2022 CPT® Updates – Physician Focused Webinar

December 2, 2021
Webinar FAQ Document

1. **Question** – If RTM, PCM, CCM or CCCM are being provided in a hospital-based outpatient department by the physician or QHP, what is the corresponding facility charge on those services?

   Answer – Remote therapeutic monitoring (RTM), principal care management (PCM), chronic care management (CCM) and complex chronic care management (CCCM) services now have codes specific for the physician or qualified healthcare provider (QHP) and for clinical staff time spent. Hospital-based outpatient departments may report the set of codes designated for clinical staff. Note that the clinical staff time spent must be documented and does not directly correlate to the time spent by the physician or QHP.

   For RTM services, the Current Procedural Terminology (CPT®) codes for facility reporting are:
   98975 *Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment*

   98976 *Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days*

   98977 *Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days*[1]

   For PCM Services, the CPT® codes for facility reporting are:
   99426 *Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, 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, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.*

   99427 *Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires*

[1] CPT® 2022 Manual, Professional Edition, "Remote Therapeutic Monitoring Services," pgs 842-843

frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 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)[2]

For CCM services, the CPT® codes for facility reporting are:
99490 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.*

99439 *Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; 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)* [3]

For CCCM services, the CPT® codes for facility reporting are:
99487 *Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.*

99489 *Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 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)* [4]

2. **Question** – Can fracture care be reported for checking a cast a week after application?

   Answer – The answer is dependent upon whether or not the physician or qualified healthcare provider (QHP) has assumed responsibility for the entirety of fracture care. Most fracture care codes have either a 10-day or 90-day global surgical period. If the provider has assumed the fracture treatment care, and this is the first time seeing the patient, then it may be appropriate to report the fracture care code.

[2] CPT® 2022 Manual, Professional Edition, "Table for Reporting Principal Care Management Services," page 68
[3] CPT® 2022 Manual, Professional Edition, "Table for Reporting Chronic Care Management Services," page 65
[4] CPT® 2022 Manual, Professional Edition, "Care Management Services," page 68

If the provider has not assumed fracture care treatment, then an evaluation and management (E/M) level may be used.[5]

3. **Question** – What codes would you use if the emergency department (ED) physician and an orthopedic specialist both treat the patient in the ED?

   Answer – Code selection is based upon the documentation for each provider. The ED physician may report the appropriate E/M level ED code, CPT® codes 99281-99285, as well as any other services provided. The orthopedic specialist may report anything from an E/M code to fracture care treatment, based upon the documentation.[6]

4. **Question** – A patient has a fractured fibula and is taken to the ED. The ED applies a cast to the leg and does some x-rays. It's determined that the patient is going to need surgery – an open reduction with internal fixation (ORIF). The patient is admitted as an inpatient. Two days later, an orthopedic surgeon takes the patient to surgery and removes the cast in the Operating Room (OR), does the surgery and reapplies the cast in the OR. Is the cast considered part of the surgical package or can the surgeon report 29515?

   Answer – For your scenario, the postoperative cast applied is considered part of the surgical treatment and not reported separately.[7]

5. **Question** – Can you provide insight into the new place of service (POS) codes 10 and how we determine what visits will be POS 02 versus POS 10?

   Answer – The POS code updates are not part of the CPT® coding updates, so were not included in the presentation. For 2022, there is a revision to POS code 02 and a new POS code. The revised and new code are:

   02 *Telehealth Provided Other than in Patient's Home*
   10 *Telehealth Provided in Patient's Home* [8]

   According to Transmittal 11045, Change Request 12427, Medicare Administrative Contractors (MACs) will add the new POS code to their adjudication systems by April 1, 2022, although the new POS code has an effective date of January 1, 2022.

   During the COVID-19 pandemic, the Centers for Medicare & Medicaid Services (CMS) is not requiring the use of telehealth POS codes. [9]

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[5] CPT® Assistant, "Reporting Fracture and Restorative Care and Dislocations", (January 2018)
[6] CPT® Assistant, "Reporting Fracture and Restorative Care and Dislocations", (January 2018)
[7] CPT® Assistant, "Reporting Fracture and Restorative Care and Dislocations", (January 2018)
[8] CMS Place of Service Code Set, available at: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set (September 2021)
[9] CMS Transmittal 11045, "New/Modifications to the Place of Service (POS) Codes for Telehealth" available at: https://www.cms.gov/files/document/r11045cp.pdf (October 13, 2021)

After the COVID-19 pandemic ends, CMS is to provide updated guidance due to two items. First, outside of the pandemic and by regulation, a patient's home is not an acceptable originating site. Second, an exception has been made for mental health and substance use disorders, effective January 1, 2022. The updated guidance for POS 10 should indicate when use of POS 10 is acceptable.[10]

[10] CMS Transmittal 11045, "New/Modifications to the Place of Service (POS) Codes for Telehealth" available at: https://www.cms.gov/files/document/r11045cp.pdf (October 13, 2021)