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On the topic:
Coding for Care Management Services

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Coding for Care Management Services

Developed and presented by
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Agenda

• Chronic Care Management (CCM)
  • Who is eligible?
  • Who can provide the service?
  • Care Plan

• Behavioral Health Integration (BHI)

• Collaborative Care Model (CoCM)

• Transitional Care Management (TCM)

• Advanced Care Planning (ACP)

• New codes for 2019
Chronic Care Management

- Chronic Care Management is a critical component of primary care that contributes to better health outcomes
- Fifty percent of all adult Americans have a chronic condition
- One in four Americans have two or more chronic conditions
- Chronic disease is a leading cause of death

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Chronic Care Management

- Chronic Care Management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions
- Chronic Care Management engages patients with chronic conditions with a goal to better self manage their care
- Chronic Care Management assists patients with coordinating care and navigating the health care system
- Chronic Care Management requires more centralized management of patient needs and extensive care coordination among all the patient’s providers
Chronic Care Management

• Who is eligible?
  • Beneficiaries with 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

Examples of common chronic conditions:
  • Alzheimer’s disease
  • Arthritis
  • Asthma
  • Atrial fibrillation
  • Cardiovascular Disease
  • COPD
  • Depression
  • Diabetes
  • Hypertension
Chronic Care Management

• Who can bill the service?
  • Physicians
  • Certified Nurse Midwives
  • Clinical Nurse Specialists
  • Nurse Practitioners
  • Physician Assistants

• Chronic Care Management codes are assigned general supervision
• Services are paid under the PFS and can be performed in facility and non-facility settings

Initiating Visit

• A face-to-face initiating visit needs to be performed if a patient is new to the provider or has not been seen within one year
• Visit can be:
  • Annual Wellness Visit (AWV)
  • Welcome to Medicare Visit - Initial Preventive Physical Exam (IPPE)
  • Other face-to-face visit (99212-99215)
  • Initiating visit can be billed separately from CCM
Patient Consent

- The patient must consent to the service before furnishing the service.
- Consent will ensure the patient is engaged and aware of the cost share involved.
- Consent may be verbal or written but must be documented in the medical record.
- Consent only has to be obtained once.
- Consent must include:
  - The cost share.
  - Explanation that only one practitioner can furnish the service and be paid during a calendar month.
  - Explanation that the patient has the right to stop CCM services at any time.

Comprehensive Care Plan

- A comprehensive care plan must be available and shared timely with involved in the patient’s care.
- Provide the patient / caregiver a copy of the care plan.
Comprehensive Care Plan

- 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
- Schedule for periodic review and, when applicable, revision of the care plan

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Examples of What Counts

- Phone calls and emails to and from the patient
- Managing referrals to other providers
- Managing prescriptions
- Talking with caregivers
- Reading consultant’s reports
- Reviewing labs and other studies
Coding For Chronic Care Management

• 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 established, implemented, revised, or monitored.
  • CCM services of less than 20 minutes duration, in a calendar month, are not reported separately
  • Only the time of the clinical staff time is counted
  • Billed once per calendar month

• 99491 (New for 2019)
  • Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, 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 established, implemented, revised, or monitored.
Coding for Chronic Care Management

• Do not report 99490 or 99491 with:
  • Home health supervision (G0181)
  • Hospice care supervision (G0182)
  • ESRD services (90951-90970)
  • Transitional care management (99495, 99496)

• 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 place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
  • Complex CCM services of less than 60 minutes’ duration, in a calendar month, are not reported separately
  • Only the time of the clinical staff time is counted
  • Billed once per calendar month
Coding for Chronic Care Management

• 99489
  • Add on code
  • 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).

Coding for Chronic Care Management

• G0506
  • Comprehensive assessment and care planning for patients requiring chronic care management services (billed separately from monthly care management services)
  • Report when extensive assessment and care planning outside of the usual effort described by the billed E/M code is performed by the billing provider
How Do I Get Started?

Identify
- Identify your patients

Designate
- Designate a staff member for each identified patient

Develop
- Develop a CCM process and schedule

Inform
- Inform the patient; invite them to participate

Create
- Create the comprehensive care plan

Provide
- Provide the patient with the comprehensive care plan

Track
- Track time

Process
- Process for termination

Outsourcing Chronic Care Management

- Codes 99487 and 99489 includes moderate to high complexity medical decision making that cannot be delegated or subcontracted to any other individual
- Code 99491 cannot be delegated
- Code 99490 assumes 15 minutes of work by the billing provider and this part cannot be delegated
- Clinical staff activities may be provided by an individual outside of the practice if all rules for the physician fee schedule are met and there is integration among team members
- CCM services cannot be billed if they are provided by individuals outside of the United States
Return on Investment

- Number of patients with two or more chronic conditions x $42.60 (National average reimbursement)
- 300 patients x $42.60 = $12,780 per month
- $12,780 x 12 months = $153,360

- Note: Other insurance companies such as Anthem are paying for chronic care management - check your local carriers!

Coding for Behavioral Health Integration

- 99484 (formerly G0507)
  - Care management services for behavioral health conditions, 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:
    - Initial assessment or follow-up monitoring, including use of applicable validated rating scales;
    - Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
    - Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation;
    - Continuity of care with a designated member of the care team
Coding for Behavioral Health Integration

- Distinct from Chronic Care Management
- Behavioral health care manager needs to have formal education or specialized training in behavioral health such as social work, nursing and psychology
- Medicare did not specify minimum education requirements
- BHI codes may be used to treat patients with any mental, behavioral health or psychiatric condition that is being treated by the billing practitioner, including substance use disorders
- The billing provider must perform all aspects of the services for behavioral health integration

Collaborative Care Model (CoCM)

- CoCM codes are billed as “incident to” codes and incorporate the services of all three members of the collaborative care team:
  - treating provider
  - behavioral health care manager
  - psychiatric consultant

- CoCM cannot be billed in the same month as BHI
Collaborative Care Model (CoCM)

• 99492 (formerly G0502)
  • First 70 minutes in the first calendar month for behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating provider
  • Must include:
    • Outreach and engagement of patients;
    • Initial assessment, including administration of validated scales and resulting in a treatment plan;
    • Review by psychiatric consultant and modifications, if recommended;
    • Entering patients into a registry and tracking patient follow-up and progress, and participation in weekly caseload review with psychiatric consultant;
    • Provision of brief interventions using evidence-based treatments such as behavioral activation, problem solving treatment, and other focused treatment activities

Collaborative Care Model (CoCM)

• 99493 (formerly G0503)
  • First 60 minutes in a subsequent month for behavioral health care manager activities
  • Must include:
    • Tracking patient follow-up and progress;
    • Participation in weekly caseload review with psychiatric consultant;
    • Ongoing collaboration and coordination with treating providers;
    • Ongoing review by psychiatric consultant and modifications based on recommendations;
    • Provision of brief interventions using evidence based treatments;
    • Monitoring of patient outcomes using validated rating scales;
    • Relapse prevention planning and preparation for discharge from active treatment
Collaborative Care Model (CoCM)

- 99494 (formerly G0504)
  - Each additional 30 minutes in a calendar month of behavioral health care manager activities listed above
  - Listed separately and used in conjunction with 99492 and 99493

Transitional Care Management

- 99495
  - Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)
- 99496
  - Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)
Transitional Care Management

- You can perform TCM when the patient is discharged from:
  - Inpatient Acute Care Hospital
  - Inpatient Psychiatric Hospital
  - Long Term Care Hospital
  - Skilled Nursing Facility
  - Inpatient Rehabilitation Facility
  - Hospital outpatient observation or partial hospitalization
  - Partial hospitalization at a Community Mental Health Center

Transitional Care Management

During the 30 days beginning on the date the beneficiary is discharged from an inpatient setting, you must furnish these three TCM components:

1. Interactive Contact
   - Made within 2 business days following discharge
   - Contact may be by telephone, email, or face-to-face
   - Made by provider of clinical staff
   - Must make at least 2 attempts to reach patient
2. Certain non-face-to-face services
   - Physicians or NPPs may furnish these non-face-to-face services:
     - Obtain and review discharge information
     - Review need for or follow-up on pending diagnostic tests and treatments
     - Interact with other health care professionals who will assume or reassume care of the beneficiary’s system-specific problems
     - Provide education to the beneficiary, family, guardian, and/or caregiver
     - Establish or re-establish referrals and arrange for needed community resources
     - Assist in scheduling required follow-up with community providers and services

Services Provided by Clinical Staff Under the Direction of a Physician or NPP:
   - Communicate with agencies and community services the beneficiary uses
   - Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living
   - Assess and support treatment regimen adherence and medication management
   - Identify available community and health resources
   - Assist the beneficiary and/or family in accessing needed care and services
Transitional Care Management

3. Face-to-face visit within 7-14 days depending on complexity of medical decision making

• Medication reconciliation:
  - You must furnish medication reconciliation and management no later than the date you furnish the face-to-face visit

• Only one health care professional may report TCM services
• Report services once per beneficiary during the TCM period
• The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services; however, the required face-to-face visit may not take place on the same day you report discharge day management services
• Report reasonable and necessary evaluation and management (E/M) services (other than the required face-to-face visit) to manage the beneficiary’s clinical issues separately
• Cannot be billed during post op period by the billing surgeon
• Do not report with:
  • Care plan oversights
  • Home health and hospice supervision
  • ESRD services
  • Chronic care management services
  • Prolonged E&M services without direct patient contact

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Advanced Care Planning

- **99497**
  - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

- **99498**
  - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

Effective January 1, 2016

Voluntary Advanced Care Planning is a face-to-face service between a physician (or other qualified health care professional) and a patient discussing advance directives with or without completing relevant legal forms

An advance directive is a document in which a patient appoints an agent and/or records the wishes of a patient pertaining to their medical treatment at a future time if they cannot decide for themselves at that time
Advanced Care Planning

- Coinsurance applies unless performed during an AWV
- Medicare waives the coinsurance and the Medicare Part B deductible for ACP when:
  - Performed on the same day as the AWV
  - Furnished by the same provider
  - Billed with a modifier 33
- ACP cannot be billed with the IPPE
- No limit on how often the service can be billed
- No place of service limitations

New Codes for 2019

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
</tr>
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<tbody>
<tr>
<td>99451</td>
<td>Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient’s treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time</td>
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<tr>
<td>99452</td>
<td>Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes</td>
</tr>
<tr>
<td>99453</td>
<td>Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment</td>
</tr>
<tr>
<td>99454</td>
<td>Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days</td>
</tr>
<tr>
<td>99457</td>
<td>Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month</td>
</tr>
</tbody>
</table>
Questions

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Resources

- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf