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Meet the Presenter…

On the topic:
Conquer the Complexities of Coding for Chronic Conditions
Conquer the Complexities of Coding for Chronic Conditions

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Introduction

• The Facts:
  – Almost one third (1/3) of the U.S. population were suffering with multiple chronic conditions (MCC) in 2010.
  – Around 49% of those working age Americans between 45-64 had MCCs in 2010.
  – Prevalence of MCCs in Americans increase with age with around 80% of people 65 and older living with MCC in 2010.
  – Healthcare needs for these individuals are complex and costly.
  – It is important to continue to monitor these statistics as the U.S. population ages and citizens live longer – as the incidence of people with MCCs in this country is expected to grow in future years.

  (Source: AQRH: “Multiple Chronic Conditions Chartbook 2010 MEPS Data”)
Centers for Disease Control and Prevention (CDC) Website – Staggering Statistics!

• “As of 2012, about half of all adults – 117 million people-had one or more chronic health conditions.”
• “One of four adults had two or more chronic health conditions.”
• “Two of these chronic diseases – heart disease and cancer-together accounted for nearly 48% of all deaths.”
• “Obesity is a serious health concern. During 2009-2010, more than one-third of adults, or about 78 million people, were obese (defined as body mass index (BMI- >30kg/m2). Nearly one of five youths aged 2-19 years was obese (BMI->95th percentile.”
• “Diabetes is the leading cause of kidney failure, lower-limb amputations other than those caused by injury, and new cases of blindness amount adults.”

Multiple Chronic Conditions Chartbook
2010 Medical Expenditure Panel Survey Data

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care  www.ahrq.gov
Prevalence and Scope of MCC

All types of people are affected by chronic disease, although older people and women are the most likely to report one or more chronic condition. The charts below present information about the prevalence of chronic disease and multiple chronic conditions, as well as the most common chronic conditions for adults and children.

In 2010, over a half (51.7%) of all Americans had at least one chronic condition and almost 1/3 (31.5%) of all Americans had multiple chronic conditions.
Age and Chronic Conditions

The prevalence of multiple chronic conditions increases dramatically with age.

Almost half of all people aged 45 – 64, and 80% of those 65 and over, have multiple chronic conditions.
Most Prevalent Chronic Conditions in Adults (18 and Older) (2010)

- Hypertension (high blood pressure): 26.7%
- Hyperlipidemia (high blood cholesterol or triglyceride levels): 21.9%
- Allergies, sinusitis and other upper respiratory conditions: 13.5%
- Arthritis: 13.0%
- Mood Disorders (depression and bipolar disorder): 10.6%
- Diabetes (Type 1 and Type 2): 9.5%
- Anxiety Disorders: 6.7%
- Asthma: 6.2%
- Coronary artery disease (includes myocardial infarction/heart attack): 5.3%
- Thyroid disorders: 4.0%
- Chronic obstructive lung disease and bronchiectasis: 3.5%

Most Prevalent Chronic Conditions in Children (17 and Younger) (2010)

- Asthma: 7.8%
- Allergies and chronic respiratory diseases (other than asthma): 7.3%
- Attention-deficit and other behavior disorders: 5.7%
- Anxiety disorders: 1.7%
- Vision problems and blindness: 1.4%
- Migraine: 1.1%
- Chronic diseases of the esophagus: 1.0%
- Tooth and jaw problems (tooth loss and jaw deformities): 0.8%
- Mood disorders (depression and bipolar disorder): 0.8%
- Autism and other pervasive development disorders: 0.6%
- Learning and language disorders: 0.6%
- Diabetes (Type 1 and Type 2): 0.4%
Healthcare Spending

• 86% of healthcare spending is for patients with one or more chronic conditions.
• 71% of healthcare spending is for patients with multiple chronic conditions.
  – In other words, 71 cents of every dollar of healthcare spending goes to treating people with multiple chronic conditions.

Total U.S. Healthcare Spending by Number of Chronic Conditions in 2010

- 35.0% for persons with more than 5 chronic conditions
- 14.2% for persons with no chronic conditions
- 14.8% for persons with 1 chronic condition
- 13.0% for persons with 2 chronic conditions
- 11.2% for persons with 4 chronic conditions
- 11.8% for persons with 3 chronic conditions
From 1980 to 2014, the number of adults in the United States aged 18–79 with newly diagnosed diabetes more than tripled from 493,000 in 1980 to more than 1.4 million in 2014.

From 1991 to 2009, the number of new cases of diabetes increased sharply from 573,000 to more than 1.7 million. However, from 2009 to 2014, the number of new cases decreased significantly to approximately 1.4 million.
Diabetes – Age at Diagnosis
Centers Of Disease Control (CDC) 2011

2016 PAYMENTS FOR CHRONIC CARE SERVICES
CMS
Chronic Care Management Services

- CMS – “Recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals as well as reducing spending.”
- **Beginning 01/01/2015 – Medicare pays separately under the MPFS – AMA CPT© code 99490:**
  - For non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions.

CPT© Code 99490

- Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, 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 place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
  - Comprehensive care plan is established, implemented, revised or monitored.

*Source: Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicare Learning Network, ICN 909188, May, 2015, “Chronic Care Management Services”, page 1.*
Examples of Chronic Conditions
(Not Inclusive)

- Alzheimer's disease and related dementia;
- Arthritis (osteoarthritis and rheumatoid);
- Asthma;
- Atrial Fibrillation;
- Autism spectrum disorders;
- Cancer;
- Chronic Obstructive Pulmonary Disease;
- Depression;
- Diabetes;
- Heart Failure;
- Hypertension;
- Ischemic heart disease; and
- Osteoporosis

Medicare Learning Network – Excerpts from "Chronic Care Management", May 2015

Practitioner Eligibility

- “Physicians and the following non-physician practitioners may bill the new CCM services:
  - Certified Nurse Midwives;
  - Clinical Nurse Specialists;
  - Nurse Practitioners; and
  - Physician Assistants
- Only one practitioner may be paid for the CCM service for a given calendar month.
- Services provided directly by an appropriate physician or non-physician practitioner, or by clinical staff incident to the billing of such, count toward the minimum amount of service time required to bill the CCM service (20 minutes per calendar month.
- Non-clinical staff cannot be counted. Consult the CPT definition of “clinical staff” and the Medicare PFS ‘incident to” rules to determine whether time by specific individuals may be counted towards the minimum time requirement. Practitioners may use individuals outside the practice to provide CCM services, subject to the Medicare PFS “incident to” rules and regulations and all other applicable Medicare rules.”
Practitioner Eligibility

“Note: Eligible practitioners must act within their State Licensure, scope of practice, and Medicare statutory benefit. The CCM service may be billed most frequently by PCPs, although specialty physicians who meet all of the billing requirements may bill the service. The CCM service is not within the scope of practice of limited licensed physicians and practitioners such as clinical psychologist, podiatrist, or dentist, therefore these practitioners cannot furnish or bill the service. However, CMS expects referral to or consultation with such physicians and practitioners by billing practitioner to coordinate and manage care.” *CMS MedLearning Network, “Chronic Care Management Services, May, 2015)

Other Requirements

• Supervision:
  – CMS provided an exception under Medicare’s “incident to” rules that permits clinical staff to provide the CCM services incident to the services of the billing physician (or other appropriate practitioner) under the general supervision rules (rather than direct supervision rules).

• Patient Eligibility:
  – Patients with two or more (multiple) chronic conditions ..........

• Patient Agreement Requirements:
  – Practitioner must inform eligible patients of the availability of and obtain consent for the CCM services before furnishing or billing the service.
    • Some of the patient agreement provisions require the use of certified Electronic Health Record (EHR) technology. See the complete MedLearning Network Article for a complete listing of requirements.
Patient Agreement Requirements

- Inform patient of availability of CCM and obtain written agreement;
- Explain and offer CCM to patient and document discussion in medical record with notations as to patient’s acceptance of declination;
- Explain to patient how to revoke the service;
- Inform patient that only one provider can furnish and be paid for the service during a calendar month.

Comprehensive Evaluation

- CMS requires the billing practitioner to:
  - Furnish a comprehensive evaluation (E/M) visit, Annual Wellness Visit, or Initial Preventive Physician Examination (IPPE) to patient prior to billing the CCM service; and
  - To initiate the CCM service as part of this visit/exam.
  - Although patient cost-sharing applies to CCM, the service may help to avoid need for more costly face-to-face services in future by proactively managing patient’s health, vs only treating disease and illness.
Scope of Service Elements

Highlights of CCM

• Structured data recording:
  – Demographics;
  – Problems;
  – Medications, and medical allergies; and
  – Create structure clinical summary records using certified EHR

• Care Plan:
  – Create patient-centered care plan based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues);
  – Provide patient with written or electronic copy of care plan and document provision of such in medical record;
  – Ensure care plan is available electronically at all times to anyone within the practice providing the CCM;
  – Share the care plan electronically outside the practice as appropriate

Comprehensive Care Plan

• A plan for all health issues typically includes, but is not limited to the following:
  – Problem list;
  – Expected outcome and prognosis;
  – Measurable treatment goals;
  – Symptom management;
  – Planned interventions and identification of individuals responsible for each interventions;
  – Medical management;
  – Community/social services order;
  – Description of how services of agencies and specialists outside the practice will be directed/coordinated; and
  – Schedule for periodic review and, when applicable, revision of care plan.
Access to Care

• Ensure 24-hour-a day, 7 day-a-week (24/7) access to care management services, providing patient with a means to make timely contact with health care practitioners in the practice who have access to patient’s electronic care plan to address his/her urgent chronic care needs;

• Ensure continuity of care with a designated practitioner or member of care team with whom patient is able to get successive routine appointments;

• Provide enhanced opportunities for patient and any caregiver to communicate with practitioner regarding patient’s care. Do this through telephone, secure messaging, secure Internet, or asynchronous non face-to-face consultation methods, in compliance with HIPAA.

Manage Care

• Care management services such as:
  – Systematic assessment of patient’s medical, functional and psychosocial needs;
  – System-based approaches to ensure timely receipt of all recommend preventive care services;
  – Medication reconciliation with review of adherence and potential interactions; and
  – Oversight of patient self-management of medications

• Manage care transitions between and among health care providers and settings, including referrals to other providers through:
  – Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.

• Coordinate care with home and community based clinical service providers.
Manage Care

• CMS requires use of certified EHR to satisfy some of the CCM scope of service elements. However, at this time CMS does not require certified EHR for some of services involving the care plan and clinical summaries, allowing for broader electronic capabilities. See Table I, CCM Scope of Service and Billing Requirements in the MedLearn article of May, 2015.

Why Is Diagnosis Coding So Important?

• Diagnosis codes placed on claim forms are used for several purposes:
  – Supports medical necessity for services rendered and, therefore, heavily impacts reimbursement.
  – Communicates the condition(s) of patient that is substantiated in the medical records. Therefore, extremely important for Compliance.
  – Used for research and monitoring statistics
  – Medicare Advantage plans are partially paid based on diagnoses risk-adjusted factors. CMS varies payment per patient, per month based on the severity of the illness(es) of population of patients.
  – Accountable Care Organizations’ reimbursement is based on determination of acuity of population of patients.
  – Most reimbursement methodologies are, or will soon be, based on severity of patient’s being treated.
ICD-10-CM Guidelines for Coding Chronic Conditions

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2016

Narrative changes appear in bold text
Items underlined have been moved within the guidelines since the FY 2014 version
Italics are used to indicate revisions to heading changes

These guidelines have been approved by the four organizations that make up the Cooperating Parties for the ICD-10-CM: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), CMS, and NCHS.

Adherence to these guidelines when assigning ICD-10-CM the Health Insurance Portability and Accountability Act

The Rules for Coding

13. Etiology/manifestation convention ("code first", "use additional code" and "in diseases classified elsewhere" notes)

Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first followed by the manifestation. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation.
G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

I. Chronic diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

J. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

K. Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the Z code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.
L. Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

HHS-HCC (Hierarchical Condition Categories)

- **HHS-HCC Diagnostic Classification** The basis of the HHS-HCC risk adjustment model is using health plan enrollee diagnoses (and demographics) to predict medical expenditure risk.

