
# What You Should Know About 2020 Coding Updates!

**Brianna Plencner, CPC, CPMA; Thomas Cornwell MD, Paul Chiang MD**

**HCCIntelligence™ Webinar and Virtual Office Hours**

**February 19th 2020**

# Introductions

## Brianna Plencner, CPC, CPMA

Manager, Practice Improvement, Home Centered Care Institute

## Thomas Cornwell, MD

CEO, Home Centered Care Institute
Founder, Northwestern Medicine HomeCare Physicians

## Paul Chiang, MD

Senior Medical and Practice Advisor, Home Centered Care Institute
Medical Director, Northwestern Medicine HomeCare Physicians

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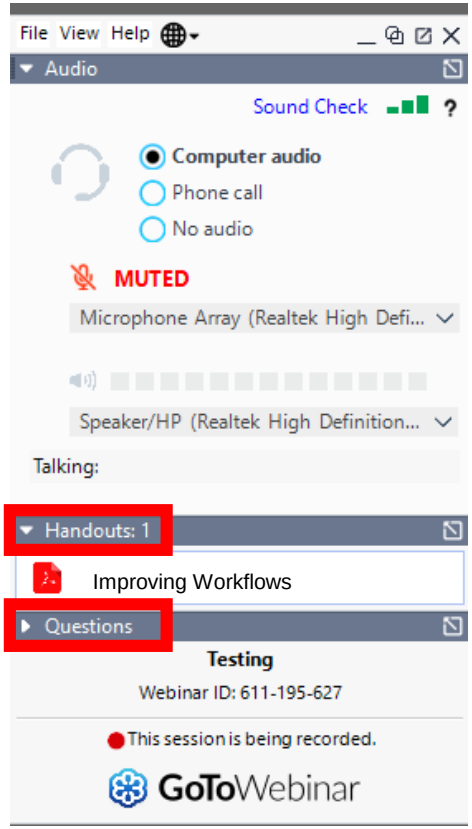
# Housekeeping

- The first 30 minutes of today's HCCIntelligence™ Webinar will consist of a slide presentation and all participants will be muted during this time.
- The following 30 minutes will be HCCIntelligence™ Virtual Office Hours, and all participants will be able to submit questions via the question box.
- To submit a question, click on the arrow next to Questions, type in your question, press send.
- Handouts can be accessed in the handout box.
  - Click on the name of the file and save to your computer
- All participants will receive a copy of the slide deck, question and responses, and a recording of the HCCIntelligence™ Webinar & Virtual Office Hours.

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**Advancing home-based primary care to ensure medically complex patients have access to high-quality care in their home.**

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# Objectives

1. Discuss 2020 coding changes and the implications on a practice.
2. Review documentation requirements to ensure coding compliance.
3. Identify & apply correct CPT codes for care management services.

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# Chronic Care Management (CCM)

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# CCM Current State

| Code | Explanation |
|---|---|
| **99490**<br>$42.22<br>wRVU 0.61 | • **20 minutes** or more **combined provider and clinical staff** (15 minutes assumed billing practitioner time)<br>• Ongoing oversight and management of established, implemented, revised or monitored care plan |
| **99491**<br>$84.09<br>wRVU 1.45 | • **30 minutes** or more<br>• Personally provided by **Physician or other qualified healthcare professional**. No combined clinical staff time.<br>• Reported instead of traditional CCM when all other requirements are met |
| **99487***<br>$92.39<br>wRVU 1.0 | • **60 minutes** or more<br>• Ongoing oversight and management of care plan that has been established or **substantially revised + medical decision making of moderate-high complexity** |
| **99489***<br>$44.75<br>wRVU 0.50 | • **Each additional** 30 minutes of clinical staff time<br>• Ongoing oversight and management of care plan that has been established or substantially revised + medical decision making of moderate-high complexity |

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# CCM Summary from Final Rule; Table 22

**TABLE 22: Chronic Care Management Services Summary**

| CCM Service Summary* |
|---|
| **Verbal Consent**<br>• Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance).<br>• Document that consent was obtained. |
| **Initiating Visit for New Patients (separately paid)** |
| **Certified Electronic Health Record (EHR) Use**<br>• Structured Recording of Core Patient Information Using Certified EHR (demographics, problem list, medications, allergies). |
| **24/7 Access** ("On Call" Service) |
| **Designated Care Team Member** |
| **Comprehensive Care Management**<br>• Systematic needs assessment (medical and psychosocial).<br>• Ensure receipt of preventive services.<br>• Medication reconciliation, management and oversight of self-management. |
| **Comprehensive Electronic Care Plan**<br>• Plan is available timely within and outside the practice (can include fax).<br>• Copy of care plan to patient/caregiver (format not prescribed).<br>• Establish, implement, revise or monitor the plan. |
| **Management of Care Transitions/Referrals** (e.g., discharges, ED visit follow up, referrals).<br>• Create/exchange continuity of care document(s) timely (format not prescribed). |
| **Home- and Community-Based Care Coordination**<br>• Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits. |
| **Enhanced Communication Opportunities**<br>• Offer asynchronous non-face-to-face methods other than telephone, such as secure email. |

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of CCM.

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# Comprehensive Care Plan Requirements

Revised language from community/social services ordered to **interaction and coordination with outside resources and practitioners and providers**

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medical management
- 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

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# New CCM Add-on Code in 2020

## Effective 01/01/2020 HCPCS Code G2058:

- Chronic Care Management Services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month
- Billed in conjunction **only with CPT 99490**
- Maximum of two units per month (1 hour)
- Cannot be reported in conjunction with complex CCM (99497, 99498, or 99491)

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# Reimbursement

| HCPCS Code | Description | wRVU | CMS National Payment Amount |
|---|---|---|---|
| G2058 | Chronic Care Management Add-on Code; Each additional 20 minutes, report with 99490 (Maximum of 2 units per month) | 0.54 | $37.89 |

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# Complex CCM Care Plan Requirements Change

**Beginning in CY 2020, for PFS billing purposes for CPT codes 99487 and 99489, we will interpret the code descriptor "establishment or substantial revision of a comprehensive care plan" to mean that a comprehensive care plan is established, implemented, revised, or monitored.**

## CPT Code 99487

- Multiple (2 or more) chronic conditions expected to last at least 12 months, or until death
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensations, or functional decline
- **Comprehensive care plan still required however does not need to substantially revised**
- Moderate or high medical decision making
- **60 minutes** of clinical staff time directed by a physician or other qualified health care professional per calendar month

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# 2020 Principal Care Management Codes (PCM)

**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**

**HCPCS G2065**
(30 minutes combined clinical staff and provider)

**HCPCS G2064**
(30 minutes physician or other qualified healthcare professional)

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# PCM Reimbursement

| HCPCS Code | Description | wRVU | CMS National Payment Amount |
|---|---|---|---|
| G2064 | PCM, 30 minutes of Provider time per month, single high risk disease | 1.45 | $92.02 |
| G2065 | PCM, 30 minutes of clinical staff & Provider time per calendar month, single high risk disease | 0.61 | $39.69 |

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# PCM Requirements

**TABLE 24: Principal Care Management Services Summary**

| PCM Service Summary* |
|---|
| **Verbal Consent**<br>• Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance).<br>• Document that consent was obtained. |
| **Initiating Visit for New Patients (separately paid)** |
| **Certified Electronic Health Record (EHR) Use**<br>• Structured Recording of Core Patient Information Using EHR (demographics, problem list, medications, allergies). |
| **24/7 Access** ("On Call" Service) |
| **Designated Care Team Member** |
| **Disease Specific Care Management**<br>Disease Specific Care Management may include, as applicable:<br>• Systematic needs assessment (medical and psychosocial).<br>• Ensure receipt of preventive services.<br>• Medication reconciliation, management and oversight of self-management. |
| **Disease Specific Electronic Care Plan**<br>• Plan is available timely within and outside the practice (can include fax).<br>• Copy of care plan to patient/caregiver (format not prescribed).<br>• Establish, implement, revise or monitor the plan. |
| **Management of Care Transitions/Referrals** (e.g., discharges, ED visit follow up, referrals, as applicable).<br>• Create/exchange continuity of care document(s) timely (format not prescribed). |
| **Home- and Community-Based Care Coordination**<br>• Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits, as applicable. |
| **Enhanced Communication Opportunities**<br>• Offer asynchronous non-face-to-face methods other than telephone, such as secure email. |

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of PCM.

# Transitional Care Management

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# 2020 Medicare Physician Fee Schedule Changes

## Effective 01/01/2020:

- **Increased wRVU** for TCM
  - 99495 - 2.36
  - 99496 - 3.10
- Traditional Chronic Care Management Codes **99490** (20 mins clinical staff) **and 99491**(20 mins performed by MD/NP/PA) **may be billed concurrently when appropriate with TCM for Medicare**

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# Unbundled with TCM as of 2020 for Medicare Purposes

- Prolonged Services Non-Face-to-Face
- INR Monitoring Services
- ESRD
- Analysis of physiologic data
- Complex CCM
- Care Plan Oversight

**TABLE 20: 14 HCPCS Codes that Currently Cannot be Billed Concurrently with TCM by the Same Practitioner and are Active Codes Payable by Medicare PFS**

| Code Family | HCPCS Code | Descriptor |
|---|---|---|
| Prolonged Services without Direct Patient Contact | 99358 | Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service |
| | 99359 | Prolonged E/M service before and/or after direct patient care; each additional 30 minutes beyond the first hour of prolonged services |
| Home and Outpatient International Normalized Ratio (INR) Monitoring Services | 93792 | Patient/caregiver training for initiation of home INR monitoring |
| | 93793 | Anticoagulant management for a patient taking warfarin; includes review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment and scheduling of additional test(s) |
| End Stage Renal Disease Services (patients who are 20+ years) | 90960 | ESRD related services monthly with 4 or more face-to-face visits per month; for patients 20 years and older |
| | 90961 | ESRD related services monthly with 2-3 face-to-face visits per month; for patients 20 years and older |
| | 90962 | ESRD related services with 1 face-to-face visit per month; for patients 20 years and older |
| | 90966 | ESRD related services for home dialysis per full month; for patients 20 years and older |
| | 90970 | ESRD related services for dialysis less than a full month of service; per day; for patient 20 years and older |
| *Analysis of Data | 99091 | Collection and interpretation of physiologic data |
| Complex Chronic Care Management Services | 99487 | Complex Chronic Care with 60 minutes of clinical staff time per calendar month |
| | 99489 | Complex Chronic Care; additional 30 minutes of clinical staff time per month |
| Care Plan Oversight Services | G0181 | Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities within a calendar month; 30+ minutes |
| | G0182 | Physician supervision of a patient receiving Medicare-covered hospice services (Pt not present) requiring complex and multidisciplinary care modalities; within a calendar month; 30+ minutes |

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https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

# TCM Reimbursement

| CPT Code | Description | wRVU | CMS National Payment Amount |
|---|---|---|---|
| 99495 | TCM, within 14 days of discharge, requires moderate MDM | 2.36 | $187.67 |
| 99496 | TCM, within 7 days of discharge, requires high MDM | 3.10 | $247.94 |

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# Online Digital E/M

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# Online Digital E/M Services

| CPT/ HCPCS Code | Description | wRVU | CMS National Payment Amount |
|---|---|---|---|
| 99421 | Online Digital E/M, established patient, cumulative 7 days, 5-10 minutes | 0.25 | $15.52 |
| 99422 | 11-20 minutes | 0.50 | $31.04 |
| 99423 | 21 minutes or more | 0.80 | $50.16 |
| G2061 | Qualified non-physician healthcare professional online E/M, cumulative 7 days, 5-10 minutes | 0.25 | $12.27 |
| G2062 | 11-20 minutes | 0.44 | $21.65 |
| G2063 | 21 minutes or more | 0.69 | $33.92 |

# Online Digital E/M Requirements

- Must be patient initiated
- Established patient
- Requires evaluation, management, and assessment. Do not report for nonevaluative communication of test results and scheduling of appointments
- Requires HIPAA compliant secure platform (EHR portals, secure email, or other digital communication platforms)
- Verbal consent required

