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Targeted Probe and Educate (TPE) - Chronic Care Management

Disclaimer

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Agenda

- Definitions
- Overview CPT 99490, 99487, 99489 - Chronic Care Management Services

Objectives

- Conduct an overview of care management services
- Enhance knowledge of billing and documentation requirements
- Review documentation tips

Chronic Care Management (CCM)

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- CCM Background:
  - ✓ In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (MPFS) for CCM services furnished to Medicare patients with multiple chronic conditions
  - ✓ Improvements to the CCM program were made in 2017:
    - ➢ Increased payment
    - ➢ Expanded the program by adding additional codes

- CCM Purpose:
  - ✓ CMS recognizes CCM as a critical component of primary care that contributes to better health care for individuals

What is CCM?

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- Comprehensive Care management services by a physician or non-physician practitioner and their clinical staff, per calendar month:
  - ✓ For patients with multiple (two or more) chronic conditions expected to last at least 12 months or until death
  - ✓ Conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

- Timed services:
  - ✓ Threshold amount of clinical staff time performing qualifying activities is required per month

What is CCM? (Continued)

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- Timely sharing of health information within and outside the billing practice:
  - ✓ Certified electronic health record (EHR):
    - ➢ Structured recording of a limited data set
- Continuity of care with designated care team member
- Enhanced communication:
  - ✓ Secure patient email
- 24/7 access to address urgent needs
- Advance beneficiary consent
- For complex CCM, moderately or highly complex medical decision making by the billing practitioner

CCM Code 99490

CPT 99490 - 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 Code 99487

- CPT 99487- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, same as 99490 with the following required elements:
- Establishment or substantial revision of a comprehensive care plan
- Moderate or high complexity medical decision making

CCM Code 99489

- 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

General Supervision for CCM

- CPT codes 99487, 99489, and 99490 are assigned general supervision
- General supervision:
  - ✓ When the service is not personally performed by the billing practitioner, it is performed under his or her overall direction and control
  - ✓ Physical presence is not required

CCM Provider Eligibility

- Physicians and the following NPPs may bill:
  - ✓ Certified Nurse Midwives
  - ✓ Clinical Nurse Specialists
  - ✓ Nurse Practitioners
  - ✓ Physician Assistants
- Only one practitioner can bill CCM per service period (month)
- The practitioner must only report either complex or non-complex CCM for a given patient for the month (not both)
- Clinical staff:
  - ✓ See CPT definition
  - ✓ Applicable State law
  - ✓ Licensure
  - ✓ Scope of practice
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Place of Service (POS)

- Place of service (POS)
  - ✓ Facility
  - ✓ Non-facility

Initiating Visit

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- Medicare requires initiation of CCM services during a face-to-face visit:
  - ✓ For new patients
  - ✓ Patients not seen within one year prior to the commencement of CCM
- Face-to-face visit can be during:
  - ✓ Annual wellness visit (AWV)
  - ✓ Initial preventive physical exam (IPPE)
  - ✓ Transitional care management (TCM)
  - ✓ Other qualifying face-to-face E/M
- Initiating visit is not part of the CCM service and is billed separately

Patient Chronic Conditions

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Examples of chronic conditions include, but are not limited to:

- 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
- Osteoporosis

Patient Consent for CCM

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Requirements:

- Informed patient consent is obtained prior to furnishing the initial CCM service
- Consent may be verbal or written
- Document the discussion and note the patient's decision to accept or decline the CCM service
- Explain availability of CCM services and applicable cost-sharing
- Explain how to revoke the service
- Inform the patient that only one practitioner can furnish and be paid for CCM during a calendar month

Patient Consent (Continued)

Obtaining advance consent ensure the patient is engaged and aware of applicable cost sharing

- A practitioner must obtain consent before furnishing or billing CCM
  - ✓ Prior to 1/1/2017 the chart needed to include a signed consent
  - ✓ After 1/1/2017 it can be verbal or written but it must be documented in the medical record and include:
    - ➢ Cost-sharing
    - ➢ One practitioner can bill
    - ➢ Right to stop services (effective at the end of the calendar month)
    - ➢ Care plan must be given to patient

Required Access to Care

Ensure 24-hour-a-day, 7-day-a-week access to urgent needs:

- Ensure continuity of care
- Provide enhanced opportunities for the patient or any caregiver to communicate with the practitioner:
  - ✓ Telephone
  - ✓ Secure messaging
  - ✓ Secure internet
  - ✓ Email

Electronica Health Record (EHR) Criteria for CCM

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CMS required EHR technology:

- Acceptable under the EHR Incentive Programs as of December 31 of the calendar year preceding each Medicare Physician Fee Schedule payment year
  - ✓ CCM Certified Technology
- Structured recording of patient health information using certified EHR:
  - ✓ Patient's demographics
  - ✓ Medical problems
  - ✓ Medications, and medication allergies
- CMS does not require the use of certified EHR technology for some of the services involving:
  - ✓ Care plan
  - ✓ Clinical summaries

Comprehensive Care Plan

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- Person-centered electronic care plan based on:
  - ✓ Physical
  - ✓ Mental
  - ✓ Cognitive
  - ✓ Psychosocial
  - ✓ Functional and environmental (re)assessment
  - ✓ Inventory of resources
- Issue patient and/or 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 patients care

Comprehensive Care Plan (continued)

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- Typically includes, but is not limited to:
  - ✓ Problem list
  - ✓ Expected outcome and prognosis
  - ✓ Measurable treatment goals
  - ✓ Symptom management
  - ✓ Planned interventions:
    - ➢ Identification of individuals responsible for each intervention
- Medication management
- Community/social services ordered
- Description of how services of agencies and specialists outside the practice will be directed/coordinated
- Schedule for periodic review:
  - ✓ Revised care plan, when applicable

Comprehensive Care Management

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- Systematic assessment of the patient's:
  - ✓ Medical needs
  - ✓ Functional needs
  - ✓ Psychosocial needs
- Timely receipt of preventive care services
- Medication reconciliation with review of adherence and potential interactions
- Oversight of patient self-management of medications
- Coordinate care with home and community-based providers

Management of Care Transitions

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- Manage transitions between and among health care providers and settings including:
  - ✓ Referrals to other clinicians
  - ✓ Follow-up after an emergency department visit
  - ✓ Follow-up after discharges from:
    - ➢ Hospitals
    - ➢ Skilled nursing facilities
    - ➢ Other health care facilities
- Create and exchange continuity of care documents timely with other providers

CCM Billing Summary

- CCM cannot be billed during same period with:
  - ✓ 99495-99496: Transitional care management
  - ✓ G0181/G0182: Home health care supervision/Hospice care supervision
  - ✓ 90951-90970: Certain end-stage renal disease services
- Complex CCM and prolonged E/M services cannot be reported the same calendar month
- Complex CCM and non-complex CCM cannot be reported for the same service period

Chronic Care Management Documentation Summary

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- Beneficiary eligibility:
  - ✓ Documentation of two or more chronic conditions expected to last at least 12 months or until the death of the patient
- Beneficiary consent:
  - ✓ Date of the signed agreement and beneficiary's decision to accept the service and was informed of revocation options
- Detailed accounting of the time furnished (start and stop time) including the performing clinical staff and details regarding how the time was spent:
  - ✓ At least 20 minutes per calendar month
- Provision of a written or electronic copy of the comprehensive care plan to the beneficiary

Documentation Summary (continued)

- Communication to and from home community-based providers regarding the patient's psychosocial and functional needs

References

- Chronic Care Management Services Fact Sheet
- Changes to Chronic Care Management Services for 2017 Fact Sheet
- Chronic Care Management Services FAQs
- Chronic Conditions in Medicare