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Care Management - The Sweet Spot for Patients and Practices

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CARE MANAGEMENT
- THE SWEET SPOT FOR PATIENTS AND PRACTICES

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AGENDA

- Chronic Care Management (CCM)
  - Who is eligible?
  - Who can provide the service?
  - Care Plan
- Principal Care Management (PCM)
- Transitional Care Management (TCM)
- Remote Patient Monitoring (RPM)
- Advance Care Planning (ACP)

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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
- The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals.
- In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions

(cms.gov, 2019)

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CHRONIC CARE MANAGEMENT

- Benefits of Chronic Care Management
  - Care Coordination
  - Quality of Life
  - Revenue Stream
  - Access to Care
  - Patient Satisfaction
  - Healthcare Savings
  - Achieving Healthcare Goals

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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

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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
- Billing practitioners may consider identifying patients who require CCM services using criteria suggested in CPT guidance (i.e., number of illnesses, number of medications, repeat admissions, or emergency department visits) or the typical patient profile in the CPT prefatory language
- CCM services can also help reduce geographic and racial or ethnic health care disparities

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CHRONIC CARE MANAGEMENT

- Examples of common chronic conditions:
  - Alzheimer's disease
  - Arthritis
  - Asthma
  - Atrial fibrillation
  - Cardiovascular disease
  - COPD
  - Depression
  - Diabetes
  - Hypertension
  - Infectious disease

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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

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INITIATING VISIT

- Before CCM services can start, an initiating visit is required for new patients or patients who the billing practitioner hasn't seen within 1 year
- Initiating visit can occur during a comprehensive face-to-face Evaluation and Management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE)
- If the practitioner doesn't discuss CCM during an E/M visit, AWV, or IPPE, it can't count as the initiating visit
- Face-to-face initiating visit isn't part of CCM and can be separately billed

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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
- Patients need to provide informed consent only once
- Consent must include:
  - 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

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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
- Ensure the electronic care plan is available and shared timely within and outside the billing practice to individuals involved in the patient's care

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COMPREHENSIVE CARE PLAN

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers
- Requirements for periodic review
- When applicable, "revision of the care plan"

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ACCESS AND CONTINUITY OF CARE

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff, including providing patients (and caregivers as appropriate) with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week
- Ensure continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care by telephone and also through secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods (for example, email or secure electronic patient portal)

(CMS, 2022)

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STRUCTURED RECORDING OF PATIENT HEALTH INFORMATION

- Record the patient's demographics, problems, medications, and medication allergies using certified Electronic Health Record (EHR) technology.
- Certified EHR means 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.

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DOCUMENTATION

- Management of chronic conditions
- Management of referrals to other providers
- Management of prescriptions
- Ongoing review of patient status
- Time spent
- Patient goals

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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

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CODING FOR CHRONIC CARE MANAGEMENT

- **CPT 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
  - Assumes 15 minutes of work by the billing practitioner per month

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CODING FOR CHRONIC CARE MANAGEMENT

- **CPT 99439** (replaces HCPCS Code G2058) Chronic care management services, each additional 20 minutes of **clinical staff time** directed by a physician or other qualified health care professional, per calendar month.
- Can be billed up to 2 times per month

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CODING FOR CHRONIC CARE MANAGEMENT

- **CPT 99491** 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

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CODING FOR CHRONIC CARE MANAGEMENT

- **CPT 99437** Chronic care management services, provided personally by a physician or other qualified health care professional, 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;
  - each additional 30 minutes by a **physician or other qualified health care professional**, per calendar month (List separately in addition to code for primary procedure)
  - CPT code 99437 is an **add-on code for CPT code 99491**

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CODING FOR CHRONIC CARE MANAGEMENT

Complex CCM

- **CPT 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
  - Establishing, revising, implementing, or monitoring the 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

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CODING FOR CHRONIC CARE MANAGEMENT

- **CPT 99489** 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)
- Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately
- Report 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

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CODING FOR CARE MANAGEMENT SERVICES

- **CPT 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
  - Billing practitioners can bill G0506 only once, as part of initiating visit

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PRINCIPAL CARE MANAGEMENT

- Beginning CY 2020, CMS introduced Principal Care Management (PCM) services to furnish CCM for patients with a single chronic condition or with multiple chronic conditions but focused on a single high-risk condition
- PCM services may be expected to last 6 months–1 year or until patient's death
- PCM services require 30 minutes before billing

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PRINCIPAL CARE MANAGEMENT

- **CPT 99424** Principal care management services, for a single high-risk disease, with the following required elements:
  - one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death,
  - the condition requires development, monitoring, or revision of disease-specific care plan,
  - the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities,
  - ongoing communication and care coordination between relevant practitioners furnishing care;
  - first 30 minutes provided personally by a **physician or other qualified health care professional**, per calendar month

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PRINCIPAL CARE MANAGEMENT

- **CPT 99425** Principal care management services, for a single high-risk disease, with the following required elements:
  - one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death,
  - the condition requires development, monitoring, or revision of disease-specific care plan,
  - the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities,
  - ongoing communication and care coordination between relevant practitioners furnishing care;
  - each additional 30 minutes provided personally by a **physician or other qualified health care professional**, per calendar month (List separately in addition to code for primary procedure)

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PRINCIPAL CARE MANAGEMENT

- **CPT 99426** Principal care management services, for a single high-risk disease, with the following required elements:
  - one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death,
  - the condition requires development, monitoring, or revision of a disease-specific care plan,
  - the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care;
  - first 30 minutes of **clinical staff** time directed by physician or other qualified health care professional, per calendar month

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PRINCIPAL CARE MANAGEMENT

- **CPT 99427** Principal care management services, for a single high-risk disease, with the following required elements:
  - one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death,
  - the condition requires development, monitoring, or revision of disease-specific care plan,
  - the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities,
  - ongoing communication and care coordination between relevant practitioners furnishing care;
  - each additional 30 minutes of **clinical staff** time directed by a physician or other qualified health care professional per calendar month (List separately in addition to code for primary procedure)

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CONCURRENT BILLING

- You can't report complex CCM and non-complex CCM for the same patient in a calendar month
- Don't report 99491 in the same calendar month as 99487, 99489, or 99490
- You can't bill CCM during the same service period by the same practitioner as HCPCS codes G0181 or G0182 (home health care supervision, hospice care supervision) or CPT codes 90951–90970 (certain ESRD services)
- You can report CCM codes 99487, 99489, 99490 and 99491 by the same practitioner for services furnished during the 30-day TCM service period (CPT 99495, 99496)
- You can't report complex CCM and prolonged Evaluation and Management (E/M) services in the same calendar month
- Consult CPT instructions for other codes you can't bill concurrently with CCM
- Other practitioner billing restrictions may apply if you're taking part in a CMS-sponsored model or demonstration program
- You can't count time toward the CCM service code for any other billed code
- Beginning CY 2022, RHCs and FQHCs can bill CCM and TCM services for the same patient during the same time period

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HOW DO I GET STARTED?

- Engage the patient
  - Explain chronic care management to the patient
  - Communicate the benefits of the program to the patient
  - Let the patient know they will have a dedicated care team
  - Describe how their care will be coordinated
  - Explain how they will receive care between provider visits

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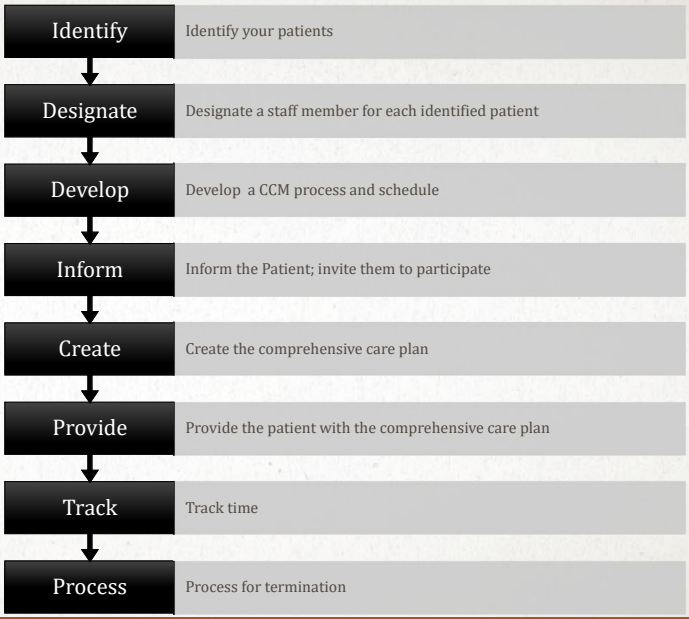
HOW DO I GET STARTED?



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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

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RETURN ON INVESTMENT

- Number of patients with two or more chronic conditions x $64.02 (National average reimbursement)
- 300 patients x $64.02 = $19,206per month
- $19,206 x 12 months = $230,472
- Note: Other insurance companies, i.e., Anthem, are paying for chronic care management. Check your local carriers!

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TRANSITIONAL CARE MANAGEMENT

- Benefits
  - After patients are discharged from an inpatient setting, they are at higher risk of readmission
  - TCM offers a warm hand off from inpatient to the community setting
  - Issues such a new diagnosis or changes in medications can be addressed in a timely manner
  - Ensures continuity of care

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TRANSITIONAL CARE MANAGEMENT

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

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TRANSITIONAL CARE MANAGEMENT

- TCM services help a patient transition 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

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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

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TRANSITIONAL CARE MANAGEMENT

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

cms.gov

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TRANSITIONAL CARE MANAGEMENT

- 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

cms.gov

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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***

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TRANSITIONAL CARE MANAGEMENT

- 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-operative period by the billing surgeon

cms.gov

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REMOTE PATIENT MONITORING

- Remote patient monitoring (RPM) is the use of physiologic readings data from a device to monitor and manage a patients care remotely
- Types of devices that can be used, depending on the patient's condition(s)
  - Blood glucose monitors
  - Blood pressure monitors
  - Scales
  - Pulse oximeters are the most common
  - Device must qualify as a medical device per Section 201(h) of the Food, Drug, and Cosmetic Act
  - Data must be collected and transmitted electronically as opposed to self-reported by the patient

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REMOTE PATIENT MONITORING – CPT CODES

- **CPT 99453** Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), plus initial set-up and patient education on use of equipment. (Initial set-up and patient education of monitoring equipment included; do not report 99453 for monitoring of less than 16 days.)
- **CPT 99454** Device(s) supply with daily recording(s) or programmed alerts transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient.)

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REMOTE PATIENT MONITORING – CPT CODES

- **CPT 99457** Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month, requiring interactive communication with the patient/caregiver during the month; first 20 minutes.
- **CPT 99458** Each additional 20 minutes (List separately in addition to code for primary procedure.)
- **CPT 99091** Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring), digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.

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REMOTE PATIENT MONITORING

- Final Rule
  - Revised definition of interactive communication
  - Clarification regarding device requirements
  - Reestablished patient requirement
  - Consent can be obtained at time of service
  - CPT 99453 and 99454 may be furnished by auxiliary personnel
  - CMS clarified that only physicians and non-physician practitioners who can bill for E&M can bill for RPM
  - Expanded to include acute conditions
  - Reestablished 16 measurement-days to bill
  - Approved billing CPT 99091 concurrently with 99457

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ADVANCE CARE PLANNING

- Voluntary Advance 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

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ADVANCE 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)

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ADVANCE 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

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QUESTIONS

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RESOURCES

- https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf
- https://aims.uw.edu/sites/default/files/CMS_FinalRule_BHI_CheatSheet.pdf
- https://www.ama-assn.org/amaone/cpt-current-procedural-terminology
- https://www.businesswire.com/news/home/20200409005176/en/COVID-19-Impacting-Disease-Management-69-Patients-Chronic
- https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/what-you-can-do.html
- https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2017-02-21-CCM-Presentation.pdf
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf
- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/advancecareplanning.pdf
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

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