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2020 Medicare Physician Fee Schedule and Quality Payment Program CMS Final Rule CPT Codes 99453, 99454, and 99457 Everything You Need to Know

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CARE MANAGEMENT SERVICES

CMS is taking steps to further refine the codes for transitional care management (TCM) and chronic care management (CCM). They have also created new codes for principal care management (PCM) services for patients that have only one serious condition.

Transitional Care Management (TCM)

CMS has finalized their proposal to allow for concurrent billing with TCM services in the following code families:

Prolonged services without direct patient contact

Home and outpatient international normalized ration monitoring services

End stage renal disease services

Interpretation of physiological data (RPM)

Chronic care management

Complex chronic care management services

Care plan oversight services.

See the full text for list of specific codes.

Chronic Care Management (CCM)

CMS had proposed to adopt two new G codes with new increments of clinical staff time instead of the existing single CPT code (99490), and two additional G codes to be used to establish and revise a comprehensive care plan. However, in response to commenters concerns that the temporary G codes replacing most of the CCM code set would create administrative burden, CMS has chosen to only finalize one code (G2058 – the add-on code for additional clinical staff time), because it addresses the need for a code to bill for additional time increments for non-complex CCM. G2058 could be reported a maximum of two times within a given service period for a given beneficiary.

Principal Care Management (PCM)

CMS has finalized their proposal to establish separate coding and payment for principal care management (PCM) services, which describes care management services for one serious chronic condition (as opposed to the multiple chronic conditions covered by CCM). A qualifying condition would be expected to last between 3 months and a year or until death, may have led to a recent hospitalization and/or place the patient at significant risk of death, acute exacerbation, decompensation or functional decline. The services would include coordination of medical and/or psychosocial care related to the single complex chronic condition, provided

by a physician or clinical staff under the direction of a physician or other qualified health professional.

Due to the similarity between the description of the PCM and CCM services, both of which involve non-face-to-face care management services, the full CCM scope of service requirements would apply to PCM, including documenting the patient's verbal consent in the medical record. PCM could not be billed by the same practitioner for the same patient concurrent with certain other care management services, such as CCM, behavioral health integration services and monthly capitated ESRD payments.

New Principle Care Management Codes:

HCPCS code G2064 – Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

HCPCS code G2065 – Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

CMS expressed concerns that this separate coding could result in a patient with multiple chronic conditions having their care managed by multiple practitioners, each only billing for PCM, which could potentially result in fragmented patient care, overlaps in services, and duplicative services. They are finalizing a requirement that ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record.

CHRONIC CARE REMOTE PHYSIOLOGIC MONITORING SERVICES

One of the codes established in Sept. 2018 CPT Editorial Board for remote physiologic monitoring was 99457. Effective for CY 2020, the code has been revised, still with 99457 as the base code that describes the first 20 minutes of treatment management services, but then allows for use of an add on code, for subsequent 20 minute intervals (99458). The codes now only require that these services be delivered with general supervision of auxiliary personnel by a physician or other qualified healthcare professional, as opposed to direct supervision, as previously required.

CMS also clarified that RPM services are not separately billable for FQHCs and RHCs because it is included in the RHC All-Inclusive Rate (AIR) or FQHC Prospective Payment System (PPS) payment.

CONSENT FOR COMMUNICATION TECHNOLOGY-BASED SERVICES

In the CY 2019 PFS, CMS finalized payment for a number of communication technology-based services, including brief virtual check in services and interprofessional consultation. Currently consent is required for each service delivered through communication technology-based services, in part to ensure that patients are aware of any fee sharing they may be responsible for. However, based on feedback CMS received that obtaining consent for each and every one of these services is burdensome, they have revised this policy for CY 2020 to only require consent once a year for technology-based services.

ONLINE DIGITAL EVALUATION SERVICE (E-VISIT)

CMS is finalizing their proposal to create new G-codes that describe the performance of an online "assessment" rather than an "evaluation" so that qualified non-physician health care professionals that fall outside the category of a practitioner able to bill for "evaluation codes", may bill for those services.

The new codes are as follows:

G2061 – Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes.

G2062 – Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes.

G2063 – Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

These codes would be valued at a lower rate than when the service is furnished by a physician because the work is likely less, due to the acuity of the patient.

ORIGINATING SITE FACILITY FEE

For CY 2020 the payment amount for HCPCS code Q3014 (the telehealth originating site facility fee) will be 80% of the lesser of the actual charge or $26.56.