TIPS FROM OUR CONSULTANT

By: Joy Newby, LPN, CPC, PCS
Newby Consulting

Chronic Care Management Services

The Centers for Medicare & Medicaid Services (CMS) included an expansion of chronic care management (CCM) services in the "Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017" (Final Rule 2017) published in the November 15, 2016 *Federal Register*.

CMS added Medicare coverage of CCM services effective 01-01-2015. Although *CPT* 2015 included three codes to describe CCM services, CMS determined that Medicare coverage was only available for *CPT* code 99490.

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.

According to professional claims data for *CPT* code 99490, utilization is steadily increasing but remains low considering the number of eligible Medicare beneficiaries. In the Final Rule for 2017, CMS notes that "to date, approximately 513,000 unique Medicare beneficiaries received the service an average of four times each, totaling $93 million in total payments."

CMS notes that in a number of forums and in public comments to the CY 2016 Physician Fee Schedule (PFS) final rule, many practitioners complained that the service elements and billing requirements are burdensome, redundant and prevented them from being able to provide the services to beneficiaries who could benefit from them. These commenters also stated that *CPT* code 99490 is underutilized because it is underpaid relative to the resources involved in furnishing the services, especially given the extensive Medicare rules for payment.

CMS notes that initial information from practitioner interviews conducted as part of the CCM evaluation efforts indicate that practitioners overwhelmingly meet and exceed the 20-minute threshold time for billing CCM. Typically, these practitioners reported spending between 45 minutes and an hour per month on CCM services for each patient, with times ranging between 20 minutes and several hours per month. These practitioners explained that CCM beneficiaries tend to exhibit a higher disease burden, are more likely to be dually eligible for Medicare and Medicaid, and are older than the general Medicare fee-for-service population.

Section 103 of the MACRA requires CMS to assess and report to Congress (no later than December 31, 2017) on access to CCM services by underserved rural and racial and ethnic minority populations and to conduct an outreach/education campaign. According to CMS, the outreach/education campaign is underway. Based on comments as well as the MACRA mandate, CMS has made several changes for CCM Services.

Beginning with dates of service on or after 01-01-2017, in addition to Medicare coverage for 99490 (20 minutes of clinical staff time), CMS added coverage for the following complex chronic care management *CPT* codes:

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

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)

CMS is following *CPT* coding instructions that less than 60 minutes of clinical staff time in the service period should not be reported separately, and similarly, less than 30 minutes in addition to the first 60 minutes of complex CCM in a service period should not be reported.

Medical Decision-Making – Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner).

Again following *CPT* coding instruction, CMS notes that *CPT* codes 99487, 99489 and 99490 may only be reported once per calendar month and only by the single practitioner who assumes the care management role with a particular beneficiary for the service period. This provision means that a given beneficiary is eligible to receive either complex **or** non-complex CCM during a calendar month, but not both.

Practitioner Eligibility

Physicians and the following qualified health care professionals may bill CCM services:

- ✓ Nurse Practitioners
- ✓ Physician Assistants
- ✓ Certified Nurse Midwives
- ✓ Clinical Nurse Specialists

CMS notes that CCM will be billed most frequently by primary care practitioners, although in certain circumstances specialty practitioners may provide and bill for CCM.

The CCM service is not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, although practitioners may refer or consult with such physicians and practitioners to coordinate and manage care.

CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the direction of the billing practitioner's general supervision. General supervision means when the service is not personally performed by the billing practitioner, it is performed under his or her overall direction and control although his or her physical presence is not required. The CCM service must be an integral part of services provided by the billing practitioner.

CMS follows *CPT*'s definition of "clinical staff":

> A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specific professional service, but does not individually report the professional service.

The clinical staff can be employees or working under contract to the billing practitioner whom Medicare directly pays for CCM.

Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month in order to bill CCM services. Non-clinical staff time cannot be counted toward the threshold.

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 CCM services.

Billing practitioners may consider identifying patients who require CCM services using criteria suggested in *CPT* guidance (such as number of illnesses, number of medications or repeat admissions or emergency department visits) or the profile of typical patients in the CPT prefatory language.

Initiating Visit (New billing opportunity)

For new patients or patients not seen within one year prior to the commencement of CCM, Medicare requires initiation of CCM services during a face-to-face visit with the billing practitioner (an Annual Wellness Visit [AWV] or Initial Preventive Physical Exam [IPPE], or other face-to-face visit with the billing practitioner). This initiating visit is not part of the CCM service and is separately billed.

Practitioners who furnish a **CCM initiating visit** and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code **may also bill** *HCPCS* code G0506.

G0506 Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service).

G0506 is **reportable once per CCM billing practitioner**, in conjunction with CCM initiation.

Patient Consent

Obtaining advance consent for CCM services ensures the patient is engaged and aware of applicable cost sharing. It may also help prevent duplicative practitioner billing. A practitioner must obtain patient consent before furnishing or billing CCM. Informed patient consent need only be obtained once prior to furnishing CCM, or if the patient chooses to change the practitioner (in a different practice) who will furnish and bill CCM.

Although patient cost-sharing applies to the CCM service, most patients have supplemental insurance to help cover CCM cost sharing. Also CCM may help avoid the need for more costly services in the future by proactively managing patient health, rather than only treating severe or acute disease and illness.

Consent may be verbal or written but must be documented in the medical record, and includes informing them about:

- ✓ The availability of CCM services and applicable cost-sharing
- ✓ That only one practitioner can furnish and be paid for CCM services during a calendar month
- ✓ The right to stop CCM services at any time (effective at the end of the calendar month)

Newby Note: We recommend physicians and qualified health care professionals continue to obtain written consent from the patient.

CCM Service Elements

The CCM service is extensive, including structured recording of patient health information, maintaining a comprehensive electronic care plan, managing transitions of care and other care management services, and coordinating and sharing patient health information timely within and outside the practice.

The following elements are included for both complex and non-complex CCM unless otherwise specified. CCM services are typically provided outside of face-to-face patient visits, and focus on characteristics of advanced primary care such as a continuous relationship with a designated member of the care team; patient support for chronic diseases to achieve health goals; 24/7 patient access to care and health information; receipt of preventive care; patient and caregiver engagement; and timely sharing and use of health information.

<u>Structured Recording of Patient Health Information</u>

- ✓ Record the patient's demographics, problems, medications, and medication allergies using certified Electronic Health Record (EHR) technology. This 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. For more information, visit https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms.

Comprehensive Care Plan

- ✓ A person-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with particular focus on the chronic conditions being managed)
- ✓ Provide the patient and/or caregiver with 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
- ✓ Care planning tools and resources are publicly available from a number of organizations

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

Access to Care & Care Continuity

- ✓ Provide 24-hour-a-day, 7-day-a-week (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)

Comprehensive Care Management

- ✓ Systematic assessment of the 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
- ✓ Oversight of patient self-management of medications
- ✓ Coordinating care with home and community based clinical service providers

Transitional Care Management

- ✓ Manage transitions between and among health care providers and settings, including referrals to other clinicians, **follow-up after an emergency department visit**, or facility discharge
- ✓ Timely create and exchange/transmit continuity of care document(s) with other practitioners and providers

Concurrent Billing

The billing practitioner cannot report both complex CCM and non-complex CCM for a given patient for a given calendar month.

CCM cannot be billed during the same service period as *HCPCS* codes G0181/G0182 (home health care supervision/hospice care supervision), or *CPT* codes 90951–90970 (certain End-Stage Renal Disease services).

CCM should not be reported for services furnished during the 30-day transitional care management service period (*CPT* 99495, 99496).

Complex CCM and prolonged Evaluation and Management (E/M) services cannot be reported the same calendar month. Consult *CPT* instructions for additional codes that cannot be billed concurrent with CCM. There may be additional restrictions on billing for practitioners participating in a CMS sponsored model or demonstration program. Time that is reported under or counted towards the reporting of a CCM service code cannot also be counted towards any other billed code.

Frequently Asked Questions

See the list of frequently asked questions on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf