; 11-20 minutes (2024 National CMS Non- Facility Payment $28.82 wRVU 0.50).
- CPT 99423 Online Digital E/M, cumulative 7 days; 21 minutes or more (2024 National CMS Non- Facility Payment $45.84; wRVU 0.80).
- CPT 98970: Online digital assessment and management, established patient, by a qualified non-physician healthcare professional cumulative 7 days, 5-10 minutes (2024 National CMS Non- Facility Payment $11.46; wRVU 0.25).
- CPT 98971: Online digital assessment and management, established patient, by a qualified non-physician healthcare professional cumulative 7 days, 11-20 minutes (2024 National CMS Non- Facility Payment $20.30; wRVU 0.44).
- CPT 98972: Online digital assessment and management, established patient, by a qualified non-physician healthcare professional cumulative 7 days, 21 minutes or more (2024 National CMS Non- Facility Payment $30.13 wRVU 0.69).
- Qualified non-physician healthcare professionals eligible to bill CPT 98970-98972 include licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists.
- Providers eligible to independently bill for E/M services (i.e. Physicians, Nurse Practitioners. Physician Assistants) bill E-visits using CPT 99421-99423.

[10] New CPT® codes for online digital E/M - 99421 (codingintel.com)

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Advance Care Planning (ACP)

ACP[11] is a face-to-face discussion between a qualified healthcare professional and the patient or caregiver to discuss the patient’s health care wishes if they become unable to make decisions about their care. It may include an explanation of advance directives, such as standard forms, with or without completing the forms. CMS anticipates ACP will be billed each time there is a significant change in the patient’s health status or the provider takes time to conduct a discussion to help the patient/caregiver decide and document their preferences.

- ACP must be voluntary, the provider should document the patient or caregiver's advance consent to voluntarily participate in the advance care planning discussion. CMS encourages providers to make patient's aware of possible cost sharing when this occurs outside of an annual wellness visit (AWV). ACP may also be furnished with no-copay as an optional element of the AWV when modifier 33 is applied.
- ACP must be face-to-face and only include the time spent discussing the patient preferences and advance directives; time spent on other aspects of the visit cannot be counted towards this service element.
- Examples of standard forms include a living will, power of attorney for healthcare, POLST/MOLST (physician’s/ medical orders for life-sustaining treatment) and POST (physician’s orders for scope of treatment).
- ACP may be billed in conjunction with AWV, 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 (2024 National CMS Non-Facility Payment $80.55; wRVU 1.50).
- CPT code 99498 - Advance care planning, each additional 30 minutes (billed in addition to 99497, at least 46 minutes to bill) (2024 National CMS Non- Facility Payment $69.75; wRVU 1.40).
- ACP is on Medicare's approved list of telehealth services meaning this can be provided and billed via telehealth. It's also one of the certain telehealth services that can be provided using audio-only (phone call) and does not require the use of video to bill for the discussion.
- Eligible qualified healthcare professionals who can bill for ACP include practitioners with E/M within their scope of practice (i.e., physicians, nurse practitioners, physician assistants).

[11] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

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Prolonged Services

Prolonged Services are when a qualified physician or healthcare provider spends extended time with a patient (with or without Direct Patient Contact) that exceeds the typical CPT code threshold time related to a particular E/M encounter. Medicare will reimburse for prolonged services provided in relation to an E/M encounter. This enables providers to be reimbursed for time spent reviewing extensive medical records or elongated telephone time discussing history or the patient's medical condition in advance of, or after, the visit.

- G0318 – Prolonged evaluation and management service beyond the total time for the primary service for Medicare patients. The time threshold is 140 minutes for new patients (99345) and 110 minutes for established patients (99350) with or without patient contact (2024 National CMS Non- Facility Payment $30.45; wRVU 0.61).
- CPT 99417 – Prolonged evaluation and management service beyond the total time for the primary service; each additional 15 minutes by a physician or qualified healthcare professional, with or without direct patient contact. This code applies to non-Medicare patients (2024 National CMS Non- Facility Payment $30.43; wRVU 0.61).
- Prolonged services are add-on codes and must be reported with their companion E/M code.
- Must be beyond the usual effort and service time a physician or qualified health care professional would spend with the patient and document why the service went beyond the normal time and effort.
- The time spent can be 3 days before the visit, the date of the visit, and 7 days after the date of the visit; however, services must be related to an E/M encounter. Documentation must describe what was reviewed or how the time was spent.
- No start/stop times are needed when documenting; only the total time spent with the patient.
- For E/M services where the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.
- Consistent with CPT's approach, there is no assigned frequency limitation.
- 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, and online medical evaluations.

