Vivifyhealth®

MOVING CLOSER TO EMBRACING REMOTE CARE

Healthcare Moving Closer to Embracing Full Remote Care in 2020

New CMS billing codes for telehealth and remote patient monitoring do more to connect the dots between connected care and reimbursement.

Note: It is possible for CMS to provide updates to billing codes at any time throughout the year.
For the most up-to-date information, check with CMS.

THE VIVID SUMMARY

After years of decline, physician office margins began to improve slightly from 2017 to 2018. Still, money remains tight for many offices due to a combination of factors, including ongoing struggles with the transition from fee-for-service (FFS) to value-based care, ever-growing government regulations, the rise in patient self-pay due to higher insurances premiums and the increase in high-deductible health plans, and physician offices' failure to take full advantage of risk adjustment factors in Medicare Advantage plans that offer additional revenue for caring for the sickest among us.

One way physician offices have attempted to address revenue shortfalls is by increasing the number of patients they see in a day. To make room, they have gone to shorter appointments – often scheduling patients for as little as 15 minutes each. Yet the net result tends to be a focus on illness rather than wellness, which is opposite the direction in which healthcare is supposed to head – and an unsatisfactory experience for both patients and providers, especially when providers inevitably fall behind schedule.

Another strategy is to extend office hours to accommodate more patients. Yet longer hours coupled with higher reporting expectations frequently leads to physician dissatisfaction and burnout. As risks of a physician shortage grow just in time for a significant rise in the number of elderly, higher-risk patients due to the aging Baby Boomer population, the pressure on the entire healthcare ecosystem becomes enormous.

Telehealth/telemedicine solutions, including remote patient monitoring (RPM) offer significant potential to relieve many of these stressors for healthcare organizations. Especially those serving large populations of Medicare patients.

When physician offices and patients are properly equipped, physicians can use telehealth to interact with patients between in-person appointments, and even do virtual check-ins and some monthly assessments in addition to RPM. They don't have to worry about angering a waiting room full of restless, impatient patients since remote calls can be initiated at the convenience of physicians and patients. Additionally, RPM offers physicians

a more complete health picture of patients over time versus the “snapshot” approach of taking vital sign and other readings in the office, giving them better insights into overall health trends, and a way to intervene earlier if a patient begins to decline

As reimbursement for more types of telehealth and RPM increases, physicians can generate additional revenue by incorporating these solutions while also doing a better job of engaging patients and improving patient satisfaction. RPM also removes one of the most common Social Determinants of Health (SDoH) barriers among elderly and low-income populations, i.e., a lack of transportation to travel to and from a physician’s office.

Telehealth/RPM is good for patient relationships (and satisfaction scores) as patients don’t have to take time off work, arrange childcare or solve other domestic challenges just so they can drive across town and wait. Instead, the entire process can be completed in 20-30 minutes during the month, start to finish. That is far more appealing than taking an hour or more out of their day for one or more simple biometrics, like a blood pressure check. It also means patients can continue on with their lives, just taking a few minutes per day to respond to some automated questions, biometrics, and perhaps view an educational video, and their physician or care team may contact them via secure messaging or virtual visit.

Physicians and patients aren’t the only ones with growing interest in telehealth/RPM. The Centers for Medicare and Medicaid Services (CMS) is increasingly recognizing its benefits and is changing its regulations accordingly – which is the subject of this report.

What is a MAC:

A Medicare Administrative Contractor (MAC) is a private healthcare insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B (A/B) medical claims, the focus of this report, or Durable Medical Equipment (DME) claims for Medicare Fee-For-Service (FFS) beneficiaries. CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. MACs are multi-state, regional contractors responsible for administering both Medicare Part A and Medicare Part B claims.

Links:

https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC

https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/AB-Jurisdiction-Map-Jun-2019.pdf

https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Downloads/MACs-by-State-June-2019.pdf

In the past, reimbursement for telehealth and RPM was often limited by type and geography, and the requirements to provide and bill for it were complex and difficult to understand. That is now changing, especially as CMS looks to improve care and reduce costs for patients in Medicare Part B or in value-based care like Medicare Advantage plans.

New 2020 Billing Codes

Here are some of the newly available 2020 billing codes you can learn more about:

Chronic Care Remote Physiologic Monitoring Codes
(99453, 99454, 99457, & 99458)

Cover set-up of devices and patient education on using the equipment, the device(s) used for monitoring, and both standard and extended actual RPM and treatment management services.

