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HOME CENTERED CARE
INSTITUTE

2022 Coding & Policy Impacts: What Home-Based Providers and Practices need to know!

The Home Centered Care Institute

HCCIntelligenceTM Webinar—December 15, 2021

Presenters



Paul Chiang, MD

Medical Director, Northwestern Medicine, HomeCare Physicians
Senior Medical and Practice Advisor, Home Centered Care Institute



Brianna Plencner, CPC, CPMA

Senior Consultant & Manager, Practice Development, Home
Centered Care Institute

Session Objectives

Participants will:

- Review the significant coding, reimbursement, and policy impacts as a result of the CY 2022 Medicare Physician Fee Schedule Final Rule (MPFS) and how to best respond to these changes.
- Discuss payment impacts to the home and domiciliary Evaluation and Management (E/M) codes.
- Call out changes to care management services, telehealth, and remote/virtual care.



Evaluation & Management (E/M) & Payment Impacts

Conversion Factor

Home and Domiciliary E/M CPT codes were at risk of an average 3-4% pay cut

TABLE 134: Calculation of the CY 2022 PFS Conversion Factor

CY 2021 Conversion Factor		34.8931
Conversion Factor without CY 2021 Consolidated Appropriations Act Provision		33.6319
Statutory Update Factor	0.00 percent (1.0000)	
CY 2022 RVU Budget Neutrality Adjustment	-0.10 percent (0.9990)	
CY 2022 Conversion Factor		33.5983

New Legislation Passed to Prevent/Delay Payment Cuts

S. 610, the “Protecting Medicare and American Farmers from Sequester Cuts Act.”

- A delay in resuming the 2% Medicare sequester for three months (Jan. 1–March 31, 2022), followed by a reduction to 1% for three months (April 1–June 30, 2022). Full 2% decrease goes into effect from July 1, 2022–December 31, 2022.
- A one-year increase in the Medicare physician payment schedule of 3%, which is 0.75% less than the conversion factor boost provided for 2021.
- A one-year delay in the cuts to the clinical laboratory payment schedule.
- A one-year delay in the Medicare radiation oncology demonstration.
- Prevents the 4% Medicare pay-as-you-go (PAYGO) cut for 2022.

Home E/M Payment Comparison

CPT Code	2021 National Non-Facility Payment	Prevented CY 2022	wRVU
99341 (New Home Level 1)	\$54.43	\$52.41 (-3.71%)	1.01
99342 (New Home Level 2)	\$76.76	\$74.59 (-2.84%)	1.52
99343 (New Home Level 3)	\$127.01	\$121.29 (-4.50%)	2.53
99344 (New Home Level 4)	\$181.10	\$174.71 (-3.53%)	3.38
99345 (New Home Level 5)	\$220.52	\$211.67 (-4.02%)	4.09
99347 (EST Home Level 1)	\$54.78	\$53.09 (-3.10%)	1.0
99348 (EST Home Level 2)	\$ 83.74	\$80.64 (-3.71%)	1.56
99349 (EST Home Level 3)	\$129.10	\$124.31 (-3.71%)	2.33
99350 (EST Home Level 4)	\$ 178.65	\$172.36 (-3.52%)	3.28

Legislation finalized to delay, and/or minimize MPFS pay cuts

Domiciliary E/M Payment Comparison

CPT Code	2021 National Non-Facility Payment	Prevented CY 2022	wRVU (2021)
99324 (New DOM Level 1)	\$54.08	\$52.41 (-3.09%)	1.01
99325 (New DOM Level 2)	\$79.21	\$76.60 (-3.29%)	1.52
99326 (New DOM Level 3)	\$ 138.53	\$132.71 (-4.20%)	2.63
99327 (New DOM Level 4)	\$ 185.63	\$178.74 (-3.71%)	3.46
99328 (New DOM Level 5)	\$ 218.43	\$210.33 (-3.71%)	4.09
99334 (EST DOM Level 1)	\$ 60.02	\$58.80 (-2.03%)	1.07
99335 (EST DOM Level 2)	\$ 95.61	\$92.40 (-3.36%)	1.72
99336 (EST DOM Level 3)	\$ 135.39	\$130.70 (-3.46%)	2.46
99337 (EST DOM Level 4)	\$ 193.66	\$187.14 (-3.36%)	3.58

Disclaimer: Payment rates shown are based on national fee schedule rates, check with your MAC for exact payment for your locality

How to Verify Fee Schedule Rates in Your Region

The screenshot shows the CMS.gov homepage with a search bar and navigation tabs. The breadcrumb trail is: Home > Medicare > Contractor Provider Customer Service Program - General Information > MAC Resources > MAC Website List. The left sidebar contains links for Comprehensive Error Rate Testing (CERT) Outreach and Education Task Forces, MAC Resources, and Performance Data. The main content area is titled "MAC Website List" and includes instructions: "Find your Medicare Administrative Contractor's (MAC) website by selecting your place of business or MAC's name. Also included at the end of the 'MAC Name' list are links to specialty contractors you may also interact with as a Medicare provider or supplier. Providers who submit claims not based on their place of business can use the MAC name list." Below this, there are two sections: "Place of Business" with a list of state and territory links (Alabama through Wyoming and District of Columbia), and "MAC Name" with links to CGS, First Coast, National Government Services, Noridian, Novitas, Palmetto, and WPS.

CMS.gov
Centers for Medicare & Medicaid Services

Search CMS Search

Medicare Medicaid/CHIP Medicare-Medicaid Coordination Private Insurance Innovation Center Regulations & Guidance Research, Statistics, Data & Systems Outreach & Education

Home > Medicare > Contractor Provider Customer Service Program - General Information > MAC Resources > MAC Website List

Contractor Provider Customer Service Program - General Information

[Comprehensive Error Rate Testing \(CERT\) Outreach and Education Task Forces](#)

[MAC Resources](#)

[Performance Data](#)

MAC Website List

Find your Medicare Administrative Contractor's (MAC) website by selecting your place of business or MAC's name. Also included at the end of the "MAC Name" list are links to specialty contractors you may also interact with as a Medicare provider or supplier. Providers who submit claims not based on their place of business can use the MAC name list.

Place of Business

[Alabama](#) - [Alaska](#) - [Arizona](#) - [Arkansas](#) - [California](#) - [Colorado](#) - [Connecticut](#) - [Delaware](#) - [Florida](#) - [Georgia](#) - [Hawaii](#)

[Idaho](#) - [Illinois](#) - [Indiana](#) - [Iowa](#) - [Kansas](#) - [Kentucky](#) - [Louisiana](#) - [Maine](#) - [Maryland](#) - [Massachusetts](#) - [Michigan](#)

[Minnesota](#) - [Mississippi](#) - [Missouri](#) - [Montana](#) - [Nebraska](#) - [Nevada](#) - [New Hampshire](#) - [New Jersey](#) - [New Mexico](#)

[New York](#) - [North Carolina](#) - [North Dakota](#) - [Ohio](#) - [Oklahoma](#) - [Oregon](#) - [Pennsylvania](#) - [Rhode Island](#) - [South Carolina](#)

[South Dakota](#) - [Tennessee](#) - [Texas](#) - [Utah](#) - [Vermont](#) - [Virginia](#) - [Washington](#) - [West Virginia](#) - [Wisconsin](#) - [Wyoming](#)

[District of Columbia](#) - [American Samoa](#) - [Guam](#) - [Northern Mariana Islands](#) - [Puerto Rico](#) - [U.S. Virgin Islands](#)

MAC Name

[CGS](#) - [First Coast](#) - [National Government Services](#) - [Noridian](#) - [Novitas](#) - [Palmetto](#) - [WPS](#)

The screenshot shows the National Government Services website for Jurisdiction 6 - Part B in Illinois. The breadcrumb trail is: Home > ENROLLMENT > CLAIMS & APPEALS > MEDICAL POLICY & REVIEW > EDUCATION > Overpayment > Provider Resources. The main content area is titled "FEE SCHEDULE LOOKUP" and includes instructions: "To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select Search." Below this is a form titled "ENTER SEARCH CRITERIA" with fields for: Select a Fee Schedule (Medicare Physician Fee Schedule Pricing), Result Type (Full Fee Schedule selected), Date of Service (01/19/2021), and Region (Illinois (area 16)). A Search button is at the bottom. A feedback link is on the left. Below the form is a section titled "CODE SEARCH RESULTS" with the text "Please Enter Search Criteria".

National Government Services
JURISDICTION 6 - PART B
IN ILLINOIS

Enter keywords or phrases Search >

Contact Us | Subscribe to Email Updates | NGSConnex

Home ENROLLMENT CLAIMS & APPEALS MEDICAL POLICY & REVIEW EDUCATION Overpayment Provider Resources

FEE SCHEDULE LOOKUP

To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select **Search**.

ENTER SEARCH CRITERIA

*Select a Fee Schedule: Medicare Physician Fee Schedule Pricing

*Result Type: ☒ Full Fee Schedule ☐ Specific To Fee Code

*Date of Service: 01/19/2021

*Region: Illinois (area 16)

Search

(* indicates a required field)

CODE SEARCH RESULTS

Please Enter Search Criteria

E/M Related- Split/Shared Visits

CMS defined their definition and policy for split/shared E/M visits which only apply to the facility (inpatient) setting including SNF

- Definition of a split (or shared) visit as an E/M visit in the facility setting that is performed in part by both a physician and NPP who are in the same group, in accordance with applicable laws and regulations, such that the E/M visit could be billed by either the physician or the NPP if it were furnished independently by only one of them in the facility setting
- The visit is billed under the physician or NPP who performs a substantive portion of the visit.
- HCPCS Modifier **FS** (Split or Shared E/M Service)

E/M Related- Split/Shared Visits (continued)

- Documentation in the medical record must identify the physician and nonphysician practitioner who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.
- CMS: it would NOT be appropriate to consider a brief or trivial interaction, with or without direct patient contact, such as where the physician merely “pokes their head” into the room, to be a substantive portion of the visit. We did not believe it would be appropriate to permit a physician to bill for a visit if they do not substantially participate in the visit, given that physicians are paid under the PFS at a higher rate than NPPs.
- May be billed for both new and established patients and initial and subsequent visits

Definition of Substantive Portion of E/M Visit

TABLE 26: Final Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/Nursing Facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

Acronyms: E/M (Evaluation and Management), MDM (medical decision-making).

*Office visits will not be billable as split (or shared) services.

A group of five healthcare professionals, including three men and two women, are seated around a table in a modern office setting. They are engaged in a discussion, with some looking at a laptop and others at a tablet. The image is overlaid with a solid blue filter. The text "Care Management & Telehealth" is centered in white.

Care Management & Telehealth

CY 2022 Increased CCM Reimbursement

CPT Code	2021 wRVU	2022 wRVU	2022 Payment
99490 (Traditional CCM, 20 mins per calendar month, clinical staff & billing provider time)	0.61	1.00	\$62.16
99439 (Traditional CCM add-on code, each additional 20 mins)	0.54	0.70	\$47.04
99491 (Provider CCM, 30 minutes per calendar month by the billing provider)	1.45	1.50	\$83.66
99437 (New CPT code, Provider CCM add-on, each additional 30 mins)	N/A	1.0	\$59.47
99487 (Complex CCM, 60 minutes per calendar month)	1.0	1.81	\$130.36
99489 (Complex CCM add-on code, each additional 30 mins)	0.50	1.0	\$68.54

New Finalized Principal Care Management (PCM)

CPT code	Payment	wRVU
99424 (Replaces G2064; Billing Provider 30 mins per calendar month)	\$80.97	1.45
99425 (New code; Provider PCM add-on code each additional 30 mins per calendar month)	\$58.46	1.0
99426 (Replaces G2065; PCM clinical staff & Provider time 30 mins per calendar month)	\$61.48	1.0
99427 (New code; PCM add-on code clinical staff/provider each additional 30 mins per calendar month)	\$47.04	0.71

Telehealth Policy

During the PHE:

- All telehealth waivers and flexibility remain in place (**Current PHE expires 01/16/22**)

After the PHE:

- Medicare telehealth only for mental health when furnished in the home
- Section 123 of the CAA removed the geographic and site of service restrictions for telehealth services **furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder**
- Requires an in-person non-telehealth services furnished to the patient within **6 months prior and subsequent in person visits to be furnished at least once every 12 month for patients receiving Medicare telehealth services at home for mental health conditions (exceptions apply)**
- Modifier will be required on the claim
- In-person service may be provided by a colleague in the same specialty and same group as the billing provider
- Retain all services added to the Medicare telehealth list on a category 3 basis until the end of CY 2023
- **Audio-Only:** *For services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in their home, interactive telecommunications may include two-way, real-time audio-only communication technology if the distant site physician or practitioner is technically capable to use an interactive telecommunications system as defined in the previous sentence, but the patient is not capable of, or does not consent to, the use of video technology*

New Remote Therapeutic Monitoring (RTM) codes

CPT Code	Description	Payment	wRVU
98975 (Once per care episode)	RTM; (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	\$18.82	0.0
98976 (Each calendar month, min. 16 days of data)	RTM; device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system , each 30 days	\$54.09	0.0
98977 (Each calendar month, min. 16 days of data)	RTM device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system , each 30 days	\$54.09	0.0

New: (RTM) Treatment Management Services

CPT Code	Description	Payment	wRVU
98980 (Once each 30 days, cannot be reported for time less than 20 mins, requires a min. Of 16 days worth of data)	RTM MGMT Services physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes	\$48.72	1.45
98981	RTM MGMT Services add-on code each additional 20 minutes	\$39.65	1.18

Requires at least 1 interactive communication with the patient/caregiver, contributes to the total time but does not need to be the complete 20 minutes

RTM Guidelines

- Must be ordered by a qualified treating provider
- Must meet the definition of a medical device
- Minimum of 16 days of data during a calendar month must be collected in order to bill for it
- Requires a specific treatment plan for the need and goals
- 98975 (Initial set-up & education only reported once per care episode)
 - **Care Episode:** an episode of care is defined as beginning when the remote therapeutic monitoring service is initiated and ends with attainment of targeted treatment goals.

A group of five healthcare professionals, including three men and two women, are seated around a conference table in a modern office setting. They are all wearing white lab coats and have stethoscopes around their necks. The group is engaged in a discussion, with one man on the right gesturing with his hands while speaking. A laptop and some papers are on the table. The entire image is overlaid with a semi-transparent blue filter.

Immunizations

Vaccine Administration

Increased Administration Payment to \$30/per dose for:

- Influenza
- Pneumococcal
- Hepatitis B virus vaccines

COVID-19 Vaccine Administration:

- CMS will maintain the current payment rate of \$40/per dose through the CY in which the PHE ends

COVID-19 Vaccinations at Home

HCPCS M0201:

- CMS will continue the additional payment of \$35.50 when a COVID-19 vaccine is administered in a beneficiary's home, under certain circumstances, until the end of the year in which the PHE ends.

Eligibility Examples for Vaccine at Home:

- They have a condition, due to an illness or injury that restricts their ability to leave home without a supportive device or help from a paid or unpaid caregiver.
- They have a condition that makes them more susceptible to contracting a pandemic disease, like COVID-19.
- They are generally unable to leave the home and if they do leave the home, it requires a considerable and taxing effort.

Add-on code M0201 may only be billed when the COVID-19 vaccine is the only service and sole reason for the visit on a date of service

COVID-19 Monoclonal Antibody Products

- CMS will continue to pay for COVID-19 monoclonal antibodies under the Medicare Part B vaccine benefit through the end of the CY in which the PHE ends.
- CMS will maintain the \$750 payment for administering a COVID-19 monoclonal antibody therapy in the home.

Refer to Resources:

HCCI Blog:

- <https://www.hccinstitute.org/getting-paid-for-covid-19-vaccine-at-home/>

CMS COVID-19 Vaccines and Monoclonal Antibodies:

- <https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies>



MSSP & MIPS CY 2022

Medicare Shared Savings Program (MSSP)

- MIPS extreme and uncontrollable circumstances policy automatically applied for individual MIPS eligible clinicians CY 2021 performance year
- Individual MIPS eligible clinicians will have all 4 performance categories reweighted to 0% and receive a neutral payment adjustment in 2023 unless they submit data
- CMS finalized longer transition for ACOs reporting electronic clinical quality measures (Alternative Payment Model Performance Pathway)
- Delayed the increase in the quality performance standard ACOs must meet to be eligible to share in savings until PY 2024, by maintaining the 30th percentile of the MIPS quality performance category score for PY 2023
- MSSP administrative clean up (revised ACO repayment mechanism, updated primary care definition including virtual services, streamline application process, clarified beneficiary notification requirements)

MIPS Performance Categories Weight

For the 2022 performance year/2024 payment year, the performance category weights are:

Performance Category	Reporting Weight
Quality	30%
Cost	30%
Improvement Activities	15%
Promoting Interoperability	25%

Exploring MIPS Quality Measures

Refer to Appendix 1: MIPS Quality Measures Final Rule PG 2029

- Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)
- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients
- Functional Assessments
- Cognitive Assessments

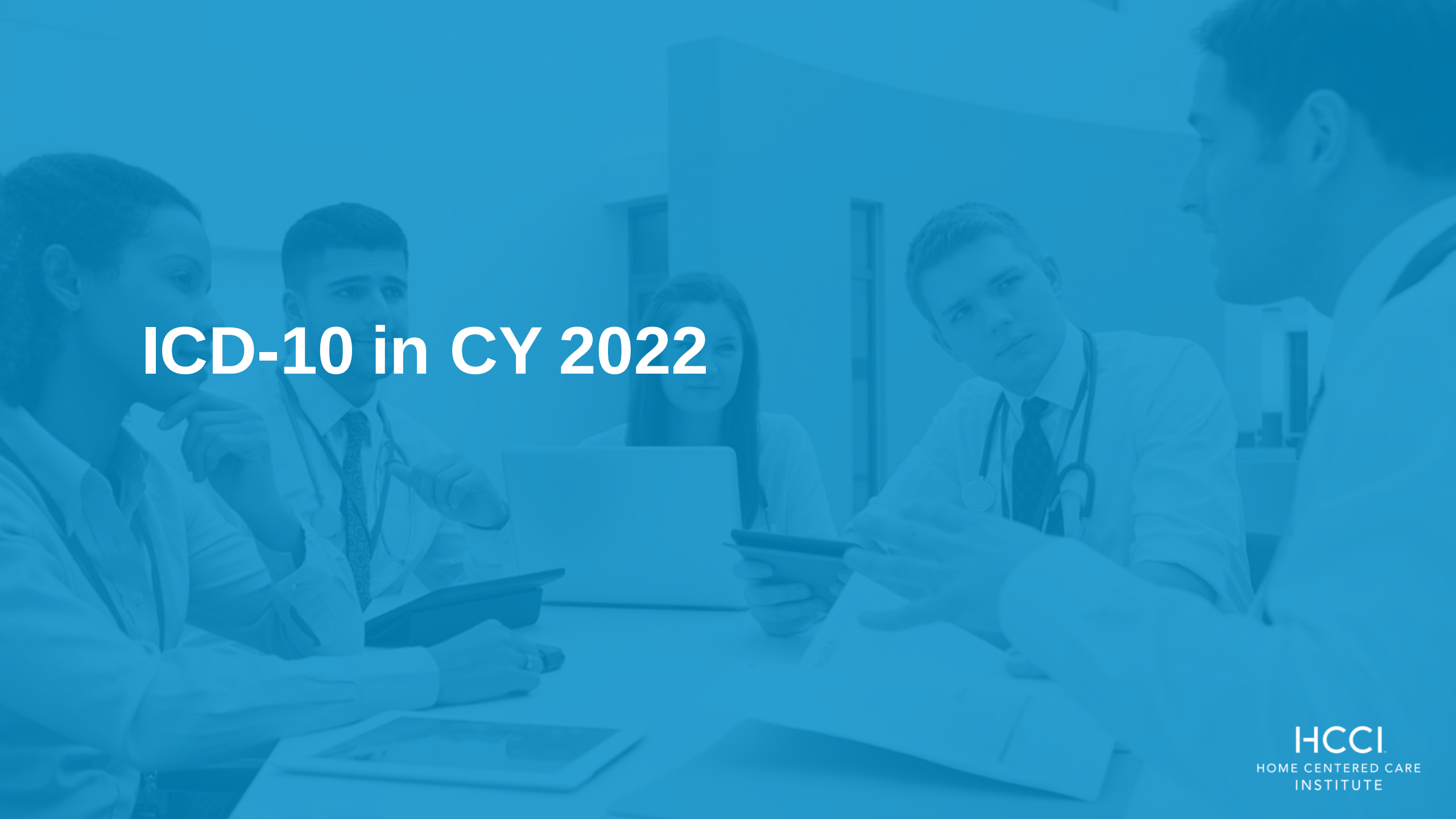
Check your MIPS/QPP Participation Status:

- <https://qpp.cms.gov/participation-lookup>

MIPS Value Pathways (MVP's)- Transition begins CY 2023

The 7 MVPs for the 2023 performance year are the following:

1. Advancing Rheumatology Patient Care
2. Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
3. Advancing Care for Heart Disease
4. Optimizing Chronic Disease Management
5. Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
6. Improving Care for Lower Extremity Joint Repair
7. Support of Positive Experiences with Anesthesia



ICD-10 in CY 2022

CY 2022 ICD-10 Codes/Changes

Post COVID-19 Condition: ICD-10: U09.0

- For sequela of COVID-19, or associated symptoms or conditions that develop following a previous COVID-19 infection, assign a code(s) for the specific symptom(s) or condition(s) related to the previous COVID-19 infection, if known, and code U09.9, Post COVID-19 condition, unspecified.
- Not used for active COVID-19 infections
- If a patient has a condition(s) associated with a previous COVID-19 infection and develops a new active (current) COVID-19 infection, code U09.9 may be assigned in conjunction with code U07.1, COVID-19, to identify that the patient also has a condition(s) associated with a previous COVID-19 infection. Code(s) for the specific condition(s) associated with the previous COVID-19 infection and code(s) for manifestation(s) of the new active (current) COVID-19 infection should also be assigned.

CY 2022 ICD-10 Codes/Changes

Z71.85 – Encounter for immunization safety counseling

- Vaccine product safety counseling, code also, Z23 for immunization administration encounters

Z79.4, Long term (current) use of insulin

Z79.84, Long term (current) use of oral hypoglycemic drugs

- If the patient is treated with both oral medications and insulin assign both codes

New Low Back Pain ICD-10 Codes:

- M54.50 (Low back pain, unspecified)
- M54.51 (Vertebrogenic low back pain)
- M54.59 (Other low back pain)

Social Determinants of Health (SDoH)

ICD-10 Categories:

- Z55 Problems related to education and literacy
- Z56 Problems related to employment and unemployment
- Z57 Occupational exposure to risk factors
- Z58 Problems related to physical environment
- Z59 Problems related to housing and economic circumstances
- Z60 Problems related to social environment
- Z62 Problems related to upbringing
- Z63 Other problems related to primary support group, including family circumstances
- Z64 Problems related to certain psychosocial circumstances
- Z65 Problems related to other psychosocial circumstances

New SDoH ICD-10 codes

ICD-10 Codes:

- Z55.5- Less than a high school diploma & no GED
- Z58.6- Inadequate drinking water supply
- Z59.00- Homelessness, unspecified
- Z59.01- Sheltered Homelessness
- Z59.02- Unsheltered Homelessness
- Z59.41- Food insecurity (Inadequate or lack of food)
- Z59.48 Other specific lack of inadequate food
- Z59.81- Housing instability, house- past due rent/mortgage or unwanted moves
- Z59.811- Housing instability with risk of homelessness
- Z59.812 – Housing instability, housed, homeless in past 12 months
- Z59.819 – Housing instability, housed unspecified
- Z59.89 – Other problems related to housing and economic circumstances • Isolated dwelling



Other Policy Impacts

Physician Assistant/Associate (PA) Scope of Practice

Beginning January 1, 2022, PAs may bill Medicare directly for their professional services, reassign payment for their professional services, and incorporate with other PAs and bill Medicare for PA services.



Standards for Electronic Prescribing

Beginning on January 1, 2021, prescribers must, except in certain circumstances conduct prescribing for **at least 70% of their Schedule II, III, IV, and V controlled substances that are Part D drugs** electronically using the applicable standards

- RX's written for a beneficiary in a long-term care facility will not be included in determining compliance until January 1, 2025.
- Compliance actions against prescribers who do not meet the compliance threshold based on prescriptions written for a beneficiary in a long-term care facility will commence on or after January 1, 2025.
- Compliance actions against prescribers who do not meet the compliance threshold based on other prescriptions will commence on or after January 1, 2023

Exceptions to Electronic Prescribing Requirement

- Prescriber and dispensing pharmacy are the same entity
- Prescriber issues 100 or fewer controlled substance prescriptions for Part D drugs per calendar year as determined using CMS claims data as of December 31st of the preceding year.
- Prescriber has an NCPDP database address in the geographic area of an emergency or disaster declared by a Federal, State, or local government entity.
- Prescriber has received a CMS-approved waiver because the prescriber is unable to conduct electronic prescribing of controlled substances (EPCS) due to circumstances beyond the prescriber's control.

Medical Nutrition Therapy (MNT) Services

MNT:

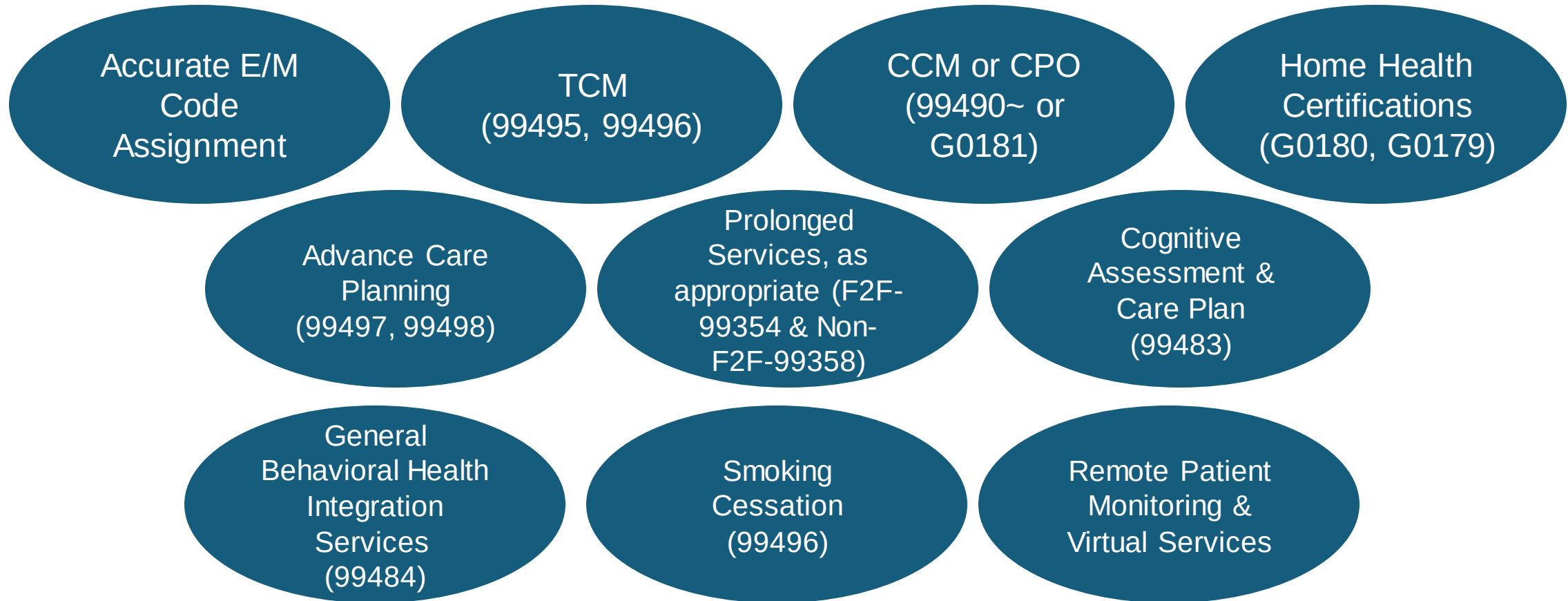
Defined as nutritional diagnostic, therapeutic, and counseling services that are furnished by a registered dietitian or nutrition professional for the purpose of managing diabetes or a renal disease. MNT establishes goals, a care plan, and interventions, as well as plans for follow-up over multiple visits to assist with behavioral and lifestyle changes relative to help address an individual's nutrition needs and medical condition or disease(s).

- Covered 100% as a Medicare Preventative Service, paid at 85% of the PFS
- Requires a referral from a physician (MD/DO), not adjusting regulation at this time
- Eligible as a telehealth service
- Refer to CPT 97802-97804, & HCPCS G0270, G0271

A group of healthcare professionals, including doctors and nurses, are gathered around a table in a modern office setting. They are engaged in a discussion, with some looking at a laptop and others at a tablet. The image is overlaid with a blue tint.

Thinking About Practice Sustainability

Determine Practice Billing Model





HCCIntelligence™ Virtual Office Hours: Ask the Experts

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Maximizing Revenue and Value in 2022: Billing, Coding and Documentation in Home-Based Care

HCCI will be hosting a 3-part HCCIntelligence Premier Webinar Series focused on maximizing revenue while decreasing workflow burdens, ensuring appropriate reimbursement for all services provided, and how to develop & implement valuable internal audit and compliance plans.

Registration Opening Soon

February 23rd – 4pm to 5:30pm CST

Mastering E/M Coding & Documentation for the Home & Domiciliary Settings

March 23rd – 4pm to 5:30pm CST

Maximizing Revenue: Beyond E/M Coding & Documentation

April 27th – 4pm to 5:30pm CST

Empowering Practices: Implementing Internal Coding Audits & Quality Improvement Plans

Contact HCCI



Website

hccinstitute.org



Phone

(630) 283-9200



Email

info@hccinstitute.org

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