HCCI
HOME CENTERED CARE INSTITUTE

Advanced Coding Opportunities

Purpose

This resource is intended for home-based primary care (HBPC) providers and practice staff and assists Home-Based Primary Care (HBPC) practices in understanding the advanced coding opportunities beyond Evaluation and Management (E/M) Current Procedural Terminology (CPT) codes that are available 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 reimbursements. Refer to the Centers for Medicare & Medicaid Services (CMS) Medicare Learning Network[1] (MLN) for a complete understanding of guidelines.

Transitional Care Management (TCM)

Transitional Care Management is the oversight and care management of 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. Research has shown practices that offer a TCM model of care reduce unplanned 30-day hospital readmissions by 30%. Consider implementing a process to manage your acute discharge patients through TCM to promote more timely 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 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 (Work wRVU 2.36, Centers for Medicare & Medicaid Services (CMS) National Payment Rate $187.67).
- 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 (Work wRVU 3.10, CMS National Payment Rate $247.94).
- Refer to the following HCCIntelligence Tools: Transitional Care Management (TCM) Face-To-Face Visit Requirements Transitional Care Management (TCM) Interactive Contact Requirements the Medicare Learning Network source[1] 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.

[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)

Chronic Care Management (CCM)

Chronic Care Management[2] (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 a comprehensive care plan to be created, implemented, monitored, and revised as necessary.

- Patient consent (verbal or written) must be obtained before initiating services; consent must be documented along with making the patient aware of applicable cost-sharing.
- 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).
- Patients enrolled in CCM must have an initiating visit, if required, structured recording of patient information using certified Electronic Health Record (EHR) technology, 24/7 access (after-hours on call), designated care team member, comprehensive a comprehensive care plan, management of transitions and referrals, home and community-based care coordination, and enhanced communication opportunities (e.g., patient portal electronic communications opportunities).
- The comprehensive care plan must include medication management and reconciliation, a complete problem list, expected outcome and prognosis, measurable treatment goals, cognitive and functional assessment, symptom management, planned interventions and identification of responsible individuals, environmental assessment, caregiver assessment, medical mangement, interaction and coordination with outside community resources and practitioners, 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 $42.22).
- HCPCS G2058- Add on code, can only be billed in conjunction with CPT 99490. Each additional 20 minutes of clinical staff time directed by a qualified provider per calendar month. Maximum of 2 units per month. (wRVU 0.54, CMS National Payment Amount $37.89).
- CPT 99491- At least 30 minutes of time personally performed by the physician or other qualified healthcare professional per calendar month (wRVU 1.45, CMS National Payment Amount $84.09).
- 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 $92.39).
- 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 $44.75).
- 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.

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

- 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.

Principle Care Management (PCM)

PCM Services[3] 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
- Patients enrolled in PCM require structured recording of patient information using certified Electronic Health Record (EHR) 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).
- HCPCS G2064 - PCM, 30 minutes of Provider time per month, single high-risk disease; CMS National Payment Amount $92.02; wRVU 1.45
- HCPCS G2065 - PCM, 30 minutes of clinical staff & Provider time per calendar month, single high-risk disease; CMS National Payment Amount $39.69; wRVU 0.61

Online Digital E/M Services (E-Visits)

The E-visits[4] 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 must be evaluative in nature. Do not report for nonevaluative communication, such as reviewing test results or scheduling appointments.
- Verbal consent must be obtained and documented
- The service cannot be related to an E/M visit that occurred within the past 7 days
- Cannot be reported during the global surgery period
- If within the 7 days of the digital communication you decide a face-to-face visit is needed, do not report the E-visit
- Clinical staff time may not be included
- 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; CMS National Payment Amount $15.52; wRVU 0.25
- CPT 99422 Online Digital E/M, cumulative 7days; 11-20 minutes; CMS National Payment Amount $31.04; wRVU 0.50

[3] 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 (Priciple care Management)

[4] 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 (Oneline Digital E/M Services (E-Visits)

- CPT 99423 Online Digital E/M, cumulative 7 days; 21 minutes or more; CMS National Payment Amount $50.16; wRVU 0.80
- HCPCS G2061 - Qualified nonphysician healthcare professional online E/M, cumulative 7 days, 5-10 minutes; CMS National Payment Amount $12.27; wRVU 0.25
- HCPCS G2062 - Qualified nonphysician healthcare professional online E/M, cumulative 7 days 11-20 minutes; CMS National Payment Amount $21.65; wRVU 0.44
- HCPCS G2063 - Qualified nonphysician healthcare professional online E/M, cumulative 7 days 21 minutes or more; CMS National Payment Amount $33.92; wRVU 0.69
- Qualified nonphysician healthcare professionals include licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists.

Advance Care Planning (ACP)

Advance Care Planning[5] (ACP) is a face-to-face discussion (with the patient and/or caregiver, family member or surrogate) that provides 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 end-of-life preferences.

- 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 a living will, power of attorney for healthcare, POLST (physician's 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 (wRVU- 1.50, CMS National Payment amount $86.98).
- 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 $76.15).
- May be billed when provided via telehealth using audio-only (phone call) technology as a result of the CMS Interim Final Rule[6] released on 04/30/20.

Prolonged Services Without Direct Patient Contact

Prolonged Services without Direct Patient Contact are when a qualifying provider (MD, DO, NP, PA) spends time that relates to an E/M face-to-face visit but goes above and beyond the usual time associated with that CPT code.