- To obtain a clinically meaningful and statistically stable system, the tens of thousands of ICD-9-CM/ICD-10-CM codes used to capture diagnoses must be grouped into a smaller number of organized categories that produce a diagnostic profile of each person.

- The adjustment risk model uses and individual’s demographics and diagnosis(es) to calculate a risk score which is relative measure of how costly that individual is anticipated to be for treatment.
CMS’s Hierarchical Condition Categories (HCCs)

- **Way back when** –
  - The Health Care Financing Administration (HCFA)
    - Balanced Budget Act of 1997 (BBA) established a new Part C Medicare program, known as the Medicare+Choice (M+C) program, effective January 1999.
    - Implemented inpatient-based risk adjustment for a portion of capitation payments to (M+C) plans on January 1, 2000
    - **Risk adjustment method used based on the Principal Inpatient Diagnostic Cost Group (DCG)**
    - DCG/HCC model utilized diagnoses for all physician and hospital encounters to profile beneficiary medical problems with diagnostic categories (HCCs)

Then In 2003…

- The M+C program in Part C of Medicare was renamed the Medicare Advantage (MA) Program under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).
  - Updated and improved the choice of plans for beneficiaries under Part C, and
  - Changed the way benefits were established and payments made.
How Are CMS Payments To Plans Determined?

- Research showed CMS Medicare Program expenditures were increasing for the managed care program as, in general, their enrollees were healthier than FFS enrollees.
- The complicated formulas for payment to the private carriers for administering Medicare enrollees did not account for this factor.

How Are CMS Payments To Plans Determined?

- The model was changed to reflect the beneficiary health status to set expected costs for upcoming year with the PIP-DCG-based payments which were introduced gradually – starting with only 10% of total Medicare capitation payments adjusted by the PIP-DCG factors in 2000.
- The other 90% were still with payments adjusted purely from demographic data.
- However, this method was only based on Principal Inpatient admissions and, therefore, if a MCO reduced admissions through better ambulatory care, they could end up with healthier patients but lower payments.
Principal Inpatient – Diagnostic Cost Group

• In 2000, Congress addressed the PIP-DCG limitations by requiring use of ambulatory diagnoses in Medicare risk-adjusted payments to be phased in from 2004 to 2007.

• CMS then was collecting data from MCOs for physician office and hospital outpatient settings – by gathering data from records of each enrollee visit to providers with dates, procedures performed, diagnoses, etc. from October of 2000 to April of 2001.

Principal Inpatient – Diagnostic Cost Group

• However, MCOs complained about the burdens of reporting encounter data so CMS suspended data collection in May, 2001, and eventually adopted a very stream-lined data reporting strategy.

• CMS evaluated several risk information systems and then decided on the DCG/HCC model which was part of the same DCG model.

• However, they enlisted funded researchers at RTI International and Boston University and with input from Harvard Medical School.
Some of the Main Principles Developed for the Diagnostic Categories

- CMS adapted some of the characteristics of the DCG/HCC model to develop the basis for Medicare risk-adjustment.

- **Main Principles:**
  - Diagnostic categories – A set of ICD-9-CM codes that relate to a well-specified disease or medical condition that defines the category
  - Diagnostic categories **should represent a meaningful way to predict next years’ costs based on the current year’s costs.**
  - Diagnostic categories should have **large enough sample size to calculate the estimated costs.**
  - For assessing a patient’s clinical profile, each **disease process should be reflected in a hierarchical method to recognize how any manifestations or unrelated diseases adds to the individual’s clinical condition.** Therefore, the more severe manifestations of a condition should dominate less serious ones.
  - Diagnostic categories **should encourage specific coding as vague diagnostic codes grouped with less severe and lower-paying categories to encourage more specific coding.**

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### Most Prevalent Chronic Diseases in Adults

<table>
<thead>
<tr>
<th>Order</th>
<th>Condition Label</th>
<th>Prevalence</th>
<th>CCS Codes Included in Label Grouping</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hypertension (high blood pressure)</td>
<td>26.6956</td>
<td>CCS 98 Essential hypertension, CCS 99 Hypertension with complications and secondary hypertension</td>
</tr>
<tr>
<td>2</td>
<td>Hyperlipidemia (high blood cholesterol or triglyceride levels)</td>
<td>21.8548</td>
<td>CCS 53 Disorders of lipid metabolism</td>
</tr>
<tr>
<td>3</td>
<td>Allergies, sinusitis and other upper respiratory conditions</td>
<td>13.4726</td>
<td>CCS 124 Acute and chronic tonsillitis, CCS 126 Other upper respiratory infection, CCS 134 Other upper respiratory disease</td>
</tr>
<tr>
<td>4</td>
<td>Arthritis</td>
<td>13.0205</td>
<td>CCS 201 Infective arthritis and osteomyelitis, CCS 202 Rheumatoid arthritis and related disease, CCS 203 Osteoarthritis, CCS 204 Other non-traumatic joint disorders</td>
</tr>
<tr>
<td>5</td>
<td>Mood Disorders (depression and bipolar disorder)</td>
<td>10.6173</td>
<td>CCS 657 Mood disorders</td>
</tr>
<tr>
<td>6</td>
<td>Diabetes (Type 1 and Type 2)</td>
<td>9.4652</td>
<td>CCS 49 Diabetes without complication, CCS 50 Diabetes with complications</td>
</tr>
<tr>
<td>7</td>
<td>Anxiety Disorders</td>
<td>6.7038</td>
<td>CCS 651 Anxiety Disorders</td>
</tr>
<tr>
<td>8</td>
<td>Asthma</td>
<td>6.1954</td>
<td>CCS 128 Asthma</td>
</tr>
<tr>
<td>9</td>
<td>Coronary artery disease (includes myocardial infarction/heart attack)</td>
<td>5.3103</td>
<td>CCS 100 Acute myocardial infarction, CCS 101 Coronary atherosclerosis and other heart disease</td>
</tr>
<tr>
<td>10</td>
<td>Thyroid disorders</td>
<td>3.971</td>
<td>CCS 48 Thyroid disorders</td>
</tr>
<tr>
<td>11</td>
<td>Chronic obstructive lung disease and bronchiectasis</td>
<td>3.4999</td>
<td>CCS 127 Chronic obstructive lung disease and bronchiectasis</td>
</tr>
</tbody>
</table>
Hierarchical Condition Categories
Aggregations of ICD-CM Codes

- ICD-9-CM Codes (n = 15,000+)
  - Diagnostic Groups (n = 804)
    - Condition Categories (n = 189)
      - Hierarchical Condition Categories

NOTE: ICD-9-CM is International Classification of Diseases, Ninth Revision, Clinical Modification. SOURCE: (Pope et al., 2000b.)

Hierarchical Condition Categories
Coronary Artery Disease Hierarchy

- Acute Myocardial Infarction
  - Unstable Angina and Other Acute Ischemic Heart Disease
    - Angina Pectoris/Old Myocardial Infarction
      - Coronary Atherosclerosis/Other Chronic Ischemic Heart Disease

SOURCE: (Pope et al., 2000b.)
HCCs – How Does It Work?

• Hierarchies – assigned among related CCs so that a person is only coded for the most severe manifestation among related diseases.

• For example in the table shown - Ischemic Heart Disease codes are organized in the Coronary Artery Disease hierarchy, consisting of 4 CCs arranged in descending order of clinical severity and cost, from CC 81 – Acute MI to CC 84 – Coronary Atherosclerosis/Other Chronic Ischemic Heart Disease.

HCCs – How Does It Work?

• A person with an ICD-CM code in CC 81 is excluded from being coded in CCs 82, 83, or 84 even if codes that group into those categories were also present.

• Similarly, a person with ICD-CM codes that group into both CC 82 Unstable Angina and Other Acute Ischemic Heart Disease, and CC 83 Angina Pectoris/Old MI is coded for CC 82, but not 83.

• After imposing the hierarchies, CCs become Hierarchical Condition Categories, HCCs.
HCCs – How Does It Work?

- HCCs reflect hierarchies among related disease categories.
- For unrelated diseases, HCCs accumulate.
  - Example: a male with heart disease, stroke and cancer:
    - Has at least three separate HCCs coded.
    - His predicted cost will reflect increments for all three problems.

HCCs – How Does It Work?

- However, the HCC model is more than simply additive as some disease combinations interact:
  - For instance – if a patient has both Diabetes and Congestive Heart Failure, the predicted cost could increase by more (or less) than the sum of the separate increments for people who have diabetes or CHF alone.
Affordable Care Act

- ACA goes beyond “reporting” programs and authorizes CMS to directly link payment rates to actual quality of care.
- ACA required implementation in Hospitals (other than psychiatric, rehabilitation, children’s, long-term care hospitals, and certain cancer treatment and research facilities).

Affordable Care Act

- ACA required implementation program for physicians through a payment modifier and development of Value-Based Purchasing programs.
- ACA implemented similar programs for SNFs, HHAs, and ASCs.
- Many state Medicaid and private payers are also developing and implementing Value Based payment methodologies.
Physicians Value-based Purchasing Program

• ACA required Secretary of HHS to develop measures of quality and cost of care.
  – Measure for quality
    • Based on composite of indicators of quality of care furnished, such as measures for outcomes of care

– Measures must be “risk-adjusted”
  – Factors such as demographics, socioeconomic, and health status of individuals
  – Evaluations of quality of care and costs, as well as establishment of a value-based modifier, are precluded from administrative or judicial review – not subject to challenge by courts.
– Final application of payment modifier began on 01/01/2015 for specific physicians and group practices.
– General application of payment modifier must begin by no later than 01/01/2017 for all physicians.
Is HCC to Be a “Crystal Ball”?

• HCC used by CMS to prospectively estimate future year’s predicted costs for enrollees.
• Been in place since 2004 for MA plans.
• Model now being applied to partially determine reimbursement for Accountable Care Organizations (ACOs) and the Hospital Value-Based Purchasing (HVBP) Program.

Is HCC to Be a “Crystal Ball”?

• Providers assume more accountability and subsequent risk- giving an opportunity for providers who properly document and code to receive additional funds. However, for those who do not do so, it can translate into lost revenues and increased risk.
• Once revenue is lost, it is not easy to get back.
ISSUES TO BE CONSIDERED

• Documentation
• Status of chronic conditions that coexist and impact care
• Assessment
• Plan of Care
• Correct coding

QUESTIONS?

• Q & A
• THANK YOU!!!!
• ENJOY NEW ORLEANS!

FYI:
• (See Appendix for information on Chronic Care Management CPT Services Requirements)
APPENDIX
FOR YOUR READING PLEASURE
AND REFERENCE -
ADDITIONAL INFORMATION ON
BILLING CHRONIC CARE
MANAGEMENT SERVICES - 99490
This fact sheet provides background on the newly payable chronic care management (CCM) service, identifies eligible providers and patients, and details the Medicare FFS billing requirements.

Examples of chronic conditions include, but are not limited to, the following:
- Alzheimer’s disease and related dementia;
- Arthritis (osteoarthritis and rheumatoid);
- Asthma;
- Atrial fibrillation;
- Autism spectrum disorders;
- Cancer;
- Chronic Obstructive Pulmonary Disease;
- Depression;
- Diabetes;
- Heart failure;
- Hypertension;
- Ischemic heart disease; and
- Osteoporosis.

2/3 of Medicare beneficiaries had 2 or more chronic conditions

About 1/3 had 4 or more chronic conditions

Source: http://www.cdc.gov/prodissues/2013/13_0137.htm

Practitioner Eligibility

Physicians and the following non-physician practitioners may bill the new CCM service:
- Certified Nurse Midwives;
- Clinical Nurse Specialists;
- Nurse Practitioners, and
- Physician Assistants.

NOTE: Eligible practitioners must act within their State license, scope of practice, and Medicare statutory benefit. The CCM service may be billed most frequently by primary care physicians, although specialty physicians who meet all of the billing requirements may bill the service. The CCM service is not within the scope of practice of limited license physicians and should not be billed by them.

Only one practitioner may be paid for the CCM service for a given calendar month.

Services provided directly by an appropriate physician or non-physician practitioner, or by clinical staff incident to the billing physician or non-physician practitioner, count toward the minimum amount of service time required to bill the CCM service (20 minutes per calendar month).

Non-clinical staff time cannot be counted. Consult the CPT definition of “clinical staff” and the Medicare FFS “incident to” rules to determine whether time by specific individuals may be counted toward the minimum time requirement. Practitioners may use individuals outside the practice to provide CCM services, subject to the Medicare FFS “incident to” rules and regulations and all other applicable Medicare rules.

Supervision

CMS provided an exception under Medicare’s “incident to” rules that permits clinical staff to provide the CCM service incident to the services of the billing physician (or other appropriate practitioner) under the general supervision (rather than direct supervision) of a physician (or other appropriate practitioner).

Patient Eligibility

Patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline are eligible for the CCM service.

Patient Agreement Requirements

A practitioner must inform eligible patients of the availability and obtain consent for the CCM service before furnishing or billing the service. Some of the patient agreement provisions require the use of certified Electronic Health Record (EHR) technology. For a complete listing of the Patient Agreement and Related EHR Requirements, see Table 1.

Patient consent requirements include:
- Inform the patient of the availability of the CCM service and obtain written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers.
- Explain and offer the CCM service to the patient. In the patient’s medical record, document this discussion and note the patient’s decision to accept or decline the service.
- Explain how to revoke the service.
- Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.
This agreement process should include a discussion with the patient, and caregiver when applicable, about:

- What the CCM service is;
- How to access the elements of the service;
- How the patient’s information will be shared among practitioners and providers;
- How cost-sharing (co-insurance and deductibles) applies to these services; and
- How to revoke the service.

Informed patient consent need only be obtained once prior to furnishing the CCM service, or if the patient chooses to change the practitioner who will furnish and bill the service.

CCM Scope of Service Elements - Highlights

The CCM service is extensive, including structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. Some of the CCM Scope of Service elements require the use of a certified EHR or other electronic technology. For a complete listing of the CCM Scope of Service elements and electronic technology requirements that must be met in order to bill the service, see Table 1.

**Structured Data Recording**
- Record the patient’s demographics, problems, medications, and medication allergies and create structured clinical summary records using certified EHR technology.

**Care Plan**
- Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (p.c.f.4) assessment, and an inventory of resources (a comprehensive plan of care for all health issues).
- Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record.
- Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service.
- Share the care plan electronically outside the practice as appropriate.

**Comprehensive Care Plan**

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list;
- Expected outcome and prognosis;
- Measurable treatment goals;
- Symptom management;
- Planned interventions and identification of the individuals responsible for each intervention;
- Medication management;
- Community/social services ordered;
- A description of how services of agencies and specialists outside the practice will be directed/coordinated; and
- Schedule for periodic review and, when applicable, revision of the care plan.

**Access to Care**

- Ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services, providing the patient with a means to communicate with their practitioner(s) who have access to the patient’s electronic care plan to address his or her urgent chronic care needs.
- Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient’s care. Do this through telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
EHR and Other Electronic Technology Requirements

CMS requires the use of certified EHR technology to satisfy some of the CCM scope of service elements. In furnishing these aspects of the CCM service, CMS requires the use of a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year (referred to as “CCM certified technology”). For more information, visit http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRincentivePrograms on the CMS website.

At this time, CMS does not require the use of certified EHR technology for some of the services involving the care plan and clinical summaries, allowing for broader electronic capabilities. These are described in Table 1, CCM Scope of Service and Billing Requirements.

Table 1. CCM Scope of Service and Billing Requirements

<table>
<thead>
<tr>
<th>CCM Scope of Service Element/Billing Requirement</th>
<th>Certified EHR or Other Electronic Technology Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intubation during an AW, IPPE, or comprehensive EM visit (billed separately).</td>
<td>None</td>
</tr>
<tr>
<td>Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record.</td>
<td>Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology.</td>
</tr>
<tr>
<td>Access to care management services 24/7 (providing the beneficiary with a means to make timely contact with health care practitioners in the practice who have access to the patient’s electronic care plan to address his or her urgent chronic care needs regardless of the time of day or day of the week).</td>
<td>None</td>
</tr>
<tr>
<td>Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.</td>
<td>None</td>
</tr>
<tr>
<td>Care management for chronic conditions including systematic assessment of the beneficiary’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.</td>
<td>None</td>
</tr>
<tr>
<td>Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (measurable and an inventory of resources and supports; a comprehensive care plan for all health issues; share the care plan as appropriate with other practitioners and providers.</td>
<td>Must at least electronically capture care plan information; make this information available on a 24/7 basis to all practitioners within the practice whose time counts towards the time requirement for the practice to bill the CCM code and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers.</td>
</tr>
</tbody>
</table>
### Table 1. CCM Scope of Service and Billing Requirements (cont.)

<table>
<thead>
<tr>
<th>CCM Scope of Service Element/Billing Requirement</th>
<th>Certified EHR or Other Electronic Technology Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.</td>
<td>Document provision of the care plan as required to the beneficiary in the EHR using CCM certified technology.</td>
</tr>
<tr>
<td>Management of care transitions between and among health care providers and settings, including referrals to other clinicians, follow-up after an emergency department visit and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.</td>
<td>Format clinical summaries according to CCM certified technology. Not required to use a specific tool or service to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by fax).</td>
</tr>
<tr>
<td>Coordination with home and community based clinical service providers.</td>
<td>Communication to and from home and community based providers regarding the patient’s psychosocial needs and functional deficits must be documented in the patient’s medical record using CCM certified technology.</td>
</tr>
<tr>
<td>Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary’s care through not only telephone access, but also through the use of secure messaging, Internet or other asynchronous non-face-to-face consultation methods.</td>
<td>None</td>
</tr>
<tr>
<td>Beneficiary consent—inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers. Document in the beneficiary’s medical record that all of the CCM services were explained and offered, and note the beneficiary’s decision to accept or decline these services.</td>
<td>Document the beneficiary’s written consent and authorization in the EHR using CCM certified technology.</td>
</tr>
<tr>
<td>Beneficiary consent—inform the beneficiary of the right to stop the CCM services at any time effective at the end of the calendar month and the effect of a revocation of the agreement on CCM services.</td>
<td>None</td>
</tr>
<tr>
<td>Beneficiary consent—inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.</td>
<td>None</td>
</tr>
</tbody>
</table>

### Other Billing Requirements

CPT code 99490 cannot be billed during the same service period as CPT codes 99490–99493 (transitional care management), Healthcare Common Procedure Coding System (HCPCS) codes G0181/G0182 (home health care supervision/hospice care supervision), or CPT codes 90951–90972 (certain End-Stage Renal Disease services). Also consult CPT instructions for additional codes that cannot be billed during the same service period as CPT code 99490. There may be additional restrictions on billing for practitioners participating in a CMS sponsored model or demonstration program.

### Payment

CMS pays for the new CCM service separately under the Medicare FEI. To find payment information for a specific geographic location, access the Medicare FEI Look-Up tool at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PTShoeup on the CMS website.

### CCM and Other CMS Advanced Primary Care Initiatives

The CCM service provides payment of care coordination and care management for a beneficiary with multiple chronic conditions within the Medicare Fee-For-Service Program. Medicare will not make duplicative payments for the same or similar services that are part of another primary care demonstration and other initiatives, such as the Multiple Advanced Primary Care Practice (MAPCP) or the Comprehensive Primary Care (CPC) Initiatives. For more information on potentially duplicative billing, consult the CMS staff responsible for these separate initiatives. As CMS implements new models or demonstrations that include payments for care management services, or as changes take place that affect existing models or demonstrations, it will address potential overlaps with the CCM service and seek to implement appropriate payment policies.

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### Resources


Table 2 provides resources for additional information on CCM services.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCM Frequently Asked Questions (FAQs)</td>
<td><a href="http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSchedule">http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSchedule</a></td>
</tr>
<tr>
<td>Chronic Conditions</td>
<td><a href="http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS">http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS</a></td>
</tr>
<tr>
<td>Chronic Conditions Data Warehouse</td>
<td><a href="https://www.cwwdata.org/webguest">https://www.cwwdata.org/webguest</a></td>
</tr>
</tbody>
</table>