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On the topic:

Coding for Chronic Care Management
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Coding for Chronic Care Management

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CCM ELIGIBILITY

• The Centers for Disease Control (CDC) reports that more than 2/3 of Medicare beneficiaries have 2 or more chronic conditions
• About 1/3 have 4 or more chronic conditions
• CMS understands that these patients require more interaction with their physician and medical staff

CCM ELIGIBILITY

Chronic care management (CCM) services require:
• At least 20 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month
• 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 established, implemented, revised or monitored
CCM ELIGIBILITY

- CCM only applies to traditional Medicare patients
- Medicare Advantage payers may follow with similar programs
- Patients must be informed in writing of the intent to bill for this service and must sign to consent they will be responsible for their portion of the bill
- Patient must be given a written or electronic care plan. This care plan must be created in the EHR and documentation must exist in the EHR that the patient was given the care plan

UNDERSTANDING CCM

- Chronic Care Management is defined as the non-face-to-face services provided to Medicare beneficiaries to have multiple (two or more), significant chronic conditions.
- In addition to office visits and other face-to-face encounters, there are services that involve communication with the patient and other treating healthcare professionals for care coordination, whether by phone or electronically.
- The patient will require frequent interaction to manage these chronic illnesses.
PRACTITIONER ELIGIBILITY

Who is eligible to bill for these services:

- Physicians
- Nurse practitioners
- Physician assistants
- Certified nurse midwives
- Clinical nurse specialists

PRACTITIONER ELIGIBILITY

Who can perform these services under the direction of these practitioners?

Clinical staff including:

- Registered nurse, LVN or CMA
- Clinical pharmacists
- Medical technical assistants
- Lab technicians
- Contracted third party
- Those who are directly employed by the clinician or practice
PATIENT CONSENT

• Obtaining advance patient consent for these services ensures that the patient is aware of:
  ▪ What the service is
  ▪ What it includes
  ▪ Their portion of the cost

• It may also help to prevent duplicate billing since chronic care management may only be reported by one practitioner. This practitioner is usually the primary care provider or the provider who is most responsible for providing patient care.

• The consent is only required once unless there is a change in the provider reporting chronic care management.

SCOPE OF SERVICES

• 24/7 Access to care management services
  – This means providing patients with a means to make timely contact with health care providers in the practice to address urgent chronic care needs regardless of the time of day or day of the week.

• Continuity of care
  – The patient must be able to get successive routine appointments with a designated provider or care team member.

• Care management for chronic conditions
  – This includes systematic assessment of a patient'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 patient self-management of medications.
SCOPE OF SERVICES

• Creation of a patient-centered care plan document to ensure that care is provided in a way that is cohesive with patient choices and values. A plan of care should be based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment along with an inventory of resources and support system. It is a comprehensive plan of care for all health problems.

• This form can serve as the basis for an EHR template.

SCOPE OF SERVICES

Management of care between healthcare providers, staff and facilities:

• Referrals to other providers
• Follow-up after patient visits to hospital or emergency room
• Follow-up after skilled nursing visits or other facility
• Coordination with home and community based clinical service providers to ensure support of psychosocial and functional deficits
• Coordination with caregiver through secure messaging, internet or telephone to communicate care needs
COMPREHENSIVE CARE PLAN

A comprehensive care plan for all health issues typically includes 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 and social services ordered
- A description of how services of agencies and specialists outside of the practice will be directed or coordinated

DOCUMENTATION AND BILLING

- Patient consent
- Each 20 minutes of non-face-to-face clinical staff time
- All after hours care provided by a clinician, call coverage
- CCM cannot be billed with:
  - Transitional Care Management – CPT 99495 and 99496
  - Home healthcare supervision – HCPCS G0181
  - Hospice care supervision – HCPCS G9182
  - Certain ESRD services – CPT 90951-90970
BILLING AND CODING

Codes:

• **CPT code 99490** – CCM services, at least 20 minutes per month; average reimbursement $42.84

• **CPT code 99487** – complex CCM services, 60 minutes of clinical staff time per month; average reimbursement $94.68

• **CPT code 99489** – complex CCM services, each additional 30 minutes of clinical staff time per month; average reimbursement $47.16

BILLING AND CODING

• **HCPCS code G0506** – care planning for chronic care management; average reimbursement $64.44
  - This is the assessment of and care planning for patients needing CCM.
  - This is listed separately in addition to the coding for CCM.

• **CPT code 99091** – collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored or transmitted by the patient or caregiver to the physician or healthcare professional; average reimbursement $58.68
HOW DO I GET STARTED?

• Identify the patients who have 2 or more chronic conditions and review to see who best fits the program
• Designate personnel for each patient identified
• Design a CCM process and schedule
• Inform the patient
• Create and document a comprehensive care plan
• Provide the patient with a written or electronic copy of the comprehensive care plan
• Document the time spent
• Terminate the program on transfer of care or death

Questions?

• Thank you for your attendance!

• Get your questions answered on PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp
PATIENT CONSENT AGREEMENT FOR CHRONIC CARE MANAGEMENT SERVICES

My physician, ________________________ has recommended that I receive Chronic Care Management (CCM) services because I have been diagnosed with two or more chronic conditions ________________________, which are expected to last at least twelve months, and place my health at risk of decline.

I understand that CCM services include; 24/7 access to a member of my care team via phone or other non-face-to-face means; a designated practitioner or care team member with whom I am able to get successive routine appointments; systematic assessment of my health care needs; processes to ensure timely receipt of preventive care services; oversight of my medication regimen; a jointly created and comprehensive care plan that is congruent with my choices and values; management of care transitions across all of my providers and settings; coordination with home and community based clinical providers.

By signing this agreement, I consent to receive these services and agree to the following:

- My provider has explained to me the availability and the elements of the CCM services that are relevant to for my condition(s).
- I consent to receive CCM services from the provider listed above and/or any associates he/she may designate to assist in providing me with CCM services.
- I understand that I have the right to stop CCM Services at any time (effective at the end of a calendar month) with this provider and the effect of a revocation of this agreement. I may revoke this agreement verbally by calling ___________________________ or in writing to ___________________________. After revocation of this agreement, I may opt to receive CCM services from another health provider the month following the revocation of this agreement.
- I understand that Medicare permits only one practitioner to furnish and be paid for these services during a calendar month.
- I understand that I will receive a written or electronic copy of my comprehensive care plan.
- I authorize electronic communication of my medical information with other treating providers.
- My provider has explained to me any potential cost-sharing obligations that may apply when receiving CCM services.

Our Goal is to provide you with the best care possible, to prevent hospital visits, and minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health are valuable and we hope that you will consider participation in the program with our practice.

I agree to participate in the Chronic Care Management program. Yes_____ No_____