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Day 1

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The information provided in this handout was current as of May 20, 2020. Any changes or new information superseding the information in this handout will be provided in articles and publications with publication dates after May 20, 2020 posted at

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Today’s Agenda

Part 1
• Medical Affairs
  – Leland E. Garrett M.D., FACP, FASN, CPC
    Chief Medical Officer
    Contractor Medical Director

Part 2
• Transitional Care Management and Chronic Care Management:
  Meeting the Needs of Patients
  – Paula Motes, RN, BSN
    Senior Provider Education Consultant
Part 1
Mayfest 2020: Medical Affairs
May 27, 2020
Leland E. Garrett M.D., FACP, FASN, CPC
Chief Medical Officer
Contractor Medical Director
Medicare Jurisdiction JM and JJ

Medical Affairs Structure

- Edwin Sanchez, Vice President of Jurisdiction M A/B MAC Operations
- Debbie Dickson, Vice President of Jurisdiction J A/B MAC Operations
- Harry Feliciano, M.D., MPH, Senior Medical Director (IM, Geriatrics)
- Melissa Robinson, Project Administrator
- Leland E. Garrett, M.D., FACP, FASN, CPC, Medical Director (IM, Nephrology)
Medical Affairs Structure (cont.)

- **Gabriel Bien-Willner, M.D.**, Medical Director MolDx (Molecular Genetics, Pathology)
- **Shane Mull, M.D.**, Medical Director (Family Practice)
- **Miguel Brito, M.D.**, Medical Director Medical Affairs and MolDx (Pathology)
- **Jason Stroud, M.D.**, Medical Director (Family Practice)
- **Judith Volkar, M.D.**, Medical Director (Ob-Gyn)
- **Lisa Banker, M.D.**, Medical Director (Internal Medicine)

Medical Affairs Structure (cont.)

- **Kim Hinson, RN**, Director Medical Review
- **Daliyl Skinner**, Data Strategy Manager
- **Allison Smith, RN, Jennifer Cooke, RN, Blaire Seigler, RN, Candance Churchwell, RN, Tamara Powers, RN, Tamara Beard, RN**, Medical Affairs Coordinators
- **Christina Harmon**, Senior Operations Analyst
- **Kelley Wilson**, Administrative Assistant
Medical Director Duties

- The Contractor Medical Director (CMD) is a physician with expertise in Medicine and Medicare who works collaboratively with all contractor teams.
- The CMD is primarily responsible for clinical coverage determinations, such as Local Coverage Determinations (LCDs) and staff trainings on clinical matters, determinations regarding Investigational Device Exemption (IDE) requests, and collaborating with medical societies and peer groups to share information and provide education.

Medical Affairs and the PHE

- Medical Affairs activity during the Public Health Emergency (PHE)
  - MolDx MDs have been pricing the new laboratory codes for COVID-19 Testing.
  - Dr. Garrett, on invitation, has been a member of the N.C. Governor’s/DHHS Payer’s council and the Governor’s Health Coalition.
  - Staff has managed questions from stakeholders or forwarded them to the proper Palmetto divisions concerning the procedural and coverage waivers being published by the Centers for Medicare & Medicaid Services (CMS).
2021: An E/M Odyssey (Time to Decide)

Special Thanks

The assistance of Robert Lewis BA CPC, Provider Relations Representative, First Coast Service Options, Inc. is greatly appreciated.
Agenda

• 2020 Final Rule: Evaluation and Management (E/M)
• 2021 Current Procedural Terminology® (CPT®) revisions
  – Medical decision-making (MDM)
  – Time
• Additional services
• Resources

Objectives

• At the conclusion of this session you will be able to:
  – Identify 2020 Final Rule updates relating to E/M
  – Explain CPT revisions that will apply to office/outpatient service level determination starting in 2021
  – Realize that medical decision-making (MDM) and time can be sole determinants of levels of service
  – Define new terms that will apply to medical documentation for code selection in 2021
2020 Final Rule E/M

2020 Final Rule

- E/M coding to be aligned with changes adopted by American Medical Association (AMA) CPT® Editorial Panel
- Changes apply to office/outpatient visits NOT inpatient visits
  - Office/outpatient E/M visits = 20 percent of Medicare Physician Fee Schedule allowed services
  - Consistent with central goal: reduce the burden
  - Retain 5 levels of coding for established patients, reduce number of levels to 4 for new patients
  - Revise times and medical decision-making process for all codes
  - History and exam only required as medically appropriate
2020 Final Rule (Cont.)

• Current guidelines to be followed for all E/M in 2020
• To be implemented 2021:
  – Adopt the AMA Relative Value Update Committee (RUC) recommendations or office/outpatient visit codes for the calendar year (CY) 2021
  • Will increase payment for office/outpatient E/M visits
  – Apply new add-on CPT codes for prolonged service time

2021 CPT Revisions
CPT Revisions 2021

• Revisions made to E/M Guidelines related to office or other outpatient Codes 99202–99215
  – New code definitions and specific time spans for each level 99201 has been deleted

• New prolonged service code (99XXX)
  – To be used with 99205 or 99215 (when 15 minutes of additional time have been attained beyond the highest-level service)

CPT Revisions 2021(2)

• Instructions for selecting a level of office/outpatient E/M service is based on
  1. Total time for E/M services performed on the date of the encounter; or
  2. Level of medical decision-making (MDM) as defined for each service
CPT Revisions (3)

• Extent of History and Physical Examination is not an element in selection of office or other outpatient services.
  – Office/outpatient services include medically appropriate history and/or physical examination when performed
  – Nature and extent of history and/or physical examination are determined by professional reporting of the service
  – Care team may collect information from patient or caregiver via multiple methods (e.g. portal, questionnaire) for review by reporting provider
MDM 2021 Elements

- Number and complexity of problems addressed
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

MDM 2021 Codes and Levels

<table>
<thead>
<tr>
<th>CODE</th>
<th>LEVEL OF MDM</th>
<th>NUMBER AND COMPLEXITY OF PROBLEMS</th>
<th>AMOUNT OF DATA</th>
<th>RISK OF COMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>99202</td>
<td>STRAIGHT-FORWARD</td>
<td>MINIMAL</td>
<td>MINIMAL OR NONE</td>
<td>MINIMAL</td>
</tr>
<tr>
<td>99212</td>
<td>STRAIGHT-FORWARD</td>
<td>MINIMAL</td>
<td>MINIMAL OR NONE</td>
<td>MINIMAL</td>
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<tr>
<td>99203</td>
<td>LOW</td>
<td>LOW</td>
<td>LIMITED: Categories 1 &amp; 2</td>
<td>LOW</td>
</tr>
<tr>
<td>99213</td>
<td>LOW</td>
<td>LOW</td>
<td>LIMITED: Categories 1 &amp; 2</td>
<td>LOW</td>
</tr>
<tr>
<td>99204</td>
<td>MODERATE</td>
<td>MODERATE</td>
<td>MODERATE Categories 1 &amp; 2</td>
<td>MODERATE</td>
</tr>
<tr>
<td>99214</td>
<td>MODERATE</td>
<td>MODERATE</td>
<td>MODERATE Categories 1 &amp; 2</td>
<td>MODERATE</td>
</tr>
<tr>
<td>99205</td>
<td>HIGH</td>
<td>HIGH</td>
<td>EXTENSIVE Categories 1–3</td>
<td>HIGH</td>
</tr>
<tr>
<td>99215</td>
<td>HIGH</td>
<td>HIGH</td>
<td>EXTENSIVE Categories 1–3</td>
<td>HIGH</td>
</tr>
</tbody>
</table>

Source: AMA Table-CPT E/M Office Revisions, Level of MDM, effective 010121
Number and Complexity of Problems

• Multiple new or established problems may be addressed at the same time

• Symptoms may cluster around a specific diagnosis
  – Each symptom is not necessarily unique
  – Comorbidities/underlying disease are not considered in selecting a level of E/M unless addressed, and their presence must increase amount/complexity of data reviewed and analyzed or risk of complications/morbidity

• Final diagnosis, in itself, does not determine complexity or risk
  – Multiple problems of lower severity may, in aggregate, create higher risk due to interaction

MDM 2021 Definitions

• 22 definitions relating to elements of MDM or office/outpatient services
  – Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint or other matter addressed at the encounter with or without a diagnosis being established at the time of the encounter
    • Problem addressed
    • Minimal Problem
    • Self-limited or minor problem
    • Undiagnosed new problem with uncertain prognosis
Definitions (cont.)

• External Physician or Other Qualified Healthcare Professional individual, individual not in the same group practice or who is of a different specialty or subspecialty
  – Includes licensed professional practicing independently
  – May also be facility or organizational provider (i.e. hospital, nursing facility, home health care agency)

Definitions (cont.)

• Independent historian(s) individual (e.g., parent, guardian, surrogate, spouse, witness) who provides history in addition to history provided by patient who is unable to provide complete or reliable history (e.g., due to developmental stage, dementia, or psychosis) or because confirmatory history is judged to be necessary. In case a where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, independent historian(s) requirement is met.
Definitions (cont.)

• Social Determinants of Health
  – Economic and social conditions that influence the health of people and communities
  – Examples: Food or housing insecurity

• Additional Terms defined for Documentation
  – Risk: Test
  – Appropriate source: Morbidity
  – Acute, complicate injury: External
  – Drug Therapy: Stable Chronic illness

 Definitions (cont.)

• Additional items
  – Acute, uncomplicated illness or injury
  – Chronic illness with exacerbation, progression of side effects of treatment
  – Acute illness with systemic symptoms
  – Chronic illness with severe exacerbation, progression or side effects of treatment
  – Acute or chronic illness or injury that poses a threat to life or bodily function
  – Independent interpretation
Time Alone

- Beginning 2021
- Time alone may be used to select appropriate code level for office or other outpatient service codes
- Whether or not counseling/coordination of care dominated the service
- Requires face-to-face encounter with physician or other qualified health care professional
- For 99211, include time spent in supervision of clinical staff who perform face-to-face services
Total Time Activities

- Total time on the date of the encounter includes face-to-face and non-face-to-face time spent by physician and/or other qualified health care professional

Total Time Activities (cont.)

- Includes:
  - Preparing to see patient (review of tests)
  - Obtaining and reviewing separately obtained history
  - Performing medically appropriate examination or evaluation
  - Counseling and educating patient/family/caregiver
  - Ordering medications, tests or procedures
Total Time Activities (cont.)

• Includes:
  – Referring and communication with other health care professionals (when not separately reported)
  – Documenting clinical information in electronic or other record
  – Independently interpreting and communicating results to patient/family/caregiver (not separately reported)
  – Care Coordination (not separately reported)

Time Ranges

<table>
<thead>
<tr>
<th>Code</th>
<th>Time Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient</td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>15–29 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>30–44 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>45–59 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>60–74 minutes</td>
</tr>
</tbody>
</table>
## Time Ranges (cont.)

<table>
<thead>
<tr>
<th>Code</th>
<th>Time Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Established patient</strong></td>
<td></td>
</tr>
<tr>
<td>99211 deleted</td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td>10–19 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>20–29 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>30–39 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>40–54 minutes</td>
</tr>
</tbody>
</table>

---

## Prolonged Services
Prolonged Services Code

• Code 99xxx
  – Used to report prolonged total time provided by a physician or other qualified health care professional on date of office/outpatient services
  – Only used when time alone is the basis for office level code selection
  – Only after total time of highest-level service (i.e., 99205 or 99215) has been exceeded
    • To report a unit of 99xxx, 15 minutes of additional time must have been attained (do not report increments less than 15 minutes)
    • Time spent performing separately reported service is not counted

Prolonged Services Code (cont.)

• Codes 99354–99357 used when physician or other qualified health care professional provides prolonged service in either inpatient, observation or outpatient setting, except with office or other outpatient services
  – E/M services that require prolonged clinical staff time and may include face-to-face services by physician or other qualified health care professional, use 99415,99416
  – Do not report 99354,99355,with 99415,99416, or 99xxx
### Prolonged Services Table

<table>
<thead>
<tr>
<th>Duration of services</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New patient use with 99205</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 75 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>75–89 minutes</td>
<td>99205x1 and 99XXX x1</td>
</tr>
<tr>
<td>90–104 minutes</td>
<td>99205 x1 and 99XXX x2</td>
</tr>
<tr>
<td>105 minutes or more</td>
<td>99205 x1 and 99XXX x3 or more for each additional 15 minutes</td>
</tr>
</tbody>
</table>

### Prolonged Services Table

<table>
<thead>
<tr>
<th>Duration of services</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Established Patient use with 99215</strong></td>
<td></td>
</tr>
<tr>
<td>Less than 55 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>55–69 minutes</td>
<td>99215 x 1 and 99XXX x1</td>
</tr>
<tr>
<td>70–84 minutes</td>
<td>99215 x1 and 99XXX x2</td>
</tr>
<tr>
<td>85 minutes or more</td>
<td>99215 x1 and 99XXX x3 or more for each additional 15 minutes</td>
</tr>
</tbody>
</table>
Additional Services

Separate Services

• Any specifically identifiable procedure/service (i.e., identified with CPT code) performed on the date of the E/M service may be reported separately
  – Performance/interpretation of diagnostic tests/studies during patient encounter are not included in determining levels of E/M when reported separately
    • If the test/study is independently interpreted to manage patient as part of the E/M but not separately reported, is part of MDM
  – If E/M service caused by symptoms or condition for which a procedure was provided modifier 25 may be added to the appropriate level of E/M
    • Different diagnoses not required for reporting procedure and E/M on same day
Shared/Split Visits

- Visits in which physician and other qualified health care professional jointly provide face-to-face and non-face-to-face work related to visit
  - When time use to select level of service, total time is summed to define total time
    - If two or more individuals meet jointly with or to discuss patient, only time of one individual will be counted

Contacts

- Jurisdiction J Provider Contact Center 877–567–7271
- Jurisdiction M Provider Contact Center 855-696-0705
  - They can place you in contact with the appropriate department for your answers
- Also see the contact listings on the Palmetto GBA website
  - Jurisdiction J
  - Jurisdiction M
Contacts (cont.)

- Send reconsideration requests and specific NCD/LCD/LCA questions to B.Policy@palmettogba.com
- If ALL else fails:
  - Leland E. Garrett, M.D., FACP, FASN, CPC
  - leland.garrett@palmettogba.com
  - (803) 763–6306

Part 2
Mayfest 2020: TCM and CCM: Meeting the Needs of Patients
May 27, 2020

Paula Motes, RN, BSN
Senior Provider Education Consultant
Palmetto GBA
Provider Outreach and Education
Agenda

- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
The Burden of Chronic Disease

- Half of adults in the U.S. suffer from a chronic condition
- 25 percent of Americans have two or more chronic conditions
- Two-thirds of Medicare beneficiaries have two or more chronic conditions
- 86 percent of health care spending in U.S. is on people with chronic conditions
- 99 percent of Medicare spending is on patients with chronic conditions
- Seven of the top 10 causes of death are from chronic conditions

What is Chronic Care Management (CCM)?

Chronic care management refers to care coordination services done outside of the regular office visits provided by a physician or nonphysician practitioner and their clinical staff for patients with multiple chronic conditions (expected to last at least 12 months or until death) that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
CCM

- A threshold amount of clinical staff time is required per month
- Requires more centralized management of patient needs
- Involves extensive care coordination

Person-centered care

Benefits of CCM

- Contributes to better health outcomes and higher patient satisfaction
- Improves quality and reduces gaps in care
- Provides care coordination
- Provides person-centered care
Patient Eligibility

- Must have two or more chronic conditions
- Expected to last at least 12 months or until death
- Place them at significant risk of death, acute exacerbation, or functional decline
- Must have no other diagnostic limitations

Examples of Chronic Conditions

- Alzheimer’s Disease and related dementia
- Arthritis
- Asthma
- Atrial Fibrillation
- Autism
- Cancer
- Cardiovascular Disease
- COPD
- Depression
- Diabetes
- Hypertension
Core Service Elements

• Initiating Visit
• Patient Consent
• Structured Recording of Patient Information Using Certified EHR Technology
• 24/7 Access and Continuity of Care

Core Service Elements (Continued)