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# Online Digital E/M Requirements

- Documentation within medical record
- Not related to an E/M visit within past 7 days
- Not reported during global surgery period
- If within 7 days of the initiation of the online service you decide to make a F2F visit, the time and MDM cannot be used to select E/M level and service should not be billed
- Clinical staff time may NOT be included
- Do not double count time for other care management activities such as anticoagulation management

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# Provider Requirements

## Physicians, Nurse Practitioners, and Physician Assistants report 98970-98972

## Who can report G2061 & G2062:

- Non-physician practitioners who are unable to bill for E/M Services.
  - *We would also like to reiterate that there are many practitioners for whom these services fall outside the scope of their benefit category and as such, may not receive separate payment for these services under Medicare. (e.g. audiologists and speech language pathologists)*

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# ICD-10 2020 Updates

## Atrial Fibrillation: I48

- **I48.11** Longstanding persistent atrial fibrillation
- **I48.19** Other persistent atrial fibrillation
- **I48.20** Chronic atrial fibrillation, unspecified
- **I48.21** Permanent atrial fibrillation

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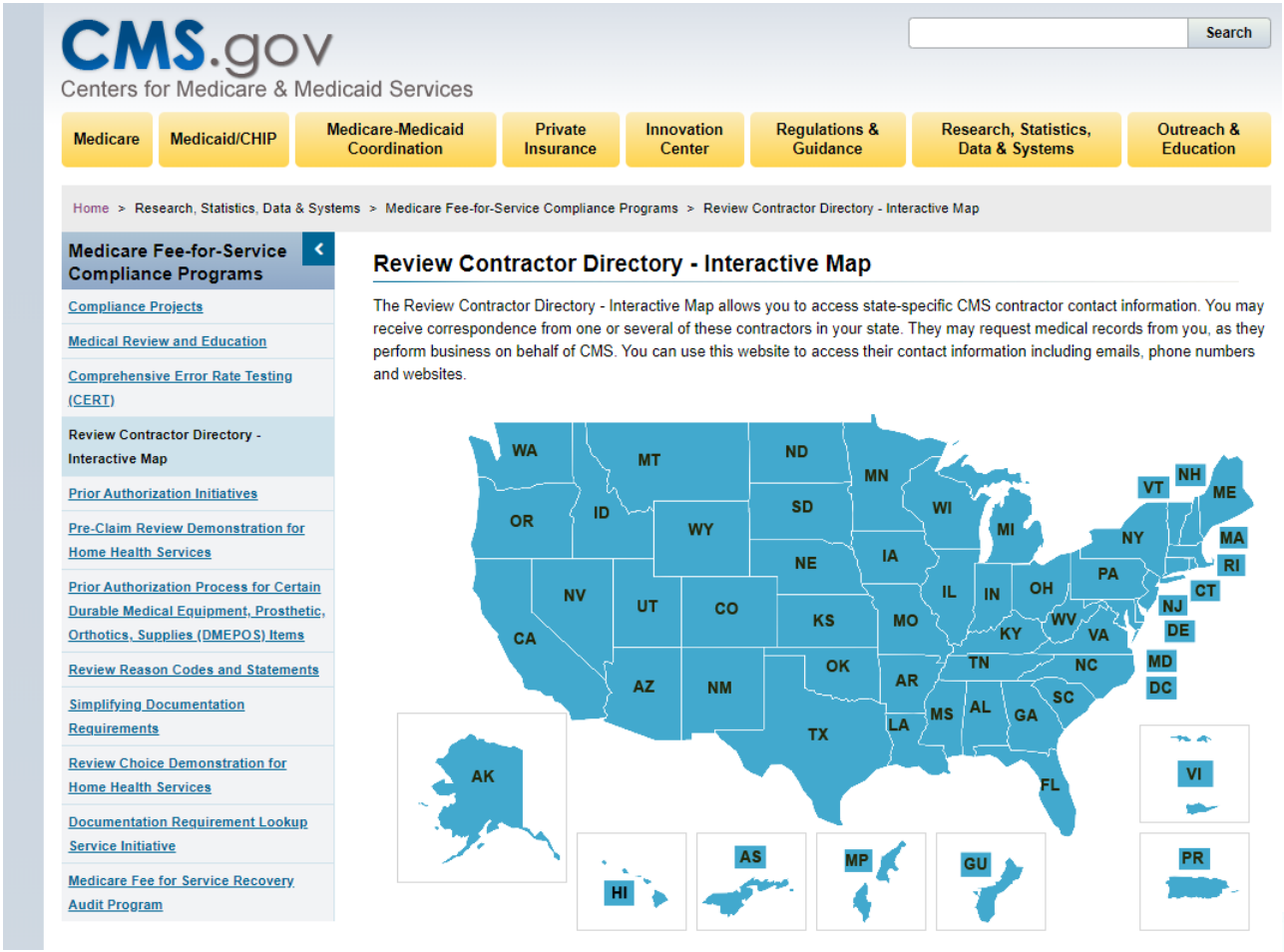
# Check with your Local MAC for Additional Policy Guidance




https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/Index

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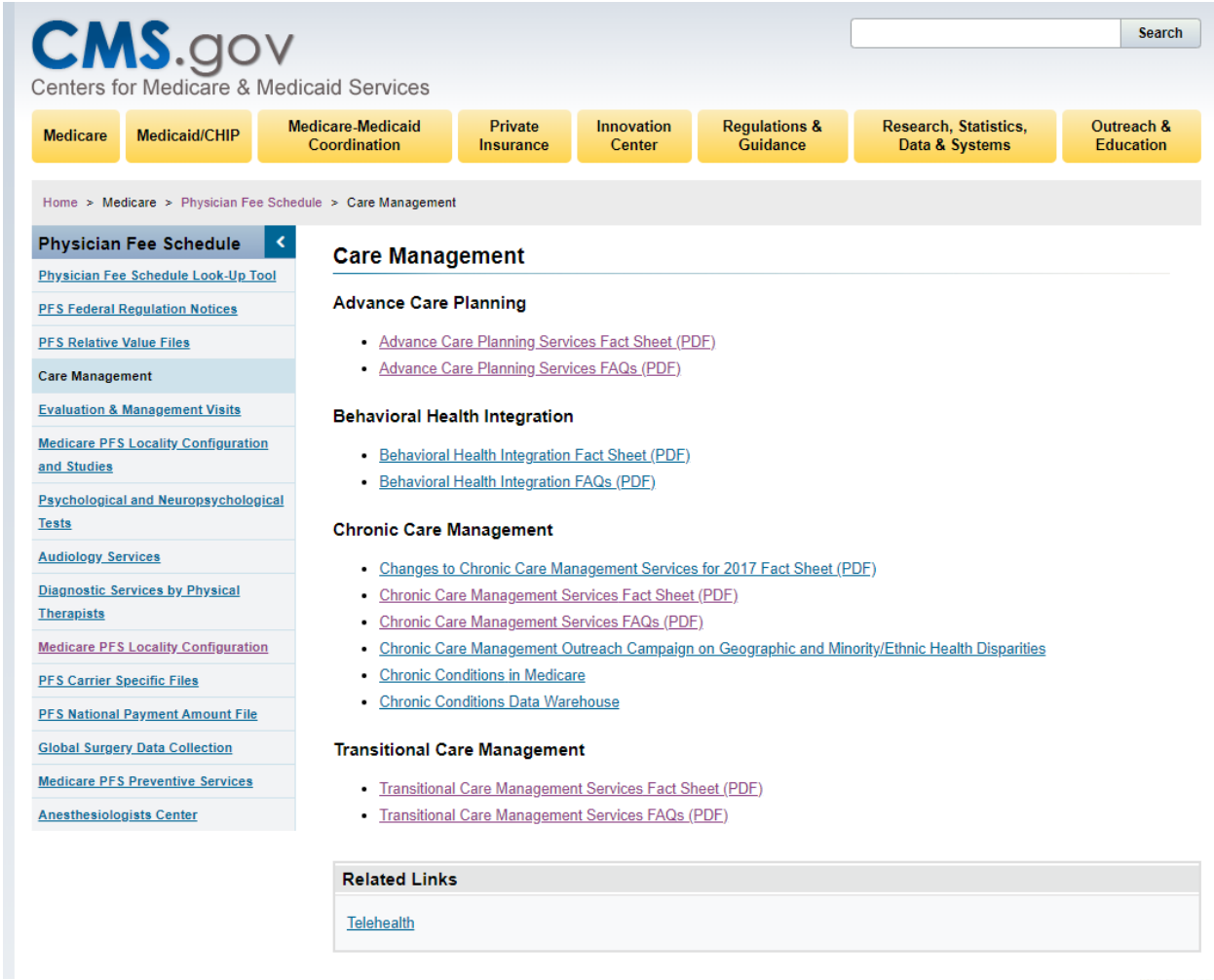
# CMS Educational Resources