Virtual Check-in Codes
(G2012)

Enables physician offices to bill for 5-10-minute technology-enabled remote conversations their physicians or qualified healthcare professionals have with established patients.

Chronic Care Management (CCM) Codes
(99490, 99478, 99489, GCCC1 & G2058)

For non-face-to-face time apply to working with patients in CCM programs who have two or more conditions.

Principal Care Management (PCM)
(G2064, G2065)

For patients with one chronic disease or high-risk condition.

Transitional Care Management (TCM)
(99495, 99496)

For transitional care management (TCM), i.e., ensuring prompt contact with patients within 2 days of discharge.

Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Management Services
(99492, 99493, 99494, 99484)

For additional revenue opportunities while helping to remove barriers to patient activation and engagement in their plans of care.

Monthly Telehealth ESRD-related Dialysis Clinical Assessments
(90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961, 90963 & 90970)

For patients with ESRD who are on dialysis generally receive monthly clinical assessments from their nephrologists.

Opioid and Substance Abuse Disorders
(G2086, G2087, G2088)

For treating substance abuse disorder (including opioids) with or without a co-occurring mental health disorder. Assessments can now be performed in the home rather than requiring an office visit.

This document will explain the changes that take effect in 2020 as well as how providers can take advantage of them. It will provide an overview of the steps needed for physician offices to submit claims to CMS. We strongly recommend conferring with a billing specialist and/or your Medicare Administrative Contractor (MAC) to determine the specifics for your practice. (This report will not include Medicaid strategies, however, since that program is administered state-by-state and requires a separate, more complex discussion.)

It will also stress the importance of providers as a whole taking advantage of the opportunities for telehealth and RPM to guard against CMS removing them in the future due to a lack of interest.

Ready?

The Changing Landscape for Telehealth and RPM

Before we look into how specific new codes will affect reimbursement, it is important to define what is meant by telehealth and RPM.

Through 2019, the industry was still operating under definitions CMS put in place in 2001. These definitions said Telehealth was limited to live, real-time, synchronous voice and video contact; no "store and forward" allowed except for federal demonstration projects in Alaska and Hawaii. The rules also stated the beneficiary must present in a health professional shortage area (HPSA). CMS specified what could be an originating site (skilled nursing facility, hospital, etc.) as well as who qualified as a distant site practitioner (physician, nurse or stipulated medical professional). Finally, CMS limited telehealth services to psychotherapy, pharmacologic management, nutrition therapy, smoking cessation, transitional care management and end stage renal disease services. In 2020, as we will explore, the definition of telehealth becomes much broader.

CPT code 99091

Originally, all remote patient monitoring was primarily covered under a single Current Procedural Technology (CPT®) code: 99091. This code covered "collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time."

In 2018, this single code was unbundled to provide more flexibility in where and how RPM was administered, and it has been expanded again. As a result, a recent Spyglass report shows that 88% of physicians have now invested in or are evaluating investments in it.

For those who are new to telehealth and RPM, the new regulations we are about to discuss may seem complex. It is important to note, however, that CMS has been making a concerted effort to make getting reimbursed for telehealth/RPM care easier. Vivify has both the technology and the expertise to further simplify the process and help providers use telehealth and RPM to improve patient care and outcomes while creating new revenue streams.

Now with that background let's look more closely at the specific changes coming into play for telehealth/RPM care for Medicare patients in 2020.

Chronic Care Remote Physiologic Monitoring Codes

Three new CPT codes for physiologic monitoring went into effect January 1, 2019: 99453, which covers set-up of devices and patient education on using the equipment; 99454, which covers the device(s) used for monitoring; and 99457, which covers the actual RPM and treatment management services.

- **Code 99453** can only be used once per episode of care, which makes sense because there will only be one instance of set-up of devices and instruction on how to use them. In 2019, CMS paid approximately $19.46 per instance. For 2020, the average payment will be approximately $18.77.

- **Code 99454** can be used once for each 30-day period the approved devices for monitoring and transmission of data to the contact center are in use. Each device should be coded separately. Again, CMS is reducing the amount it will pay, from approximately $64.15 in 2019 to an approximate $62.07 in 2020.

- **Code 99457** covers the first 20 minutes each month that clinical staff, the physician or other qualified healthcare professionals spend communicating with the patient or caregiver about the RPM program or specific services within it. It pays the same amount regardless of how many parameters are being monitored. In 2019 it paid approximately $51.54 for non-facility and $32.44 for facility-based contacts. In 2020, CMS is slightly adjusting the payment to $51.61 non-facility and $32.84 facility based physiologic monitoring services.

Code 99458

If your patient(s) require more time during the month, there is great news. A new CPT code, 99458, takes effect on January 1, 2020. This code proposes paying approximately $36.09 for up to two additional 20 minute blocks of time in a calendar month spent on treatment management services by non-facility clinical staff and approximately $27.07 for facility clinical staff. This new code reflects the realities of RPM and the amount of time required to optimize health outcomes and patient management. The caution is that providers must remember to bill against 99457 for the first qualifying 20 minutes each month, then use 99458 in subsequent 20 minute blocks that month.

Change to Incident to General Supervision for CPT codes 99457 and 99458

Another significant and welcome change to regulations for reporting RPM services in 2020 is that **CPT codes 99457** and the new **99458**, designated as care management services, can now be furnished incident to the general supervision of the billing provider, instead of the previous direct supervision requirement.

What this means is that the physician or other qualified healthcare professional[1] supervising the clinical staff delivering the RPM service does not have to be located in the same site as the person or group delivering the treatment management services. This is a welcome change for providers focused on broader population health management initiatives since aggregating contacts in a single contact center can be restricted by space or other resources, and allowing the clinical staff to be in other locations enables efficiencies for greater economies of scale.

1 According to CMS, a qualified healthcare professional is an individual who is qualified by education, training, licensure/regulation (where applicable), and facility privileging (where applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from clinical staff, which is defined as a staff member who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional services, but who does not individually report that professional service. Examples of a qualified healthcare professional include nurse practitioners, certified nurse specialists, physician assistants, clinical social workers and physical therapists.

Virtual Check-ins by Healthcare Professionals

- **HCPCS code G2012**, which went into effect January 1, 2019, enables physician offices to bill for 5-10-minute technology-enabled remote conversations their physicians or qualified healthcare professionals have with established patients. Examples include real-time audio-only telephone interactions and synchronous, two-way audio interactions enhanced with video or other data.

- **HCPCS code G2012** is in effect as long as the conversation isn't related to evaluation and management (E/M) services provided in the previous seven days or doesn't lead to an E/M service or procedure within the next 24 hours or soonest available appointment (if more than 24 hours). There are no other restrictions on the frequency of these check-ins, making this code particularly appropriate for chronic care management (CCM) patients.

Billing rates in 2019 were approximately $14.78 for non-facility and $13.33 for a facility-based payment. For 2020 the payment will be approximately $12.27 for non-facility and $9.38 for a facility.

It is important to understand one physician can bill for CCM and RPM for the same patient in the same month but must spend 20 minutes separately on each. Additionally, two physicians, such as a primary care physician (PCP) and a specialist, cannot bill for CCM in the same month.

Chronic Care Management (CCM) Codes for 2 or More Conditions

Chronic Care Management began in 2015, with improvements in 2017, and more changes for 2020. These codes for non-face-to-face time apply to working with patients in CCM programs who have two or more conditions. CMS recognizes that helping these patients manage their chronic conditions is time-consuming but pays huge dividends in keeping them healthier (and out of the ED or inpatient stays).

Because they are time-based codes, the tools being used to document the encounters must be accurate in the way they capture time spent. The data must then be transferred to a certified electronic medical records (EMR) system for billing to CMS.

Code 99490

CPT code 99490 is for at least 20 minutes of non-complex Chronic Care Management of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements:

- **Multiple (2 or more) chronic conditions expected to last at least 12 months or until the death of the patient;**
- **Chronic conditions place the patient at significant risk of death, acute exacerbation, decompensation, or functional decline;**
- **Comprehensive care plan established, implemented, revised, or monitored**

Code GCCC1

For 2020, this is now HCPCS code GCCC1 for the initial 20 minutes during a calendar month, the 2020 rates are approximately $42.22 non-facility, and $32.84 facility.

Code G2058

For the second or third 20-minute increment of non-complex CCM care, the HCPCS code is G2058 and the 2020 rates are approximately $37.89 non-facility, $28.84 facility.

Code 99478

CPT code 99487 covers the first 60 minutes of clinical staff or QHP or Provider time for moderately or highly complex CCM, and in 2019 paid approximately $92.98 for non-facility and $52.98 for facility-based contacts per encounter. The 2020 rates will be approximately $92.39 and $53.41 respectively.

Code 99489

CPT code 99489 is for high or moderate complexity patients who require more time, covering an additional 30 minutes where the Comprehensive care plan is established, implemented, revised, or monitored. The 2019 rates were $46.49 for non-facility and $26.67 for facility-based encounters. The 2020 rates will be approximately $44.75 and $26.35 respectively.

Principal Care Management (PCM)

For patients with one chronic disease or high-risk condition, there are new codes for 2020. These new HCPCS codes for Principal Care Management services may be utilized for comprehensive care management services of at least 30 minutes of physician or other qualified healthcare professional time per calendar month where one complex chronic condition lasts at least 3 months, is the focus of the care plan, the patient is at risk of hospitalization or has been recently hospitalized and the condition requires development or revision of disease-specific care plan, frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to co-morbidities.

- **HCPCS code G2064 is for at least 30 minutes of physician or other qualified healthcare professional time per calendar month, and 2020 rates will be approximately $92.03 for non-facility, and $78.68 for facility.**
- **HCPCS code G2065 is for at least 30 minutes of clinical staff time per calendar month, and 2020 rates of approximately $39.70 are the same for both facility and non-facility.**

Transitional Care Management and Behavioral Health Codes

To adequately service patients in both a transitional care and principle care fashion, specific codes are alloted and employed for each.

Transitional Care Management (TCM)

CPT code 99495 and 99496 are for transitional care management (TCM), i.e., ensuring prompt contact with patients within 2 days of discharge. The contact must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care. If two or more separate attempts are made in a timely manner, but are unsuccessful and other transitional care management criteria are met, the service may be reported. This could include ensuring that moves, from one site of care to another (such as from a hospital or outpatient center to a home, skilled nursing facility or hospice), go smoothly and that patient needs continue to be met. PCPs and other Medicare Part B providers can manage (and bill for) this process. Home Health and Federally Qualified Health Centers (FQHCs), however, are excluded.

- **CPT code 99495** covers TCM services including contact with the moderately complex patient within 2 days of discharge, with a face-to-face visit within 14 days of discharge. The 2019 billing rate was $166.50 for non-facility and $112.08 for facility-based services. The 2020 rates will be approximately $175.76 and $119.02 respectively.

- **CPT code 99496** offers extra incentives for highly complex patients with contact within 2 days of discharge for TCM services, with a face-to-face visit within seven (7) days of discharge. The 2019 rates were approximately $234.97 for non-facility and $162.54 for facility-based services, a significant increase over the 14-day rates. The 2020 rates continue to offer incentives at approximately $237.11 for non-facility and $171.04 for facility-based services.

Links:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
https://familymedicine.med.uky.edu/sites/default/files/TCM-CPT.pdf
https://www.acponline.org/practice-resources/business-resources/coding/what-practices-need-to-know-about-transition-care-management-codes

Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Management Services

This code set also offers additional revenue opportunities while helping to remove barriers to patient activation and engagement in their plans of care.

Collaborative Care Management (CoCM) includes a team of three individuals to provide care: the Behavioral Health Care Manager, the Psychiatric Consultant and the Treating (Billing) Practitioner for enhanced care management support for patients receiving behavioral health treatment, and enabling regular psychiatric inter-specialty consultation.

Code 99492

CPT code 99492 addresses initial psychiatric collaborative care management (CoCM), specifically the first 70 minutes in the first month of treatment. The 2020 rate is approximately $161.00 for non-facility and $89.50 for facility billing.

Code 99493

If more psychiatric collaborative care management (CoCM) is required, CPT code 99493 covers the first 60 minutes of psychiatric collaborative care management in a subsequent month. The 2020 rate is approximately $161.00 for non-facility and $89.50 for facility billing.

Code 99494

If the initial or subsequent psychiatric collaborative care management requires more time than is allotted in CPT codes 99492 or 99493, CPT code 99494 provides payment for each additional 30-minute encounter in any calendar month. The 2020 rates are approximately $65.00 per half hour for non-facility and $43.50 for facility billing. This code can be billed more than once if additional time is required.

Code 99484

Finally, CPT code 99484 covers behavioral health integration (BHI) services that require at least 20 minutes of clinical staff time for models of care other than CoCM that may also include “core” service elements such as assessment and monitoring, care plan revision for patients whose outcome is not improving as desired, or promoting a continuous relationship with a designated care team member. In 2020 it pays approximately $48.50 for non-facility and $32.50 for facility billing. Again, this code can be billed more than once in a month. Beneficiaries may, but are not required to have, co-morbid, chronic, or other medical condition(s) that are being managed by the billing practitioner, enabling concurrent billing of those services.

Links:

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

https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid

https://aims.uw.edu/sites/default/files/CMS_FinalRule_BHI_CheatSheet.pdf

Consolidations of Consent for All Services

CMS' ad hoc approach to moving slowly into population health management created a nightmare for patients in terms of giving consent for various services. Under Medicare Part B they had to sign one consent form for CCM, another for RPM, another for virtual check-ins and a fourth for TCM via telehealth.

Sometimes they even had to sign individual consent forms for the same services per episode of care. Both patients and providers were frustrated by the cumbersome, time-consuming process. There was also tremendous confusion as patients believed they had already signed a consent form for one service when, in fact, they had signed it for a different service.

All of that has been consolidated, which means patients under Medicare Part B only must sign a single form to consent to receiving all covered telehealth and RPM services. The only caveat is that providers must explain what the patient's co-pay will be, typically 20%.

Of course, if the patient is dual-eligible (qualifies for Medicare and Medicaid) or has supplemental insurance that co-pay may be $0. Providers will need to have their messaging, documentation, billing and accounting in order to understand what the patient's payment situation is so they can accurately calculate and collect the co-pays.

Monthly Telehealth ESRD-related Dialysis Clinical Assessments

Another area in which telehealth/RPM has been expanded is end stage renal disease (ESRD). Patients with ESRD who are on dialysis generally receive monthly clinical assessments from their nephrologists.

Until recently, most of these clinical assessments had to be performed in-person. The only exceptions were for patients in rural areas who would have to travel great distances to attend these assessments; they were allowed to choose telehealth visits instead.

- **End-Stage Renal Disease (ESRD)-related services are included in the monthly capitation payment of CPT codes: 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961.**

- **End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients of younger than 2 years of age to seniors, include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents and various services in CPT codes 90963 to 90970 can now be delivered via telehealth, meaning patients with ESRD receiving dialysis at home, qualifies as their home is now an originating site for the monthly assessment. CMS payment will vary depending on the codes that are appropriate for the patient's age and assessments. As a result, both patients and providers can fulfill their obligations (and providers can capture the revenue) without placing undue travel stress on patients going through difficult times.**

This, incidentally, is an area where Vivify is uniquely qualified to help. Our Bring Your Own Device (BYOD) solutions in particular can help providers deliver connected care to their ESRD patients to both monitor their day-to-day progress and enable video conferencing with their provider team.

Opioid and Substance Abuse Disorders

Telehealth was also recently approved for treating substance abuse disorder (including opioids) with or without a co-occurring mental health disorder. Assessments can now be performed in the home rather than requiring an office visit. There are no restrictions on geographic location, which is good news for elderly and other patients with mobility or transportation challenges wrestling with opioid or other substance abuse issues.

For 2020, CMS is adding three Communication Technology-Based Services codes enabling providers to bill Medicare for telehealth services included in bundled episodes of care for opioid abuse treatment, including care delivered to the home. The HCPCS codes for these services are:

- **G2086 is for at least 70 minutes of treatment for opioid use disorder during the first month, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling. The approximate 2020 fee is $415.00 for non-facility, $299.00 for facility billing.**

- **G2087 is for at least 60 minutes in a subsequent month . The approximate 2020 fee is $370.00 for non-facility, $292.00 for facility billing.**

- **G2088 covers each additional 30 minutes beyond the first two hours of office-based treatment for opioid use disorder in any month. The approximate 2020 fee is $370.00 for non-facility, $292.00 for facility billing. There is a slight increase in the RVU for 2020, to 36.0896. As with ESRD patients, Vivify's solutions can get providers up and running quickly in this largely untapped revenue source.**

Links:
https://mhealthintelligence.comnews/cms-expands-telehealth-coverage-for-opioid-abuse-disorder-treatment

MORE CHANGES Expected

This document covers many of the changes and updates that took effect January 1, 2020. But as RPM and telehealth generally continue to prove their effectiveness in improving health outcomes, reducing costs and increasing patient engagement and provider satisfaction, providers should expect more changes to come in the future.

This is good news for providers from a financial aspect as well, as it allows them to increase revenue, while operating more effectively and efficiently.

CMS is definitely committed to expanding the use of telehealth and RPM. Vivify stands ready to partner with providers to help them succeed on this journey.

Sources
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

https://www.cms.gov/newsroom/fact-sheets/finalized-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar

https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/feesched/ES-2020FinalMPFS-110219.pdf

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