Preparing for 2020 Updates

The AMA updates CPT codes annually, effective January 1 of each year. CMS updates HCPCS quarterly, with significant updates also effective every January 1.

CDM Coordinators must understand the code changes thoroughly, including deleted codes and replacement codes as well as revised codes. Revisions may represent a significant change in the intent of CPTs and HCPCS, as well as units applicable per reportable code. The financial implications of combined codes and changes to reportable units must be conveyed to departments and Finance annually.

Revenue Cycle Analysts must coordinate a team including Managers, HIM, Coding, Billing and others to ensure that all updates are accurate and consistent and that they maximize revenue and reimbursement efforts.

Downstream, costly billing errors persist even where timely and accurate CDM reviews are performed. Each EMR and billing system uses exclusive tools and language to describe processes, so care must be taken to ensure that everyone has the same interpretation regarding changes. Orders may continue to reflect deleted codes or deleted code descriptions. Order Sets, Order Entry, templates, Preference lists, Smart Sets, Smart Phrases, SOAP notes, and any other tools used to guide documentation and charging for services must be reviewed and corrected. Education must also be provided to servicing departments, and charge mechanisms must be updated to ensure accuracy. Paper charge sheets, templates, end-of-exam rules and Order Entry processes must be reviewed and updated where necessary.

CDM Coordinators and Revenue Analysts must:

1. Read and thoroughly understand the code changes and details provided
2. Schedule meetings with billing, providers, HIM and coders to review changes and gain feedback on proper replacement codes and likely combination of codes
3. Identify all internal processes impacted by changes and coordinate necessary updates
4. Convey changes in descriptions and units to Finance
5. Obtain fees for new charge codes that combine separately reportable services
6. Update encounters and chargemaster
7. Communicate both CDM and process change requirements to billers, coders and departments
8. Follow up with a review within one month of change implementation to ensure that orders, templates, rules, and other documentation requiring change have been updated
9. Sign off on education updates and CDM completion

The AMA will delete 68 codes effective January 1, 2020, implement 171 new codes and revise 70 codes. CMS will delete 78 HCPCS, create 183 new HCPCS and revise 62 codes. The summary below provides details on impactful changes for 2020.

Physician Final Rule – Areas of Focus

Review and Verification of Medical Record Documentation:

Physicians, physician assistants, and advanced practice registered nurses (APRNs – nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists) can review

and verify (sign and date), rather than re-document notes made in the medical record by other physicians, residents, medical, physician assistant, and APRN students, nurses, or other members of the medical team.

Action Items / Next Steps:

Check with all commercial and government payors to confirm policies in 2020. Although this will save time for practitioners, education should be provided to ensure all providers continue to review and address relevant information thoroughly.

Two new HCPCS G codes, G2082 and G2083 for treatment-resistant depression (TRD) using esketamine:

These codes will not be available for RHCs or FQHCs in 2020.

G2082 "Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of up to 56 mg of esketamine nasal self-administration, includes 2 hours post-administration observation"

G2083 "Office or other outpatient visit for the evaluation and management of an established patient that requires the supervision of a physician or other qualified health care professional and provision of greater than 56 mg esketamine nasal self-administration, includes 2 hours post-administration observation". These codes include a visit and a drug.

CMS clarified the requirement for one patient consent per year to report G2012 (Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, 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

Action Items / Next Steps:

Practitioners considering Esketamine therapy should review private payor requirements and preauthorization guidelines. New services should be added to the chargemaster, order entry and all staff should be trained. Registration must understand this new service because monitoring times are considerable.

New Evaluation and Management HCPCS:

Care Management Services:

G2058 - Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure). (Do not report G2058 for care management services of less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month.) (Use G2058 in conjunction with 99490.) (Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491.)

CMS created two new care management codes to report a single high-risk condition in addition to the current codes for Chronic Care management and Complex Chronic Care Management. The new codes

will not be available for RHCs or FQHCs in 2020. RHCs and FQHCs are paid for general care management services using HCPCS code G0511, which is an RHC and FQHC-specific G-code for 20 minutes or more of CCM services, complex CCM services, CCM furnished by a physician or other qualified health care professional, or general behavioral health services, CMS will allow G0511 to be billed when the requirements for Principle Care Management are met.

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 three 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

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 three 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

Action Items / Next Steps:

Practitioners already providing chronic care services should add these codes to their chargemaster and educate staff and patients. Tracking mechanisms, education and notification processes should be implemented. All primary care providers should review the benefits of providing care management services

New E-visit codes assigned for Physicians and Non-Physician Practitioners:

G2061 (Qualified nonphysician 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 nonphysician 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 nonphysician 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).

Physician E-visits:

99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

99422 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes

99423 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Action Items / Next Steps:

Providers considering E-visits should check with commercial payors and identify reimbursement rates and commercial payor guidelines. The chargemaster should be updated with new service codes and the front desk and nurses trained. Patients must understand that non-face-to-face contacts may constitute visits and charges may be incurred. All staff should be aware of these new policies.

Changes to E/M CPT leveling effective 2021:

Changes include deletion of 99201, although facilities should retain the code for Workers comp and/or MVA insurance. The code should have edits applied to ensure proper usage if any.

Medicare will reimburse one rate for new patient Evaluation and Management visits levels II-IV and one rate for establish patient Levels II -IV.

Leveling criteria will be based on Medical Decision Making or Time based. Other elements of E/M such as History and Exam will still be required but will not contribute to the level assigned. This is a significant change and facilities should begin preparing providers by mid-year to ensure understanding.

Action Items / Next Steps:

Providers should evaluate the impact on net reimbursement of new Medicare payment methodology. Review current Evaluation and Management coding and billing practices and obtain the education necessary to comply with new guidelines by January 2021 to minimize risk and mitigate reimbursement changes.

Medication Assisted Therapies

CMS is creating 10 new HCPCS to report Medication Assisted Therapies to combat the opioid crisis. Providers must obtain waivers to prescribe or dispense these medications. To receive a waiver to practice opioid dependency treatment with approved buprenorphine medications, a practitioner must notify the SAMHSA Center for Substance Abuse Treatment (CSAT) of their intent to practice this form of medication-assisted treatment (MAT). The notification of intent must be submitted to CSAT before the initial dispensing or prescribing of opioid treatment.

Action Items / Next Steps:

Providers considering MAT should obtain education, and check with commercial payors to understand payor specific guidelines. New codes should be added to the chargemaster. The HER should be updated. Nurses and schedulers should be trained on the new benefit.

2020 OPPS Final Rule– Areas of Focus

Changes to the Inpatient Only List:
Removal of total hip arthroplasty, six spinal surgical procedures and certain anesthesia services from the list,

Two-year exemption from certain medical review activities relating to patient status for procedures removed from the inpatient-only list beginning in CY 2020 and subsequent years. Claims will not be denied based on patient status (that is, site of service) alone.

Action Items / Next Steps:

Ensure HIM and inpatient coders are educated. Educate providers and ensure that patients are not unnecessarily admitted and update the admissions process and orders.

Supervision Requirements for Outpatient Services:

Supervision requirements for hospital outpatient therapeutic services furnished by all hospitals and CAHs change from direct supervision to general supervision. General supervision means that the procedure is furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure. This change ensures a standard minimum level of supervision for each hospital outpatient therapeutic service furnished incident to a physician's service. Hospitals may require a higher level of supervision for certain services.

Action Items / Next Steps:

Review Hospital policies. If internal policies allow for the change to general supervision educate providers, clinical staff and scheduling

Device Pass-through:

Five devices granted transitional pass-through status for a period of three years, including

- AquaBeam Robotic System
- AUGMENT Bone Graft
- Surefire Spark Infusion System
- Optimizer Smart System
- CustomFlex Artificial Iris.

Action Items / Next Steps:

Query providers and hospital new device committee. If these devices will be used, update Chargemaster, EHR and order entry systems. Check with commercial payors from authorization and reimbursement requirements. Ensure appropriate staff are aware of billing requirements and educate coding and billing.

340B Purchased Drugs:

CMS will continue to pay an adjusted amount of ASP minus 22.5 percent for separately payable drugs or biologicals that are acquired through the 340B Program. In the proposed rule, CMS acknowledged that the CY 2018 and 2019 OPPS payment policies for 340B-acquired drugs are the subject of ongoing litigation, and the agency is currently appealing the decision in the United States Court of Appeals for the District of Columbia Circuit.

Action Items / Next Steps:

No action at this time, continue to monitor decisions.