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Home > Medicare > Physician Fee Schedule > Care Management

**Physician Fee Schedule**

- Physician Fee Schedule Look-Up Tool
- PFS Federal Regulation Notices
- PFS Relative Value Files
- Care Management
- Evaluation & Management Visits
- Medicare PFS Locality Configuration and Studies
- Psychological and Neuropsychological Tests
- Audiology Services
- Diagnostic Services by Physical Therapists
- Medicare PFS Locality Configuration
- PFS Carrier Specific Files
- PFS National Payment Amount File
- Global Surgery Data Collection
- Medicare PFS Preventive Services
- Anesthesiologists Center

## Care Management

### Advance Care Planning

- Advance Care Planning Services Fact Sheet (PDF)
- Advance Care Planning Services FAQs (PDF)

### Behavioral Health Integration

- Behavioral Health Integration Fact Sheet (PDF)
- Behavioral Health Integration FAQs (PDF)

### Chronic Care Management

- Changes to Chronic Care Management Services for 2017 Fact Sheet (PDF)
- Chronic Care Management Services Fact Sheet (PDF)
- Chronic Care Management Services FAQs (PDF)
- Chronic Care Management Outreach Campaign on Geographic and Minority/Ethnic Health Disparities
- Chronic Conditions in Medicare
- Chronic Conditions Data Warehouse

### Transitional Care Management

- Transitional Care Management Services Fact Sheet (PDF)
- Transitional Care Management Services FAQs (PDF)

**Related Links**

Telehealth

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# HCCIntelligence™ Virtual Office Hours: Ask the Experts

*An open forum for questions and answers*

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# Questions

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# HCCIntelligence™ Resource Center

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Monday through Friday

### Webinars

Every third Wednesday of the month, HCCI hosts a webinar on topics relevant to HBPC.

### Virtual Office Hours

Immediately following the monthly webinar, HCCI hosts Virtual Office Hours where experts address questions on any HBPC topic.

### Tools & Tip Sheets

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

The John A. Hartford Foundation

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# HCCI Upcoming Events

**HCCI Essential Elements of Home-Based Primary Care™ Workshop**
March 26-27, 2020 in Schaumburg, IL

**HCCI Advanced Applications of Home-Based Primary Care™ Workshop**
April 16-17 in Schaumburg, IL

**HCCI Workshop at American Association of Nurse (AANP) Practitioners National Conference**
June 23 in New Orleans, LA

**HCCIntelligence™ – Webinars**
Every third Wednesday of the month, HCCI hosts a free webinar on a clinical or practice management topic relevant to home-based primary care (HBPC).
Visit www.HCCInstitute.org for more details.

- Medication Management: The art of deprescribing medications
  Wednesday, March 18th, 4 pm – 5 pm CST

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# HCCI Consulting Services

## Relationship focused. Results driven.

HCCI is pleased to offer affordable consulting services that assist organizations in enhancing the patient experience, improve health outcomes, and reduce costs.

**Our consultants include:**

- **Providers** with extensive experience in HBPC.
- **Practice managers** skilled in running house call programs and recognized with national certifications in coding and medical auditing.
- **Other professionals** with expertise in strategic planning, marketing, education and training, and quality.

**To connect with HCCI, call 630.283.9222 or email help@HCCInstitute.org.**

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