Revenue Cycle Management

A UPA Billing Office Newsletter

December 2023

In This Issue

Jennifer Bright, CPC, CPB, CPPM
Director, Quality & Education
jtbright@utmck.edu
865.670.6700

CMS Traditional Medicare Telehealth Reminders

Through the Consolidated Appropriations Act of December 2022, CMS has extended telehealth flexibilities through December 31, 2024, until permanent updates to telehealth policies can be made available. Through December 31, 2024, all providers who are eligible to bill Medicare for professional services can provide distant site telehealth. Traditional Medicare patients can receive telehealth services wherever they're located, including the patient's home, as there are no geographic restrictions through 12/31/2024.

- Through December 31, 2023, CMS requires that telehealth services be reported with the place of service (POS) code where the face-to-face service would typically be provided, office, outpatient, or inpatient in most cases, with modifier 95 appended.
- **Beginning January 1, 2024, CMS will require that telehealth services be reported with POS 02 or 10, depending on where the patient was located.** No modifier for telehealth should be reported, as the POS indicates telehealth. For this purpose, it is imperative that providers document where the patient was located when the telehealth service was performed.
  - POS 02 Telehealth Provided Other than in Patient's Home
  - POS 10 Telehealth Provided in Patient's Home

Please work with your billing department to ensure that the appropriate place of service is reported for telehealth.

Resources:
CMS Telehealth Factsheet: MLN901705 - Telehealth Services (cms.gov)
CMS Approved Telehealth Services List: List of Telehealth Services | CMS

Transitional Care Management

Reporting of Transitional Care Management (TCM) services requires that the healthcare professional accept care of the patient post-discharge from certain facilities to transition the patient back to a community setting. This service requires a moderate to high level of medical decision making and commonly involves a patient needing care for a high-risk medical condition. The intent of TCM services is to improve care coordination and reduce hospital readmissions. This service requires communication with the patient, face-to-face visits, and medication management for 30 days post facility discharge. The 30-day TCM period begins on the date of discharge and continues for 29 days after.

Reminders:

- TCM (including the required face-to-face component) is eligible as a telehealth service.
- Provider or directed clinical staff must make and document contact with the patient or caregiver within 2 business days of discharge to initiate the TCM service via phone, email, face-to-face or have made 2 or more unsuccessful attempts.
- The face-to-face service is a required component of the TCM service and should not be reported separately.
- Reasonable and necessary E/M services to manage the patient's clinical issues may be reported separately during a TCM period, apart from the required face-to-face service.
- The provider MUST perform medication reconciliation & management on or before the face-to-face visit.
- Only 1 provider may report TCM services and should only be reported once per TCM period.
- TCM cannot be reported on the same day as discharge management services.

-continued Page 2-

-continued- Transitional Care Management

- TCM services are not eligible during a post-operative period if reported by the same provider who performed the surgical procedure.
- TCM services are not eligible if the patient is readmitted during the 30-day TCM period and provider may report the appropriate E/M visit based on the documentation for any face-to-face component performed.
- TCM services are not eligible if the face-to-face component was not completed within the required timeframe (within 14 days post discharge) and provider may report the appropriate E/M visit based on the documentation instead.

Qualifying Facility Discharges:

- Inpatient acute care, psychiatric, or rehabilitation hospital
- Long-term care hospital
- Skilled nursing facility (SNF)
- Hospital outpatient observation or partial hospitalization at a community mental health center

Qualifying Post-Discharge Community Settings:

- Patient's home or domiciliary
- Rest home or assisted living

Qualifying face-to-face visit:

- 99495 - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge At least moderate level of medical decision making during the service period Face-to-face visit, within 14 calendar days of discharge
- 99496 - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge High level of medical decision making during the service period Face-to-face visit, within 7 calendar days of discharge

Documentation Requirements:

- Patient discharge date
- Patient/Care giver initial interaction date
- Face-to-face visit date & documentation
- Medical decision making of moderate to high complexity (time is NOT a factor for TCM)

CMS Factsheet Resource:
Transitional Care Management Services (cms.gov)

Add-on Code G2211 for Primary Care Complexity

Beginning January 1, 2024, CMS will allow reimbursement for HCPCS G2211 when furnished by primary care and other specialty providers treating complex conditions, consistently, over a long period of time. This primary care focused add-on code for E/M complexity will help providers account for the resource costs associated with longitudinal care of complex patients, according to the CMS 2024 Medicare Physician Fee Schedule Final Rule, however there will be limitations for reimbursement from traditional CMS Medicare, as well as potentially other private payers. Per CMS MLN article MM13272 (link below) traditional Medicare will not reimburse for this service when reported with an associated office or outpatient visit reported with modifier 25. This means if your primary E/M service is performed in conjunction with a significant or separately identified in office procedure or other service on the same day which requires modifier 25 to be reported, then the add-on code G2211 for complexity will be denied.

Reminder, this code is reported in addition to primary E/M codes 99202-99215 only.

G2211- Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

CMS MLN Article: MM13272 - Edits to Prevent Payment of G2211 with Office/Outpatient Evaluation and Management Visit and Modifier 25 (cms.gov)

Additional Resources: CMS will implement G2211 in 2024 - CodingIntel

Office / Outpatient Prolonged Services:

When reporting prolonged services for outpatient or office services beyond the maximum required time of the primary evaluation and management service, you may report CPT 99417 for each additional 15 minutes of time, when coding the E/M on time.However, some payers prefer the related HCPCS code G2212, instead. United Healthcare plans and Humana plans require G2212, instead of CPT 99417 when report prolonged care.

Medicare Preventive Services - IPPE & AWV

- Who is eligible for an Initial Preventive Physical Exam (IPPE) G0402? A beneficiary who is within the first 12 months after the patient's Part B benefits eligibility date.
- Who is eligible for an Annual Wellness Visit (AWV) G0438 & G0439? - A beneficiary who is no longer within 12 months after the effective date of his or her first Medicare Part B coverage and who has not received either an IPPE or an AWV within the past 12 months.

Reminders:

- Medicare Part B does not provide coverage for routine physical examinations
- Depression screening G0444 is bundled with G0438/G0402 (Initial AWV & IPPE) exams
- Depression screening G0444 is separately payable with G0438 (Subsequent AWV) when documentation supports and modifier 25 applied.

Additional Resources:
MLN6775421 – Medicare Wellness Visits (cms.gov)
MLN006559 – Medicare Preventive Services (cms.gov)

Medicare Crossover Claims to TennCare MCOs in 2024

FEE-FOR-SERVICE MEDICARE CROSSOVER CLAIMS WILL BE TRANSITIONED TO TENNCARE'S EXISTING MANAGED CARE ORGANIZATIONS

- The Division of TennCare is pleased to announce that all institutional and professional Fee-For-Service Medicare crossover claims will be transitioned to TennCare's existing Managed Care Organizations (MCO); Amerigroup, BlueCare and UnitedHealthcare for adjudication. TennCare will no longer process Medicare crossover claims with dates of service on or after the transition go-live date of 1/1/2024.
- What does this mean for me?
  - Nothing is changing with the current process. Everything that is done today by providers on submitting Medicare crossover claims to TennCare will continue for claims with dates of service up to 12/31/2023.
  - After the 1/1/2024 go-live date, COBA and the DSNPs will submit Medicare crossover claims to the member's assigned MCO for processing and adjudication.
  - TennCare will continue to accept claims with dates of service through 12/31/23 as well as handling adjustments and voids with dates of service prior to 12/31/23.
  - The MCOs will communicate additional details on the transition in the upcoming months.

We look forward to the transition of Medicare crossover claims processing to the MCOs as it will create an operating model that supports TennCare's managed care approach and increases claims processing operational efficiency.

UPA Billing Clients:
Beginning with January 2024 dates of service, Dual-eligible Medicare/Medicaid members, will no longer need Medicaid of Tennessee as a secondary insurance plan during patient registration. The patient's TennCare MCO (BlueCare, TennCare Select, Amerigroup, or UHC Community Plan) should be registered as the secondary plan.