Medicare will reimburse for non-face-to-face prolonged services 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 of, 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 $113.68)
- 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 $55.58)
- Must be beyond the usual 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.

[5] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf (Advance Care Planning)

[6] https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

- 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.
- 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.
- Requires start and stop times, the total time, and date of service be documented in the medical record; the time does not need to be continuous, however, it must occur on the same calendar date (time cannot be added from various days).
- CMS published guidance[7] 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 Medicare Administrative Contractor (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.
- For E/M services in which 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.
- Prolonged Services Non-Face-to-Face is bundled, meaning it cannot be reported within the same calendar month as the following services: Care Plan Oversight (G0181, G0182), INR Monitoring Services (93792, 93793), Online Digital E/M (99421, 99422, 99423), General Behavioral Health Integration Services (BHI) (99484), Chronic Care Management (99487-9/ 99490/99491), and BHI Integrated Care Management (99492, 99493, 99494)

Prolonged Services With Direct Patient Contact

Prolonged Services with Direct Patient Contact are when a qualifying provider (MD, DO, NP, PA) spends extensive face-to-face time with the patient that exceeds the typical CPT code threshold time for that particular service. Medicare will reimburse for prolonged services[8] 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, in the outpatient setting, beyond the typical primary procedure service time, first hour, (wRVU 2.33, CMS National Payment Amount $132.09).
- CPT 99355 - Prolonged evaluation and management or psychotherapy, in the outpatient setting, each additional 30 minutes (listed separately in addition to 99354) (wRVU 1.77, CMS National Payment Amount $100.33).

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[9] or Coding Intel article[10].

- CPT 99483 - 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. (wRVU 3.44, CMS National Payment amount $256.26)

---

[7] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9905.pdf

[8] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5972.pdf

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

[10] https://www.codingintel.com/cpt-code-99483-cognitive-assessment-care-plan-services/

- 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.
  - 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 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.
- 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

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[11,12]. 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. (wRVU 0.24, CMS National Payment rate $15.52)
- CPT 99407 Smoking and tobacco use cessation counseling visit, intensive, greater than 10 minutes. (wRVU 0.50, CMS National Payment rate $29.59)
- 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

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

[12] https://www.codingintel.com/a2-smoking-cessation/ (Smoking Cessation Counseling Services)

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

An SBIRT 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). The Substance Abuse and Mental Health Services Administration (SAMHSA) Screening Tools webpage[13] includes more information on SBIRT assessment and other screening tools.
  - 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; CMS National Payment Amount $17.32; 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; CMS National Payment Amount $36.81; 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; CMS National Payment Amount $68.90; wRVU 1.30

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 home and outpatient International Normalized Ratio (INR) monitoring services in the management of anticoagulation therapy. For full details, please refer to the Medicare Learning Network source[14,15]. The two new services available are as follows:

[13] https://www.integration.samhsa.gov/clinical-practice/screening-tools (SAMHSA) Screening Tools webpage)

[14] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6313.pdf (Anticoagulation Management)

- 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 (No wRVU, National Payment Rate $66.40).
- CPT 93793 (wRVU- 0.18, CMS National Payment Rate $11.19).
- 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 (BHI) Care Management

General BHI, utilized for billing monthly services furnished by providing integrated behavioral health and primary care services. CPT code 99484 (wRVU 0.61, CMS National Payment Amount $48.00), 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[16] for full details.

Service elements includethe following:

- Systematic assessment and monitoring with the use of applicable validated rating scale; if initial assessment is required, it 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 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. For additional information, please visit the Medicare Learning Network link below or contact HCCI.

---

[15] https://www.codingintel.com/new-cpt-codes-2017-anticoagulation-management-education-for-home-inr-monitoring/ (Additional source Anticoagulation management)

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

Additional Key Coding Updates

- 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 (see below) were 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.

Interprofesional Consult Services

Following are the existing consult codes that 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 $18.41).
- 99447 - 11-20 minutes of medical consultative discussion and review (wRVU 0.70, CMS National Payment Amount $37.17).
- 99448 - 21-30 minutes of medical consultative discussion and review (wRVU 1.05, CMS National Payment Amount $55.58).
- 99449 - 31 minutes or more of medical consultative discussion and review (wRVU 1.40, CMS National Payment Amount $73.98).

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 (wRVU 0.70, CMS National Payment Amount $37.53).
- CPT 99452 (wRVU 0.70, CMS National Payment Amount $37.53).

Brief Communication Technology-Based Virtual Check-ins

Brief Communication Technology-Based Virtual Check-ins offer an opportunity for reimbursement for remote patient monitoring and virtual visits that avoid an unnecessary face-to-face visit and do not enforce rural or geographic area restrictions as the Medicare approved list of telehealth codes do.

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 thepast seven days and may not result in an E/M visit within the next 24 hours or next available appointment. (wRVU 0.18, CMS National Payment Amount $12.27)

- 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.
- Patient's verbal consent is required, and must be documented in the medical record to ensure they're aware of potential cost-sharing. As of 2020 annual consent for Communication Technology Based Services (CTBS) is allowed.
- Prerecorded 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 $14.80).

- 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)
- Patient's verbal consent required and must be documented in the medical record to ensure they're made aware of potential cost-sharing. As of 2020 annual consent for CTBS services is allowed.
- 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.