Cognitive Assessment and Care Plan Services

Cognitive Assessment and Care Plan Services is a comprehensive evaluation 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. Medicare reimburses physicians and other qualified health care professionals for an evaluation of a patient with cognitive impairment. For additional information, please refer to the Alzheimer's Association Guide[12] or the CMS Cognitive Assessment & Care Plan[13] webpage.

- CPT 99483 (Typically a 60 minute visit) - Assessment of, and care planning for, a patient with cognitive impairment, requiring an independent historian, and development of a cognitive specific care plan, which can be billed once every 180 days per provider. Approved settings include office/outpatient, home/domiciliary, care facility, or telehealth (2024 National CMS Non- Facility Payment $268.18; wRVU 3.84).
- This code (CPT 99483) 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.

[12] https://www.alz.org/careplanning/downloads/cms-consensus.pdf

[13] https://www.cms.gov/cognitive

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- ➤ Evaluation for neuropsychiatric and behavioral symptoms, including depression, using a standardized screening instrument.
- ➤ Evaluation of safety (e.g., home environment), 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 cognitive specific care plan, including initial plans to address any neuropsychiatric symptoms, neurocognitive symptoms, functional limitations, and referral to community resources as needed (e.g., adult day careprograms, rehabilitation services, support groups). Note that the written care plan must be shared with the patient and/or caregiver with initial education and support.

- Please be advised this code is not to be reported for routine cognitive screenings (e.g., Mini-COG screen) or the basic cognitive screen that's a required element of AWV's. This is intended to be a separate comprehensive assessment when impairment is detected, and more detailed care planning efforts are needed. Per CMS, "If you detect cognitive impairment at an AWV or other routine visit, you may perform a more detailed cognitive assessment and develop a care plan during a separate visit."

Smoking Cessation Counseling Services

Smoking Cessation Counseling Services is a service in which the provider counsels the patient on the importance of stopping tobacco use. 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 twelve-month period. Note that each attempt may include a maximum of four intermediate or intensive sessions, with a total benefit of eight annually. For additional information, please refer to the CMS Preventative Services Guide[14]. Documentation must include the following elements:

- The exact amount of time spent on cessation counseling (minimum four minutes to bill).
- Brief description of 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 barriers to changing behavior and provide specific resources (e.g., 1-800-784-8669- Quit Now) or other specific action suggestions determined by the provider.
- CPT 99406 Smoking and tobacco use cessation counseling visit, intermediate, greater than 3 minutes up to 10 minutes (2024 National CMS Non- Facility Payment $14.41; wRVU 0.24).
- CPT 99407 Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes (2024 National CMS Non- Facility Payment $26.85; wRVU 0.50).
- The patient must have a valid diagnosis of F17.2xx (Nicotine dependence, unspecified, cigarettes, chewing tobacco, other) or Z87.891 (Personal history of nicotine dependence) to qualify for reimbursement.
- Document the patient's specific tobacco use, your guidance for quitting and the negative health impact of smoking, assessing the patient's readiness for change in smoking behavior, advising a specific change and setting a quit date.

[14] https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#TOBACCO (Smoking Cessation Counseling Services)

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Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services

An SBIRT[15] service is an evidence-based approach to delivering early intervention treatment services for persons with substance use disorders, and those at risk of developing a substance use disorder. SBIRT is intended for early intervention for people with non-dependent substance use to help them before more specialized and extensive treatment is needed.

- Eligible providers who can bill for SBIRT services for Medicare purposes include Physicians (MDs and DOs), Physician Assistants (PA), Nurse Practitioners (NPs), Clinical Nurse Specialist (CNS), Clinical Psychologist (CP), Clinical Social Worker (CSW), Certified Nurse Midwife (CNM), Independently Practicing Psychologists (IPPs).
- There are three elements to SBIRT Services described below:
  - Screening: Screen or assess the patient using a Medicare Structured Assessment Tool to determine the severity and appropriate treatment. You may use tools that include the World Health Organization's Alcohol Use Disorders Identification Test (AUDIT) Manual and the Drug Abuse Screening Test (DAST).
  - Brief Intervention: Focused on raising awareness and providing insight on substance use and motivation towards behavior change. These are brief conversations where the provider raises awareness, gives feedback, motivation, and advice. Medicare covers up to five counseling sessions.
  - Referral to Treatment: Refer patients whose screening shows a need for additional treatment to brief therapy or specialty care.

Documentation for each patient encounter must include

- Start and stop times or total face-to-face time with the patient.
- The patient's progress, response to changes in treatment, and diagnosis revision.
- The rationale for ordering diagnostic and other ancillary services or ensure it is easily inferred.
- Assessment, clinical impression, and diagnosis.
- Physical examination findings and prior diagnostic test results.
- Plan of care.
- Reason for encounter and relevant history.
- Identify appropriate health risk factors.
- Make past and present diagnoses accessible for the treating and consulting physicians.

HCPCS G2011 - Alcohol and/or substance abuse (other than tobacco) structured assessment (e.g., AUDIT, DAST), and brief intervention, 5–14 minutes (2024 National CMS Non- Facility Payment $16.37; wRVU 0.33).

HCPCS G0396 - Alcohol and/or substance abuse (other than tobacco) structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes (2024 National CMS Non- Facility Payment $33.73; wRVU 0.65).

HCPCS G0397 - Alcohol and/or substance abuse (other than tobacco) structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes (2024 National CMS Non- Facility Payment $65.48; wRVU 1.30).

[15] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf

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Anticoagulation Management

Anticoagulation Management is the oversight of Prothrombin Time International Normalized Ratio (PT/INR) monitoring for patients on long-term Warfarin, Coumadin, and other self-administered oral-anticoagulation medications. Medicare reimburses physicians and other qualified health care professionals for the management of home and outpatient International Normalized Ratio (INR) monitoring services which includes the management of warfarin therapy, ordering, review, and interpretation of new INR test result(s), patient instructions, and dosage adjustments as needed. For additional information, please refer to the following Coding Intel Article[16]. The two new services available are as follows:

- CPT 93792 - 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 - 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.
- CPT 93792 - typically performed by clinical staff (2024 National CMS Non- Facility Payment $65.49; wRVU 1.30).
- CPT 93793 (2024 National CMS Non- Facility Payment $11.13 wRVU 0.18).
- Neither 93792 nor 93793 is billable during the same service period as Chronic Care Management services; instead, consider that as CCM minutes. Anticoagulation Management is unbundled and may be reported in conjunction with Transitional Care Management services if time is separate and distinct.
- CPT 93793 cannot be reported on the same date as an E/M service (e.g., not done during a face-to-face visit, this is non-face-to-face management of test results and therapy). This service is also bundled with Telephone E/M services or Online Digital E/M Services.

General Behavioral Health Integration (BHI) Care Management

General BHI, utilized for billing monthly services furnished by providing integrated behavioral health and primary care services. CPT code 99484 (2024 National CMS Non- Facility Payment $654.02; wRVU 0.93), 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 a billing practitioner and clinical staff. Medicare assumes 15 minutes is spent by the billing practitioner. Please refer to the Medicare Learning Network[17] for full details.

Service elements include the following:

- An initial assessment must be performed to enroll the patient and explain BHI management services. During the initiating visit (separately billable E/M service, when applicable), the administration of a validated rating scale for the mental health condition is performed and used to develop the care plan.
- Systematic assessment and monitoring with the use of applicable (e.g., PHQ-9, Altman scale, GAD-7, PDSS-SR).
- Care planning with the primary care team and the patient, with revision if the condition is not improving.

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[16] https://codingintel.com/anticoagulation-management/

[17] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf (Behavioral Health Integration Services)

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- 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 99490) may, in some instances, 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 and HCPCS G2214 for the behavioral care manager's time. For additional information, please review the MLN BHI Fact Sheet[18] or contact HCCI.

Community Health Integration (CHI)

Community Health Integration services are designed to specifically include care involving community health workers, who link underserved communities with critical health care and social services in the community and expand equitable access to care, improving outcomes for the Medicare population.

- G0019 - Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month (2024 CMS National Non-Facility Payment $79.24; wRVU 1.00).
- G0022 - Community health integration services, each additional 30 minutes per calendar month (List separately in addition to G0019) (2024 CMS National Non-Facility Payment $49.44; wRVU 0.70).

Social Determinants of Health Risk Assessment

Per CMS, Calendar Year 2024 coding and payment has been finalized for the administration of SDOH risk assessments. The risk assessment must be provided in conjunction with a qualifying visit, including an E/M visit, some behavioral health visits, or the Annual Wellness Visit (AWV). The SDOH risk assessment used by providers and practices must be standardized and evidence-based covering, at minimum, the following domains:

1. Housing security **2.** Food insecurity **3.** Transportation needs **4.** Utility difficulty

- G0136 - Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, no more than every 6 months (2024 CMS National Non-Facility Payment $18.66; wRVU 0.18).

CMS has listed the following resources that can be utilized when performing the SDoH Risk Assessment. These tools are simply resources that can be used as an example or guide when customizing a template for your practice or utilized to perform the assessment when providing care for patients.

- Accountable Health Communities Health-Related Social Needs Screening Tool
- American Academy of Family Physicians Social Needs Screening Tool
- HealthBegins
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- Virginia Commonwealth University Health System: Social Needs Assessment

[18] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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Consult Services

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. Consider these reimbursement opportunities as a potential opportunity for partnerships with specialists who may be virtually available to collaborate on the care of complex patients at home

- 99446 - 5-10 minutes of medical consultative discussion and review (2024 CMS National Non-Facility Payment $17.35; wRVU 0.35).
- 99447 - 11-20 minutes of medical consultative discussion and review (2024 CMS National Non-Facility Payment $35.36; wRVU 0.70).
- 99448 - 21-30 minutes of medical consultative discussion and review (2024 CMS National Non-Facility Payment $52.39; wRVU 01.05).
- 99449 - 31 minutes or more of medical consultative discussion and review (2024 CMS National Non-Facility Payment $69.75; wRVU 01.40).
- 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 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 they do not require a written and verbal medical discussion.
- CPT 99451 (2024 CMS National Non-Facility Payment $34.05; wRVU 0.70).
- CPT 99452 (2024 CMS National Non-Facility Payment $33.07; wRVU 0.70).

Brief Communication Technology-Based Virtual Check-ins

Brief Communication Technology-Based Virtual Check-ins offer an opportunity for reimbursement for virtual visits that avoid an unnecessary face-to-face visits and do not enforce rural or geographic area restrictions as the Medicare approved list of telehealth codes do. During the PHE, refer to other covered services and telehealth flexibilities such as Telephone E/M codes. CMS clarified their final policy that once annual documentation of consent for all CTBS services a practice provides is sufficient, service-specific consent is not required.

HCPCS G2010 - Remote evaluation of recorded video and/or images submitted by an established patient (prerecorded patient-generated 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 the past seven days and may not result in an E/M visit within the next 24 hours or next available appointment (2024 CMS National Non-Facility Payment $12.12; wRVU 0.18).

- Prerecorded 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. (Except during the Public Health Emergency).
- 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.
- Prerecorded information must be of sufficient quality for the provider to be able to review and interpret the image or video.

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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 (2024 CMS National Non-Facility Payment $13.75; wRVU 0.25). Note, virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication.

- Five to 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. (Except during the Public Health Emergency).
- Virtual Brief Check-In is permitted for use as part of a treatment regimen for opioid use disorders.
- Documentation required to include: consent, date, time, duration of the service, along with a brief summary of what topic(s) were discussed.
- CMS believes the virtual check-in codes will be valuable at the end of the Public Health Emergency when they no longer reimburse audio-only telephone E/M (CPT 99441-99443).

HCPCS G2250 - Remote assessment by a non-physician healthcare professional (i.e. without E/M within their scope of practice) of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment (2024 CMS National Non-Facility Payment $12.12; wRVU 0.18).

HCPCS G2252 - Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion (2024 CMS National Non-Facility Payment $25.87; wRVU 0.50).

Visit the HCCIntelligence™ Resource Center

HCCI has developed a number of free and premium resources to help home-based primary care (HBPC) providers and practice staff through our HCCIntelligence™ Resource Center at https://www.hccinstitute.org/hccintelligence/

Hotline

Call (630) 283-9222 or email Help@HCCInstitute.org 9:00 am–5:00 pm (CT) Monday through Friday.

Webinars

HCCI hosts free and premium webinars on topics relevant to HBPC. Visit the HCCIntelligence™ Resource Center for upcoming dates and topics.

Tools & Tip Sheets

Downloadable tools, tip sheets, sample forms, and how-to guides on a variety of HBPC topics.

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