Basics of Physician Billing and Coding for Dialysis, Apheresis, and CRRT

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Disclosure

Speaker’s Bureau, Horizon Pharmaceuticals
I am not here to defend or justify these rules and guidelines, only to help us understand them
Outline

• Documentation
• Outpatient and inpatient HD
• Outpatient and inpatient PD
• AKI patients on outpatient Dialysis
• CRRT
• Apheresis
Disclaimers

• This only covers basic professional fee billing
  – MD/DO/APP

• This is not comprehensive

• There is some intentional redundancy

• Extraordinarily difficult to cover *everything* in one talk

• Fraudulent versus denied
Cloning (Copy Forward)

• On the radar of the OIG and CMS
• It is not fraudulent or illegal to utilize this feature of your EHR (as of now)
• The official “warning” from CMS is in same document as:
  – Don’t fraudulently bill or upcode
  – Systems must document who changed, amended, or added which text and when
Cloning—This practice involves copying and pasting previously recorded information from a prior note into a new note, and it is a problem in health care institutions that is not broadly addressed.[16, 17] For example, features like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused. The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter. Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable. Using electronic signatures or a personal identification number may help deter some of the possible fraud, waste, and abuse that can occur with increased use of EHRs.[18] In its 2013 work plan, the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) indicated that due to the growing problem of cloning, its staff would be paying close attention to EHR cloning.[19, 20]

Make today’s note today’s note!!
Monthly Capitated Payment

• MCP are the professional fees physicians bill (and hopefully collect) for the overall care of outpatient dialysis patients for a calendar month
• CMS sets the standards
• Must meet documentation requirements
  – Monthly assessment (comprehensive, if app)
  – Incenter HD patients can have additional unique in-center visits for additional charges
Outpatient Incenter HD

• One visit **must** be a patient assessment/plan of care with IDT

• The remainder of visits must take place in the Dialysis unit
  – Preferably during the run
  – CMS prefers them to spread out “evenly”

• Better reimbursement with additional visits
Monthly Capitated Payment

- PD or Home HD as of Jan 1, 2015
  - No partial months
  - Entire month should be billed for with a comprehensive monthly visit independent of admission
  - If hospitalized without a comprehensive visit, per diem codes may be used if you document active management away from hospitalization for months of transplants or deaths
Monthly Capitated Payment

• PD or Home HD as of Jan 1, 2015
  – Requires one face-to-face (telehealth*) comprehensive assessment for monthly payment
  – For home therapies, MFIs (Medicare Fiscal Intermediary) have the discretion to waive the face-to-face requirement on a case-by-case basis
    • Documentation MUST indicate active management of the patient
  – Can bill per diem codes for:
    • Months of death, transplant, admission without comprehensive visit
Monthly Capitated Payment

- Per diem codes (90963-66) for in-center HD
  - Transient patients
    - Bill for the total number of days under care
    - For a full month transient, need comprehensive assessment (and monthly MCP code)
  - Partial months with HD face-to-face visits but without a comprehensive assessment
    - Only for deaths, transplants, no comprehensive visit due to hospitalization
  - If not admitted and no comprehensive, cannot bill per diem
Monthly Capitated Payment

• Billing the MCP for a new patient start during a month must include a comprehensive assessment
  – Only on the first month, if not admitted, can you bill per diem codes (if you can document active management)

• If unable to perform a comprehensive assessment for in-center HD patient that does **not** get admitted, MCP cannot be billed for
MCP Documentation

• Main guidelines come from the 2008 CMS Document End Stage Renal Disease (ESRD) Program Interpretive Guidance Version 1.1
  • aka: Conditions for Coverage
  • Key role for treating or attending nephrologist as part of the IDT (interdisciplinary team)
    – Comprehensive IDT patient assessments
    – Monthly IDT patient assessments
  • Individual state regulations may also apply
MCP Documentation

• Critical basic components according to CMS
  – Patient assessments/evaluation
  – Plan of care – including long and short term goals
• There is no regulation to specify the format for the assessments but very detailed specifics as to what information is required
• How important is plan of care?
  – LDOs routinely report internally that Plan of Care and Patient Assessments are in their top 10 citations from CMS surveyors every year
MCP Documentation

- Comprehensive initial IDT assessments
  - Must be done within 30 days or 13 HD treatments of outpatient admission
  - Patients returning to dialysis from a failed transplant or changing modalities are also considered “new” patients
  - Receiving facility’s IDT must conduct a reassessment within 30 days of the patient’s admission to the new facility
  - Entire IDT must participate
MCP Documentation

• Comprehensive IDT patient assessments must occur at least:
  – Within 30 days of admission
  – Within 3 months of the initial CIPA
  – Every 12 months as long as patient is stable
  – Within 30 days if patient meets unstable criteria
MCP Documentation

• Unstable Dialysis patients (according to CMS)
  – Extended (>15 days) or frequent (>3) hospitalizations in a calendar month
  – Marked deterioration in health status
  – Significant change in psychosocial needs
  – Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis
  – Other condition(s) as determined by IDT
MCP Documentation

• Physician responsible for participating in key areas
  – Health status (updated morbidities)
  – Dialysis therapy, access, and prescription
  – Hypertension, fluid management
  – Labs, immunizations, and medications
  – Anemia of CKD and iron status
  – Metabolic Bone Disease of CKD
  – Transplant suitability
MCP Documentation

- Surveyors looking to see evidence of IDT participation in PA/POC areas
- MD can participate in any area
  - Dietician evaluation
    - Includes growth
  - MSW evaluation
    - Very lengthy and multifaceted
MCP Documentation

• Ongoing stable patients still require a monthly assessment addressing similar components of the comprehensive assessment
• There is no specific format required
• Assessments and specific attention to plan of care are still necessary for patient assessments and plans of care from previous
• Ongoing documentation is consider “fluid”
Outpatient Home Dialysis Documentation

• Home dialysis patients
  – Same documentation requirements
  – Require monthly evaluations (PA/POC) and communication directly with patient/family
  – Minimum face-to-face every 3 months required
  – Can document reason(s) for not seeing the patient monthly
    • Must have those reason acknowledged by Medicare FI so requirement is waived for the affected months
Telehealth for Home Dialysis

• Passed in bipartisan Senate Budget Act 2018
• Effective Jan 1, 2019
  – No restrictions on equipment for now
• Dialysis Facility and patient’s home approved as telehealth originating sites
• 2 of 3 monthly visits in a 3 month period are allowed
Outpatient Dialysis Documentation

• Admission
  – Initial comprehensive patient assessment by IDT
  – Other requirements vary by state
    • *e.g.* Arizona requires a new History and Physical
  – Initial orders
    • No “rubber stamped” orders per CMS

• Discharge
  – No specific requirements by CMS
  – May be state statutes to consider
    • *e.g.* Arizona requires a Discharge Summary
Outpatient Documentation

• Considerations for documentation
  – Justifying medication and doses
  – Justification of HD runs greater than 13 in a 30 day month (14 in a 31 day month)
  – Justifying laboratory studies not covered in the Bundled reimbursement
Outpatient Dialysis Billing

• ICD-10 codes
  – Commonly used codes
    • N18.6 ESRD
    • D63.1 Anemia of CKD
    • N25.0 Metabolic Bone Disease of CKD
    • I15.1 Hypertension due to Renal Disease
    • Z99.2 Renal Dialysis Status

..........many others
# Outpatient Incenter HD CPT Codes

<table>
<thead>
<tr>
<th>Incenter HD</th>
<th>&lt; 2 yrs</th>
<th>2-11 yrs</th>
<th>12-19 yrs</th>
<th>&gt; 20 yrs</th>
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<tbody>
<tr>
<td>1 visit</td>
<td>90951</td>
<td>90954</td>
<td>90957</td>
<td>90960</td>
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<tr>
<td>2-3 visits</td>
<td>90952</td>
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<td>90958</td>
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</tr>
<tr>
<td>4+ visits</td>
<td>90953</td>
<td>90956</td>
<td>90959</td>
<td>90962</td>
</tr>
</tbody>
</table>
Chairside Visit Documentation

• No specific format
• Must pass “the sniff test”
  – Were you truly there to see them?
• Visits must be furnished face-to-face by a physician, clinical nurse specialist, nurse practitioner, or physician’s assistant
• MCP physician or APP does not have to be present when other physicians or APPs provide visits
Chairside Visit Example