• Comprehensive Care Management
• Comprehensive Care Plan
• Management of Care Transitions
• Care Coordination
  • Home- and Community-Based
  • Enhanced Communication Opportunities
Getting Started

Initiating Visit

- New patients or patients not seen within one year
- Performed by billing practitioner
- Face-to-face encounter
- Separately billed (not part of CCM code)

Patient Consent

- Obtain prior to furnishing CCM services
- Oral or written
- Inform patient
  - Availability of CCM services
  - Applicable cost sharing
  - Right to stop services at any time
  - Only one practitioner can provide this service
- Document in medical record
Meeting The Requirements

**Structured Recording of Patient Information**

- Must use **certified** Electronic Health Record (EHR)
- **Record**
  - Patient demographics
  - Problems
  - Medications
  - Allergies
  - Care Plan
  - Care coordination
  - Clinical care provided

Meeting The Requirements

**24/7 Access and Continuity of Care**

- Access 24 hours per day, seven days per week
- Access to qualified health care professionals
- Provide patient/caregiver with means to make contact
- Designated team member for the patient
- Enhanced opportunities for communication
Meeting The Requirements

Comprehensive Care Management

- Systematic assessment of patient needs
- Approach to ensure preventive care
- Medication reconciliation/review
- Oversight of patient self-management
- Coordination of care

Meeting The Requirements: Comprehensive Care Plan

- Problem list
- Expected outcome and prognosis
- Measurable Treatment goals
- Symptom management
- Planned interventions and responsible parties

- Medication management
- Community/social services ordered
- Description of coordination of outside services
- Schedule for review/revision of care plan
- Any other applicable information
Meeting The Requirements

**MANAGEMENT OF CARE TRANSITIONS**
- Among health care providers
- From setting to setting
- Referrals
- Follow-up

**CARE COORDINATION**
- Home- and community-based
- Psychosocial needs
- Functional needs

Who Can Bill CCM?

**Eligible Practitioners**
- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Nurse Midwives

**Other Eligible Healthcare Entities**
- Federally Qualified Health Centers (FQHC)
- Rural Health Centers (RHC)
- Hospital Outpatient Departments
Billing: Initiating Visit

- **CCM Initiating Visit**
  - AWV
  - IPPE
  - TCM
  - Other face-to-face E/M

- **Add-on to CCM Initiating Visit**
  - HCPCS G0506
  - Care planning established
  - Billing practitioner personally performs extensive assessment and CCM care planning beyond the usual effort

Levels of Care

<table>
<thead>
<tr>
<th>Billing Code</th>
<th>Clinical Staff Time</th>
<th>Care Planning</th>
<th>Billing Practitioner Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Complex CPT 99490</td>
<td>20 minutes or more of clinical staff time</td>
<td>Established, implemented, revised or monitored</td>
<td>Ongoing oversight, direction and management</td>
</tr>
<tr>
<td>Non-complex CCM 99491</td>
<td>30 minutes or more of clinical staff time</td>
<td>Established, implemented, revised or monitored</td>
<td>Ongoing oversight, direction and management</td>
</tr>
<tr>
<td>Complex CCM CPT 99487</td>
<td>60 minutes</td>
<td>Established or substantially revised</td>
<td>Ongoing oversight, direction and management PLUS Medical decision-making of moderate-high complexity</td>
</tr>
<tr>
<td>Complex CCM Add-on CPT 99489, use with 99487</td>
<td>Each additional 30 minutes of clinical staff time</td>
<td>Established or substantially revised</td>
<td>Ongoing oversight, direction and management PLUS Medical decision-making of moderate-high complexity</td>
</tr>
</tbody>
</table>
Billing Guidelines

- Bill once per calendar month
- Can only be billed by one practitioner per calendar month
- Time counted toward the reporting of a CCM code cannot be counted towards any other billed code
- Date of service can be the date that the requirements to bill for the service have been met for that month, or any date after that but on or before the last day of the month
- Supervision: General

Billing Restrictions

- Do not bill both complex CCM and non-complex CCM for a given patient during the same month
- Do not bill CCM during the same service period as home health care supervision or hospice care supervision
- Do not bill concurrently with certain End-Stage Renal Disease services
- Do not bill during the 30-day TCM service period
- Complex CCM and prolonged E/M services cannot be billed in the same calendar month by the same practitioner
- Other services excluded by CMS reporting rules or additional CMS guidance
FQHC and RHC CCM Billing

- Report with HCPC code G0511, revenue code 052x
- May be billed or alone or with other payable services
- Can only bill one care management service for an individual
- Payment is average of the national non-facility PFS payment rate for CPT codes 99490, 99487, 99491 and 99484
- Coinsurance and deductibles apply to all care management services in RHCs
- Coinsurance applies to all care management services in FQHCs

Hospital Outpatient Departments

- POS-practitioners who furnish CCM in the hospital outpatient setting, including provider-based locations, must report the appropriate place of service for the hospital outpatient setting
- Payment for CCM furnished and billed by a practitioner in a facility setting will trigger PFS payment at the facility rate
- CPT 99490 cannot be billed to the PFS for patients who reside in a facility that receives payment from Medicare for care of that beneficiary
Transitional Care Management (TCM)

- Services during the beneficiary’s transition to the community setting following discharge from certain health care facility settings
- Health care professionals take responsibility for the beneficiary’s post-discharge care
- No gap in care during this transition
- Moderate or high complexity medical decision-making
- TCM period is 30 days
Approved TCM Settings

**DISCHARGE FROM**
- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long-Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

**DISCHARGE TO**
- Home
- Domiciliary
- Rest home or Nursing Home
- Assisted living facility

TCM Components

**Interactive Contact**
- Must occur within **two business days** following the beneficiary’s discharge
- With the beneficiary or their caregiver
- Via telephone, email, or face-to-face
- Address patient status and needs
- Document attempts at contact in the medical record
TCM Components

• Must furnish one face-to-face visit
  • Must be furnished within the allowable timeframe
  • May be furnished via telehealth (if all telehealth requirements are met)
  • Not reported separately

TCM Components

• Non-face-to-face services: **Physicians and Nonphysician Practitioners**
• Non-face-to-face Services: **Clinical Staff**
  - Provided under the direction of Physician or NPP
TCM Services

CPT Code 99495 — Transitional care management with the following required elements
- Contact within two business days of discharge
- Medical decision-making of at least moderate complexity
- Face-to-face visit within 14 calendar days

CPT Code 99496 — Transitional care management with the following required elements
- Contact within two business days of discharge
- Medical decision-making of high complexity
- Face-to-face visit within seven calendar days

Documentation

Minimum Documentation Requirements
- Beneficiary discharge date
- Interactive contact date
- Face-to-face visit date
- Medical complexity decision-making
**TCM Billing**

- Report services once per beneficiary during the TCM period
- May be reported by only one health care professional
- May be billed by the same practitioner that discharged the beneficiary from the hospital and billed discharge services
- Required TCM face-to-face cannot take place on the same day the practitioner reported discharge day management services
- Bill reasonable and necessary E/M services separately (except required TCM face-to-face)

**TCM Billing**

- Cannot bill TCM within a post-operative global period (same practitioner)
- Date of service reported on claim should be the date of service of the face-to-face visit
- May submit claim once the face-to-face visit is furnished
- Place of service (POS) reported on the claim should correspond to the place of service of the TCM face-to-face visit
Billing Restrictions

• When billing CPT codes 99495 or 99496, do not bill the following services during the TCM service period:
  – Can Plan Oversight Services
  – Home health or hospice supervision (G0181/G0182)
  – End-Stage Renal Disease services (90951–90970)
  – Chronic Care Management Services
  – Prolonged E/M Services (99358–99359)
  – Other services excluded by CMS reporting rules or additional CMS guidance

Resources


Physician Fee Schedule: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html
What’s Next?

• Register and join us for Day 2 of the JJ/JM Part B Mayfest Virtual Symposium:
  – When: May 28, 2020, 10 a.m., ET
  – [Link](https://event.on24.com/wcc/r/2296423/2DD10FABBE6C7246630F602E19C93B78)
  – Topics
    • Medicare Part B Jurisdiction J and M Clinical Updates
    • Top Time-Saving Tools for Palmetto GBA Providers

Thank You!
Please Take a Moment to Complete Our Post Test

Post-Test Link: