Cardiovascular Summit

"Add-On Codes" – Embedding Them Into Your Daily Practice

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WILL
WORK
FOR FREE

Type		Code	wRVU	$
Portal exchanges	With images	G2010	0.25	14
	No image	99421-23	0.25 - 0.80	14 - 44
Interprofessional consults		99451	0.80	44
COVID Vaccine counseling		99401	0.48	26

Transitional care management	Within 14 days	99495	2.78	153
	Within 7 days	99496	3.79	209
Chronic care management	Physician/APP (first 30 min, each add'l 30)	99491, 99437	1.5, 1.0	83, 55
	Staff (first 30 min, each add'l 30)	99490, 99439	1.0, 0.7	55, 39
Complex chronic management	Staff (first 60 min and each add'l 30)	99487, 99489	1.81, 1.0	100, 55
Principal care management	Physician/APP (first 30 min, each add'l 30)	99424, 99425	1.45, 1.0	80, 55
	Staff (first 30 min, each add'l 30)	99426, 99427	1.0, 0.71	55, 38

Care Management Services

Transitional Care (TCM)

CPT Codes: 99495 - 99496

Post Discharge Management

Non-face to face/Non-provider interaction 2 days of D/C. Face to Face visit within 7 or 14 days.

Physicians, QHPs, Clinical Staff

Non-Face-to Face

Face-to-Face

Chronic Care (CCM)

CPT Codes: 99437, 99439, 99487, 99489 -99491

Monthly care services based on time, medical decision making, pt. complexity for **multiple** chronic conditions **(2 or >) lasting 12 months or until death** and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Operational Aspects - Guidelines for consent, care plan, individuals providing services, ongoing communication, time thresholds and some bundled services.

Physicians, QHPs, Clinical Staff

Non-Face-to Face

Face-to-Face

Principal Care (PCM)

CPT Codes: 99424 - 99427

Monthly care services for a **single high- risk disease** based on **1 complex** chronic condition lasting **3 months** and includes condition/treatment requirements.

Operational Aspects - Guidelines for consent, care plan, individuals providing services, ongoing communication, time thresholds and some bundled services.

Physicians, QHPs, Clinical Staff

Non-Face-to Face

Face-to-Face

**Refer to complete CMS and AMA CPT coding guidelines.

Table For Reporting Care Management

CPT CODE	Services	Unit Duration (Time Span)	wRVU	National Fee Non-Facility (Single Unit)	Staff Type	Unit Max Per Month
99424	PCM	30 minutes (30-59 minutes)	1.45	$83.40	Physician or QHP	1
+99425	Add On PCM	30 minutes (60 minutes or more)	1.00	$60.21	Physician or QHP	No limit
99426	PCM	30 minutes (30-59 minutes)	1.00	$63.33	**Clinical staff**	1
+99427	Add On PCM	30 minutes (60 minutes or more)	0.71	$48.45	**Clinical staff**	2
99490	CCM	20 minutes (20-39 minutes)	1.00	$64.02	**Clinical staff**	1
+99439	Add on CCM	40-59 minutes X 1 , (60 or more minutes X 2)	0.70	$48.45	**Clinical staff**	2
99491	CCM	30 minutes (30-59 minutes)	1.50	$86.17	Physician or QHP	1
+99437	Add on CCM	30 minutes (60 minutes or more)	1.00	$61.25	Physician or QHP	No limit
99487	Complex CCM	60 minutes (60-89 minutes)	1.81	$134.27	**Clinical staff**	1
+99489	Add on Complex CCM	30 minutes (≥90 minutes X 1), (≥120 minutes X 2, etc)	1.00	$70.60	**Clinical staff**	No limit

**Refer to complete CMS and AMA CPT coding guidelines.
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Key Processes for Care Management

- Proactive versus Reactive patient identification
- Patient education and enrollment
- What services are you already performing that qualify?
- Provider buy-in, purposeful standardization, etc.
- Documentation requirements
- Coding and billing workflow
- Staff resources and ownership
- Measure success (pt. satisfaction, reimbursement, downstream impacts)

Portal Exchanges & Store Forward

Secure Patient Consent

- This involves a change in the athena pt portal

Patient Consent/notification is required.
How can you secure this?

Ensure documentation is available to support the charge.

-done by creating a "pt case"

Develope workflow to drop the charge

-will involve sending to a dedicated person in the practice

Create guardrails to ensure only appropriate exchanges are billed

Complete

Create Athena holds to suport the billing process

- check for encounters 7 days before

Create Educational material to support implementation

Drafted

Post implementation monitoring

- payor status

-spot check documentation

Patient consent will enable billing options for both a written Q/A exchange with the patient as well as an exchange that includes the upload of an image (store forward).

Documentation and Billing Guidance For Clinician/Patient Portal Exchanges

Established Patient Initiated Portal exchange with Clinician

Does the contact include an Image? i.e., photo, apple watch data, etc.

NO

1) Is the contact related to a visit in the past 7 days? **OR**

2) Did it result in your suggestion and their agreement that they schedule a visit at your next available time?

NO

Exchange involved your evaluation and management of situation

Select time spent
99421- 5-10 min
99422 - 11-20 min
99423 - 21 or more min

Less than 5 min not billable, staff time not billable

AND

Internal Guideline

The exchange would meet requirement for a level 3 on MDM (below)

YES

Not a billable service

Additional Information

1) The portal codes of 99421-23 are inclusive of 7 days' worth of time spent in exchanges. An Athena hold will be implemented to hold the charge for 7 days and combine multiple charges when applicable.

2) Clinicians will need to "route" the charge to a designated office associate for charge entry. If a clinical associate is involved, indicate to them to forward when their role is complete.

Did you respond within 24 hours?

YES

1)is the contact related to a visit in the past 7 days? **OR**

2) Did it result in your suggestion and their agreement that they schedule a visit at your next available time?

NO

Bill **G2010 5-10 min**

Additional Information

1) Unlike the 994 codes above, this requires a response within 24 hours

2) If the exchange represented by the 994 codes also includes an image both codes could be billable

NO

Not billable with the G2010 code service. May qualify for 99421-23 See above

YES

Not a billable service

Low
- **2** or more self-limited or minor problems;
  or
- **1** stable chronic illness;
  or
- **1** acute, uncomplicated illness or injury

Limited *(Must meet the requirements of at least 1 of the 2 categories)*
Category 1: Tests and documents
- **Any combination of 2 from the following:**
  - Review of prior external note(s) from each unique source*;
  - review of the result(s) of each unique test*;
  - ordering of each unique test*

or Category 2: Assessment requiring an independent historian(s)
(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)

Low risk of morbidity from additional diagnostic testing or treatment

CAUTION: Exchanges via the portal are automatically stored as a "Patient case" providing us with supporting documentation for billing. YOU CAN NOT HAVE THIS EXCHANGE VIA YOUR E-MAIL

Codes, Reimbursement and WRVU

- **Portal communications** – Includes a 7-day time frame. This would be helpful when one response results in additional exchanges as all eligible portal exchanges within a 7-day time frame are included in the one charge submitted that is an accumulative time-based code.
- **· 99421: Online digital E/M , established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes WRVU .25 $14.07**
- **· 99422: Online digital E/M established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes WRVU .50 $28.14**
- **99423: Online digital E/M established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes. WRVU .80 $44.74**

- **"Store/Forward" communications** – The patient submits an image we then respond with our review and interpretation of that image. This must be done within a 24-hour window of the patient's submission, and includes permanent storage of that image.
- **G2010 - Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment WRVU .25 $13.76**

Interprofessional Consults

AKA – How to Earn WRVU for Those Pesky Pre-Op Forms

- Codes 99446 – 99449 and 99451 describe:
- Assessment and management services conducted through telephone, internet, or electronic health record consultations
- Furnished when a patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a consultant
- Consultant has specific specialty expertise to assist with the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact with the consulting physician or qualified healthcare professional
- Can be provided and or billed by a Physician and or an APP

Billable services are NOT limited to the completion of Pre-Op clearance forms.

Any service meeting the criteria could qualify – but workflow is easiest with the Pre-op in order to get you started.

Interprofessional Consults – 2 Options

Two code sets are available: **1)** Verbal **plus** written **2)** Written only

- Neither code series can be billed if the pt was seen in the previous 14 days, or leads to a decision to see the pt at next available opportunity
- Written response back is required for both categories of services – add'l guidelines when this includes verbal

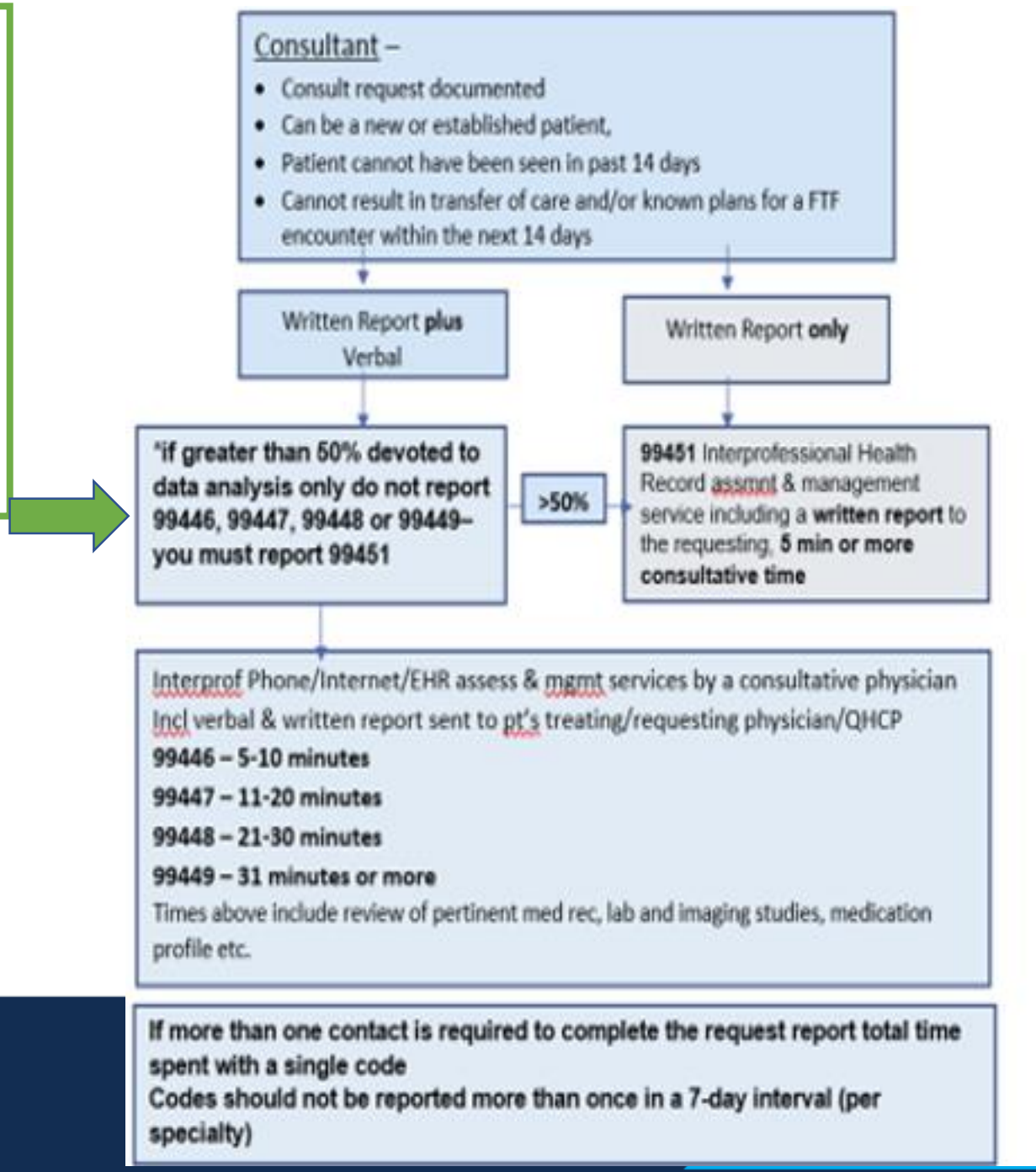
Create a billing hold to assist. i.e. will look back 7 days and hold for 7 days before releasing the charge

$ WRVU	**Interprofessional telephone/ internet / electronic health record assessment and management services provided by a consultative physician, including a verbal AND written report to the patient's treating/requesting physician or other qualified health care professional**
$17 .35	99446 – 5-10 minutes of medical consultative discussion and review
$35 .70	99447 – 11-20 minutes of medical consultative discussion and review
$52 1.05	99448 – 21-30 minutes of medical consultative discussion and review
$69 1.40	99449 – 31 minutes or more of medical consultative discussion and review
$35 .70	**99451** – Interprofessional telephone/ internet / electronic health record assessment and management service provided by a consultative physician, including **written report (verbal report not required)** to the patient's treating/requesting physician or other qualified health care professional, **5 minutes or more of medical consultative time**

NOTE: If you also have a verbal exchange with the requesting physician you would total your time spent in data review plus the conversation to determine total time to bill.

When data review makes up greater than 50% of that total time bill the record review service only.

CPT	$	WRVU
99446	17	.35
99447	35	.70
99448	52	1.05
99449	70	1.40
99451	36	.70
99452	37	.70

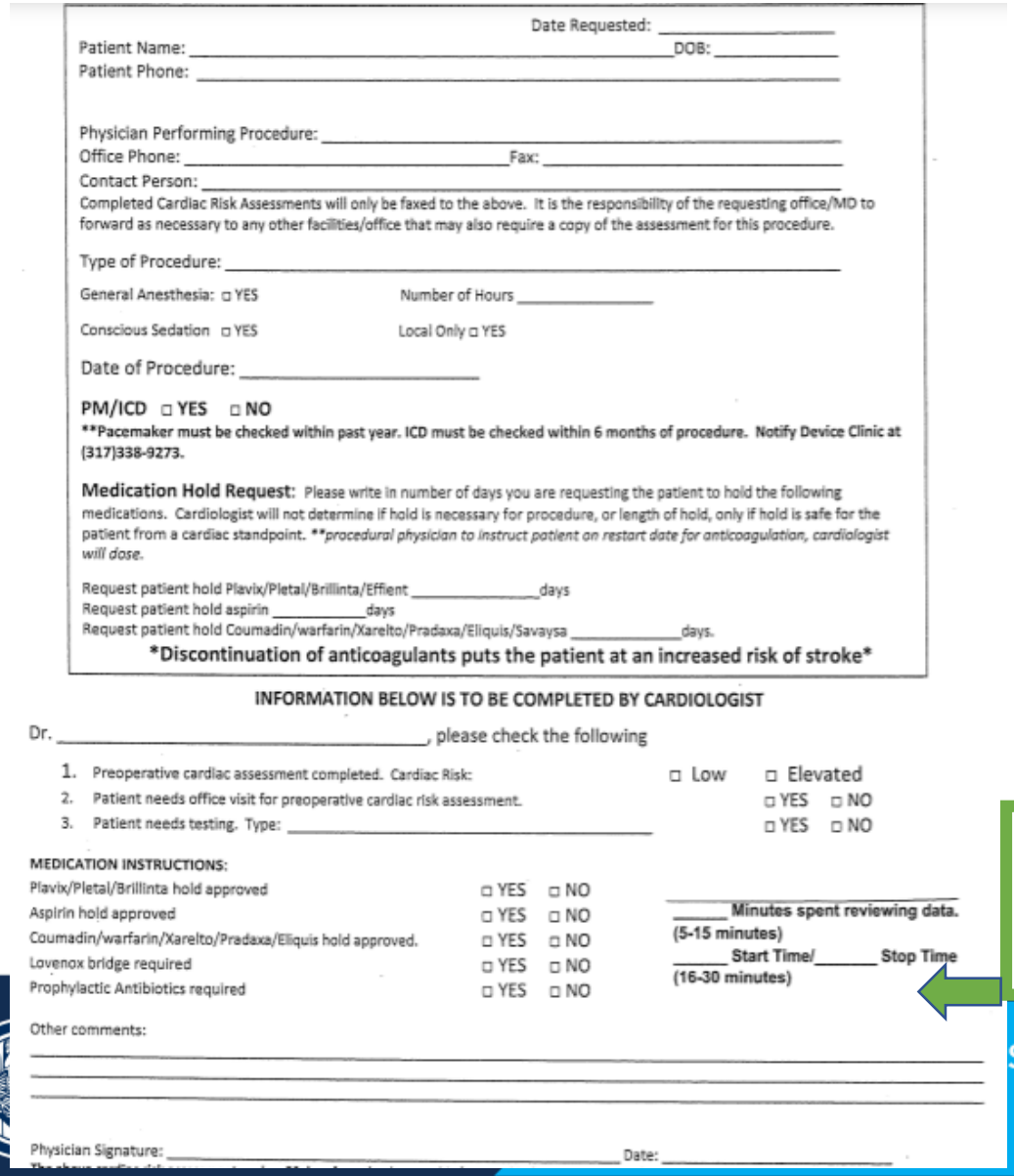


Sample Implementation Process

Common Process Flow:

- Fax from Surgeon/Requesting Provider comes in either via Athena or outside of Athena
- Nurse retrieves Fax, pulls all relative documents (test results, meds, etc)
- Pre-Op form (either from requesting provider or our internal form) and all retrieved medical data referenced above are given to MD for review
    - If patient has not been seen in a while contact is made for either a phone conversation or office visit is scheduled
- MD reviews all data, assigns risk level, and signs off on the form.
- Form is returned to Nurse and gets scanned back into Athena
- Form is faxed back to Surgeon/Requesting Provider
- Patient is added to Billing Log and given to Front Office for charge entry

The billing log mentioned above was implemented by the manager to assist in their billing process



Date Requested: _____

Patient Name: _____ DOB: _____

Patient Phone: _____

Physician Performing Procedure: _____

Office Phone: _____ Fax: _____

Contact Person: _____

Completed Cardiac Risk Assessments will only be faxed to the above. It is the responsibility of the requesting office/MD to forward as necessary to any other facilities/office that may also require a copy of the assessment for this procedure.

Type of Procedure: _____

General Anesthesia: ☐ YES Number of Hours _____

Conscious Sedation ☐ YES Local Only ☐ YES

Date of Procedure: _____

PM/ICD ☐ YES ☐ NO

****Pacemaker must be checked within past year. ICD must be checked within 6 months of procedure. Notify Device Clinic at (317)338-9273.**

Medication Hold Request: Please write in number of days you are requesting the patient to hold the following medications. Cardiologist will not determine if hold is necessary for procedure, or length of hold, only if hold is safe for the patient from a cardiac standpoint. ***procedural physician to instruct patient on restart date for anticoagulation, cardiologist will dose.*

Request patient hold Plavix/Pletal/Brillinta/Effient _____days

Request patient hold aspirin _____days

Request patient hold Coumadin/warfarin/Xarelto/Pradaxa/Eliquis/Savaysa _____days.

Discontinuation of anticoagulants puts the patient at an increased risk of stroke

INFORMATION BELOW IS TO BE COMPLETED BY CARDIOLOGIST

Dr. _____, please check the following

1. Preoperative cardiac assessment completed. Cardiac Risk: ☐ Low ☐ Elevated
2. Patient needs office visit for preoperative cardiac risk assessment. ☐ YES ☐ NO
3. Patient needs testing. Type: _____ ☐ YES ☐ NO

MEDICATION INSTRUCTIONS:

Plavix/Pletal/Brillinta hold approved	☐ YES	☐ NO
Aspirin hold approved	☐ YES	☐ NO
Coumadin/warfarin/Xarelto/Pradaxa/Eliquis hold approved.	☐ YES	☐ NO
Lovenox bridge required	☐ YES	☐ NO
Prophylactic Antibiotics required	☐ YES	☐ NO

_____ **Minutes spent reviewing data. (5-15 minutes)**

_____ **Start Time/**_____ **Stop Time (16-30 minutes)**

Other comments:

_____

_____

_____

Physician Signature: _____ Date: _____

Time spent is required

Counseling Patients Regarding the Benefits of Receiving the COVID-19 Vaccine

- These codes are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury.
- They are distinct from evaluation and management (E/M) services that may be reported separately with modifier 25 when performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment.
- CPT 99401: Preventative medicine counseling and/or risk factor reduction intervention (s) provided to an individual, approximately 15 minutes Can be used to counsel patients regarding the benefits of receiving the COVID-19 vaccine.

You must document time – greater than half or 8 minutes.
Document what the counseling consisted of.
Attach DX code Z71.89 Other specific counseling to the code for claim processing.

KEY TAKEAWAYS

- Ambulatory services are not just about face-to-face services – Think about non-face-to-face.
- Considering implementing at least one of these in 2022.