• Acceptable
  – *S*: no complaints; no concerns by RN
  – *O*: seen on dialysis
    • alert, NAD
    • 128/75
    • access visible: no issues
    • No new labs
  – *A*: no concerns
  – *P*: Continue current prescription and meds
Chairside Visit Example

• Unacceptable
  – Stable; no changes
<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description by CMS</th>
<th>2020 wRVUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90951</td>
<td>Esrd serv 4 visits p mo &lt;2yr</td>
<td>18.46</td>
</tr>
<tr>
<td>90952</td>
<td>Esrd serv 2-3 vsts p mo &lt;2yr</td>
<td>0.00</td>
</tr>
<tr>
<td>90953</td>
<td>Esrd serv 1 visit p mo &lt;2yrs</td>
<td>0.00</td>
</tr>
<tr>
<td>90954</td>
<td>Esrd serv 4 vsts p mo 2-11</td>
<td>15.98</td>
</tr>
<tr>
<td>90955</td>
<td>Esrd srv 2-3 vsts p mo 2-11</td>
<td>8.79</td>
</tr>
<tr>
<td>90956</td>
<td>Esrd srv 1 visit p mo 2-11</td>
<td>5.95</td>
</tr>
<tr>
<td>90957</td>
<td>Esrd srv 4 vsts p mo 12-19</td>
<td>12.52</td>
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<td>90958</td>
<td>Esrd srv 2-3 vsts p mo 12-19</td>
<td>8.34</td>
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<td>90959</td>
<td>Esrd serv 1 vst p mo 12-19</td>
<td>5.50</td>
</tr>
<tr>
<td>90960</td>
<td>Esrd srv 4 visits p mo 20+</td>
<td>5.18</td>
</tr>
<tr>
<td>90961</td>
<td>Esrd srv 2-3 vsts p mo 20+</td>
<td>4.26</td>
</tr>
<tr>
<td>90962</td>
<td>Esrd serv 1 visit p mo 20+</td>
<td>3.15</td>
</tr>
<tr>
<td>CPT code</td>
<td>Description by CMS</td>
<td>2020 wRVUS</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>90963</td>
<td>Esrd home pt serv p mo &lt;2yrs</td>
<td>10.56</td>
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<td>90964</td>
<td>Esrd home pt serv p mo 2-11</td>
<td>9.14</td>
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<tr>
<td>90965</td>
<td>Esrd home pt serv p mo 12-19</td>
<td>8.69</td>
</tr>
<tr>
<td>90966</td>
<td>Esrd home pt serv p mo 20+</td>
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<tr>
<td>90967</td>
<td>Esrd home pt serv p day &lt;2</td>
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</tr>
<tr>
<td>90968</td>
<td>Esrd home pt srv p day 2-11</td>
<td>0.30</td>
</tr>
<tr>
<td>90969</td>
<td>Esrd home pt srv p day 12-19</td>
<td>0.29</td>
</tr>
<tr>
<td>90970</td>
<td>Esrd home pt serv p day 20+</td>
<td>0.14</td>
</tr>
</tbody>
</table>
Professional fees for Home Training

• Training for home modalities does not carry any wRVUs
• Generally reimbursed at $500
• CPT is 90989, training complete
• Physician must “actively participate” in training
• Should document in a narrative what aspects of the patient’s training they reviewed
• Only for the first month, can a physician bill for both MCP and training for home therapies
Outpatient AKI

• As of Jan 1, 2017, CMS provided coverage and payment for outpatient dialysis
• No weekly limit on dialysis treatments
• Both in-center HD and in-center PD are covered
AKI Prof fees

• MCP cannot be charged
• For incenter HD: 90935-90937
• For incenter PD: 90945-90947
• Utilize an AKI code (N17.9, N17.5)
  – Primary code
AKI Documentation

• Document individual dialysis treatments
• Must see the patient on the dialysis run
• CMS not planning to modify CfCs based on covering AKI services
• Telemedicine for outpatient incenter AKI dialysis treatments will not be covered
• State regulations
  – H/P, IDT, etc...
Sample Procedure Format

• Date/Time:
• Procedure: HD, PD, CRRT, etc…
• Indication(s): ESRD, AKI, Anuria, pulmonary edema, etc…
• Complications: Hypotension, hypocalcemia, etc…
• Settings: Dialyzer, Dialysis Bath, Dianeal, Prismsate, etc…
• Data: Vitals, exam, labs
• Assessment/Plan:
Inpatient Billing

• Modifiers AI and AF
  – Used for patients with Medicare as their primary insurance; though some insurers may request
  – Needed due to elimination of consult codes for Medicare patients
    – **AI**: added to the admit E&M code (99221-99223) to indicate the attending physician of record
    – **AF**: added to a consult E&M code (99221-99223) to indicate a consulting physician
Inpatient Dialysis/CRRT

• Hemodialysis
  – 90935 single evaluation
  – 90937 repeat evaluation documenting necessity

• Peritoneal Dialysis or CRRT
  – 90945 single evaluation
  – 90947 repeat evaluation documenting necessity

• Document as a procedure note
Sample Procedure Format

• Date/Time:
• Procedure: HD, PD, CRRT, etc…
• Indication(s): ESRD, AKI, Anuria, pulmonary edema, etc…
• Complications: Hypotension, hypocalcemia, etc…
• Settings: Dialyzer, Dialysis Bath, Dianeal, Prismsate, Dialysis Prescription, replacement fluids, etc…
• Data: Vitals, access, exam, labs, etc…
• Assessment/Plan:
Inpatient Dialysis Billing

• For codes 90937, 90947
  – Unstable/Critically ill for repeat visits documenting why the patient required another evaluation
  – Note for each face-to-face evaluation
  – Must be present during the treatment
  – Another physician from the same group can perform the repeat evaluation but only one physician from the same group may bill*
Inpatient Dialysis Billing

• Inpatient dialysis services can be billed on the same day as certain E&M codes
  – Requires a -25 modifier on the E&M
  – Admit (including short stay codes*)
  – Discharge (99238, 99239, 99217)
  – Inpatient Consult
  – First day of Critical Care (99291)

• If you are the attending, the dialysis note can serve as your note for the day
Inpatient Dialysis Billing

• Modifiers
  – **25**: placed on an E&M CPT code (e.g. 99223) to distinguish a separate and identifiable procedure code on the same day
  – **XE (-59)**: placed on a procedure CPT code (e.g. 50200) to distinguish another identifiable procedure code on the same day
Inpatient wRVU for 2020

<table>
<thead>
<tr>
<th>Code</th>
<th>2020 wRVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>0.76</td>
</tr>
<tr>
<td>99232</td>
<td>1.39</td>
</tr>
<tr>
<td>90935 (HD)</td>
<td>1.48</td>
</tr>
<tr>
<td>90945 (PD/CRRT)</td>
<td>1.56</td>
</tr>
<tr>
<td>99233</td>
<td>2.00</td>
</tr>
<tr>
<td>90937 (repeat eval)</td>
<td>2.11</td>
</tr>
<tr>
<td>90947 (repeat eval)</td>
<td>2.52</td>
</tr>
</tbody>
</table>

- No wRVU changes since 2011
- Single visit HD and PD more wRVU than a level 2 follow-up visit
- Repeat visits of HD, PD and CRRT more wRVU than a level 3 follow-up visit
- **Document**
“-59 modifier”

• -59 used prior to 2015 to distinguish distinct procedures performed on the same day
  – e.g. Apheresis and CRRT (36514-59 and 90945), renal biopsy and HD (50200-59 and 90935), etc...

• Between professional fees and facility fees, $770 million in error related to -59 usage in 2012-2013

• Starting in 2015, replaced by −X{ESPU}
Changes to -59 modifier

- **XE**: separate encounter
  - Distinct service because it occurred during a separate encounter
  - Example: Apheresis and CRRT evaluations at different times (36514-XE and 90945-XE)

- **XP**: separate practitioner
  - Distinct service because it was performed by a different practitioner
  - Example: Two nephrologists perform CRRT evaluations at different times on an unstable patient (90945-XP for each)
Changes to -59 modifier

• XS: separate structure
  – Distinct service because it was performed on a separate organ or structure
  – Examples are primarily surgical

• XU: unusual non-overlapping service
  – Distinct service because it does not overlap the usual components of the main service
  – CMS included this to cover “everything else”
ICU considerations – 99291, 99292

• Dialysis time is **not** included
• Dialysis and CRRT can be reported separately on the initial day of an ICU note provided the ICU time does **not** include the dialysis time
• Use a -25 modifier, then add the appropriate 90935, 90937, 90945, or 90947 code
ICU considerations

• As of 2008 (aka a really long time ago), on one day, you may bill for both an E&M visit and ICU code on the same day
  – Example: treating a patient with hyperkalemia on the floor after your E&M visit
  – For patients ≥ 6 years of age (99291, 99292)
# Critical Care

<table>
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<tr>
<th>CPT code</th>
<th>Description</th>
<th>2018 wRVUS</th>
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<tbody>
<tr>
<td>99468</td>
<td>Neonates 0-28 days, per diem, initial</td>
<td>18.46</td>
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<tr>
<td>99469</td>
<td>Neonates 0-28 days, per diem, subseq</td>
<td>7.99</td>
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<tr>
<td>99471</td>
<td>Infants 29d-23m, per diem, initial</td>
<td>15.98</td>
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<td>99472</td>
<td>Infants 29d-23m, per diem, subseq</td>
<td>7.99</td>
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<tr>
<td>99473</td>
<td>Pediatric 2-5 yrs, per diem, initial</td>
<td>11.25</td>
</tr>
<tr>
<td>99474</td>
<td>Pediatric 2-5 yrs, per diem, subseq</td>
<td>6.75</td>
</tr>
<tr>
<td>99291</td>
<td>≥ 6 years, first hour (35-74 minutes)</td>
<td>4.50</td>
</tr>
<tr>
<td>99292</td>
<td>≥ 6 years, additional 30 mins (105,135...)</td>
<td>2.25</td>
</tr>
</tbody>
</table>
## Inpatient wRVU for 2020

<table>
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<tbody>
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<td>2.11</td>
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<td>90947 (repeat eval)</td>
<td>2.52</td>
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<tr>
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<td>4.50</td>
</tr>
<tr>
<td>99291+99292 (75-104 mins)</td>
<td>6.75</td>
</tr>
</tbody>
</table>

- No wRVU changes since 2011
- Critical care codes are highest value
- Repeat visits of HD, PD and CRRT more wRVU than a level 3 follow-up visit

**Document**
Apheresis Billing/Documentation

• Procedure Note
  – The better the details, the less risk for claim denial
• Must see patient during the treatment
• Can be billed on same day as other procedures
• Billable with a -25 modifier on first day as consult. Otherwise, cannot combine with E&M codes
# Apheresis wRVUs

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>2017 wRVU</th>
<th>2020 wRVU</th>
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</thead>
<tbody>
<tr>
<td>36511</td>
<td>WBC depletion</td>
<td>1.74</td>
<td>2.00</td>
</tr>
<tr>
<td>36512</td>
<td>RBC exchange</td>
<td>1.74</td>
<td>2.00</td>
</tr>
<tr>
<td>36513</td>
<td>Platelet depletion</td>
<td>1.74</td>
<td>2.00</td>
</tr>
<tr>
<td>36514</td>
<td>Plasmapheresis</td>
<td>1.74</td>
<td>1.81</td>
</tr>
<tr>
<td>36522</td>
<td>Photopheresis</td>
<td>1.67</td>
<td>1.75</td>
</tr>
<tr>
<td>38205</td>
<td>Stem Cell harvest for allogenic tx</td>
<td>1.50</td>
<td>1.50</td>
</tr>
</tbody>
</table>

Last changed in 2018
# Inpatient wRVU for 2020

<table>
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<tr>
<th>Code</th>
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<tr>
<td>99232</td>
<td>1.39</td>
</tr>
<tr>
<td>38205 (stem cell)</td>
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<tr>
<td>36522 (photo)</td>
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<tr>
<td>36514 (plasmaph)</td>
<td>1.81</td>
</tr>
<tr>
<td>99233</td>
<td>2.00</td>
</tr>
<tr>
<td>36511,36512,36513 (RBC, WBC, Plt)</td>
<td>2.00</td>
</tr>
</tbody>
</table>

- Last wRVU changes 2018
- All pheresis therapies have more wRVU than a level 2 follow-up visit
- Unless patient has complex Nephrology involvement, best to simply document pheresis for the day
- **Document**
Questions?
ESRD Prospective Payment System

• Overall conversion factor increased by $4.06
• Base rate for 2020 at $239.33
  $240.36 (2013)
ESRD Prospective Payment System

• Pediatric outlier service decreased to $32.32 per treatment
  – $35.18 (2019), $47.79 (2018), $68.49 (2017),

• Likely that Pediatric facilities are doing worse reporting associated costs
ICU considerations

• New codes started in 2009
  – ≤ 28 days of age – 99468, 99469
  – 29 days thru 24 months – 99471, 99472
  – 2-5 years – 99475, 99476

• These are per diem codes
• Only will pay one code of these per day
• Intensivists likely under same tax ID #
ICU considerations

• For children 6 years of age and older
• 99291
  – 30-74 minutes, wRVU 4.50
• 99292
  – Each additional 30 minutes (≥ 75 minutes for first 99292 code), wRVU 2.25
• Both intensivist and other physicians can bill on same day as long as times do NOT overlap
ICU considerations – 99291, 99292

• Must meet definition of critical care
• Critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition without a high level of support
• Document specifics of ICU illness – narrative fine
ICU considerations – 99291, 99292

• Potential phrases to document:
  – I was the sole provider of critical care for this patient from xx:xx through xx:xx.
  – This patient requires (ongoing) critical care due to potential life threatening [conditions/complications]
    • Hyperkalemia
    • Kidney failure
    • others
ICU considerations – 99291, 99292

• Times documented with patient cannot overlap between billing physicians
• Exact time with patient in ICU devoting all time for patient
• Cannot duplicate a 99291 on the same date for the same specialty group
  – ICU and nephrology separately are ok
  – 2 nephrologists or 2 ICU are not
  – Only one billing physician per group
ICU considerations – 99291, 99292

• Cannot include resident teaching time, literature research time
• Can include review of management, data, etc... with other physicians
• Family discussion times can be included
Transitional Care Management

• CMS had data to support that the sooner the patients were seen after discharge, the lower the risk of readmission (saving them money)

• Allowable as of Jan 1, 2020

• 99495 – moderate medical decision complexity (face-to-face visit within 14 days of discharge)

• 99496 – high medical decision complexity (face-to-face visit within 7 days of discharge)
## TCM code value

<table>
<thead>
<tr>
<th>Code</th>
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</tr>
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<tr>
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<td>0.97</td>
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<tr>
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<td>1.50</td>
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<tr>
<td>99215</td>
<td>2.11</td>
</tr>
<tr>
<td>99495 [14d]</td>
<td>2.36 ($187.67)</td>
</tr>
<tr>
<td>99496 [7d]</td>
<td>3.10 ($247.93)</td>
</tr>
</tbody>
</table>
TCM requirements

• Must have been discharged from one of the following:
  – Inpatient Acute Care Hospital
  – Inpatient Psychiatric Hospital
  – Long Term Care Hospital
  – Skilled Nursing Facility
  – Inpatient Rehabilitation Facility
  – Hospital outpt observation or partial hospitalization
  – Partial hospitalization at a Community Mental Health Center
TCM Requirements

• Initial *office* contact within 2 business days
• Non-face-to-face management (many)
  – Community and physician referrals
  – Lab/imaging follow-up
  – Education services
• Face-to-Face visit
TCM Documentation

• Date the beneficiary was discharged
• Date of interactive contact with the beneficiary and/or caregiver
  – Staff must attempt to contact within 2 business days of discharge
• Date you furnished the face-to-face visit
• The complexity of medical decision making (moderate or high)
TCM – Other Considerations

- Only can be provided by one care provider
- Only can be reported once per beneficiary
- Cannot report ESRD or CCM codes
- Surgeons cannot report during post-op global
- Can be done by Telehealth
  - Replaces face-to-face portion