



## Update on New Coordination of Care and Transition of Care Coding

*Michele Olivier ACP Colorado Chapter*

*February 5, 2015*

# Agenda

- Introduction
- Chronic Care Management Coding
- Advanced Care Planning Coding
- Transition of Care Coding
- Scenarios
- Questions

# Introduction

Pinnacle Healthcare Consulting is a nationally recognized leader in business valuation, physician compensation, performance improvement, compliance support, coding and auditing as well as strategic and operational consulting.

We solve complex challenges by applying real-world expertise, industry insight and innovative thinking to create dramatic results for our clients.





# Introduction

CMS says it has recently “recognized primary care and care coordination as critical components in achieving better care...” and wants to “encourage long-term investment in primary care and care-management services” through “accurate payment.”



# Chronic Care Management Coding



# Chronic Care Management

## New for 2015

- CPT Code 99490- Chronic care management on a monthly basis, for a patient who has at least 2 chronic medical problems which are expected to continue for at least 12 months (or death), 20 minutes of time spent with the patient
- CPT Code 99487- Complex chronic care management on a monthly basis, for a patient who has chronic medical problems which require moderate or high medical decision making- 60 minutes of time spent with the patient
- CPT Code 99489- Each Additional 30 minutes (only with 99487)

# Chronic Care Management

- CPT 99490
- Reported when the clinical staff time reaches 20 Minutes
- Services:
  - Medical and/or psychosocial needs
  - Establish, implement, revise, monitor a care plan
  - 2 chronic conditions that are expected to last 12 months or until the death of the patient
  - Place a significant risk of death, acute exacerbation/decompensation, or functional decline

# Complex Chronic Care Management

- CPT 99487
- Reported when the clinical staff time reaches 60 Minutes
- Services:
  - Medical and/or psychosocial needs
  - Establish or substantially revise a care plan
  - Problems requiring moderate or high complexity Medical Decision Making (MDM)
  - Multiple Illnesses, multiple medication use, inability to perform ADL, require a caregiver, and/or repeat ED visits
    - i.e. Dementia, COPD, Substance Abuse, Diabetes (that complicate their care)



# Complex Chronic Care Management

- Office must have these capabilities
  - 24/7 availability to patient and caregiver
  - Provide Continuity of care for all care givers
  - Provider timely follow up to ED visits or Admissions
  - Use Electronic Health Record (EHR)
  - Use standardized methodology for identifying patients
  - Have internal care management process/function
  - Use a standardized format in the medical record
  - Be able to engage and education patient and care givers
  - Coordinate care among all providers

# Chronic Care Management

## Medicare Payment for New Codes

CPT	Description	Medicare 2015 Allowable
99490	Chronic Care Management - 20 Minutes	\$43.28
99487	Chronic Care Management - 60 Minutes	\$0
99489	Chronic Care Management – Each Additional 30 Minutes	\$0

# Chronic Care Management

Physicians and other qualified healthcare professionals must implement a documented care plan to coordinate multiple disciplines and agencies that is shared with the patient and/or family or caregiver.

These may include:

- Developing and maintaining a comprehensive care plan
- Facilitating access to care and services needed by patient and/or family
- Assessing and supporting patient compliance with treatment plan including schedule of medication
- Educating patient, family, and/or caregiver to enable and support self-management, independent living, as well as ADL

# Chronic Care Management

- Identifying community and healthcare resources available to the patient and/or family
- Communicating with home health agencies and other community services available and used by the patient
- Communicating aspects of care to patient, family, and/or caregiver
- Collecting health outcomes data and registry documentation



# Chronic Care Management

May only be reported once per calendar month. They also cannot be reported during the same month as any of the excluded codes.

May only be reported by the single physician who assumes the care coordination role



# Advanced Care Planning

## New for 2015

- CPT Code 99497 – Explanation and discussion of advanced directives such as standard forms (with completion of forms, when performed) by the physician; first 30 minutes face-to-face with the patient, family member(s), and/or surrogate
- CPT Code 99498 – Each Additional 30 Minutes

# Advanced Care Planning

- CPT Code 99497 – Discussion about advance directive, with or without filling out forms
  - Advance Directives are:
    - Healthcare Proxy
    - Durable Power of Attorney for Healthcare
    - Medical Orders for Life-Sustaining Treatment
- No active management of problem is undertaken during the time period
- Patient does not have to be present
- Can report E&M but not Critical Care, Neonatal/Pediatric Critical care, or Intensive Care Services (99291, 99292, 99468-99476, and 99477-99480)



# Advanced Care Planning

## Medicare Payment for New Codes

CPT	Description	Medicare 2015 Allowable
99497	Advanced Care Planning- 30 minutes	\$0
99498	Each Additional 30 minutes	\$0

# Transitional Care Management Coding

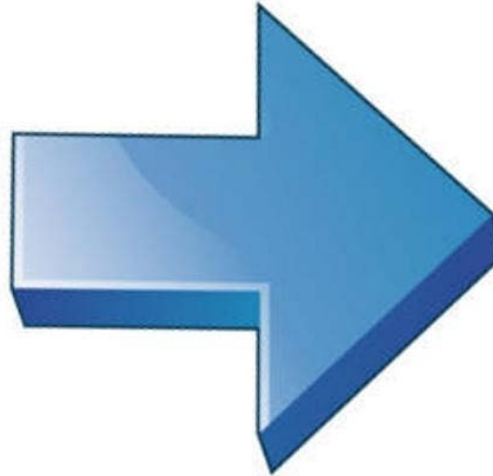
# Transitional Care Management Codes

- CPT Code 99495 covers communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision making of at least moderate complexity and a face-to-face visit within 14 days of discharge.
- CPT Code 99496 covers communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision making of high complexity and a face-to-face visit within seven days of discharge.

# Transitional Care Management Codes

- FROM

- Inpatient Hospital Setting
- Partial Hospital
- Observation Status at a Hospital
- Skilled Nursing Facility/Nursing Facility



- TO

- Home
- Domiciliary
- Rest Home
- Assisted Living



# Transitional Care Management Codes

- Medication reconciliation and management should happen no later than the face-to-face visit.
- The codes can be used following "care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospitalization, observation status in a hospital, or skilled nursing facility/nursing facility."
- The codes cannot be used with G0181 (home health care plan oversight) or G0182 (hospice care plan oversight) because the services are duplicative.

# Transitional Care Management Codes

- Billing should occur at the conclusion of the 30-day post discharge period.
- They are payable only once per patient in the 30 days following discharge, thus if the patient is readmitted TCM cannot be billed again.
- Only one individual can bill per patient, so it is important to establish the primary physician in charge of the coordination of care during this time period
- The codes apply to both new and established patients.

# Transitional Care Management Codes

## Medicare Payment for TCM Codes

CPT	Description	Medicare 2015 Allowable
99495	TCM- Face to face within 14 days of discharge- Moderate Complexity	\$166.93
99496	TCM- Face to face within 7 days of discharge- High Complexity	\$234.30

# Scenarios

Sorry, I'm busy creating perfect scenarios in my mind that will never come true.



your  cards  
someecards.com

more awesome pictures at [THEMETAPICTURE.COM](http://THEMETAPICTURE.COM)



# Chronic and Complex Care Management

99490- 75 year old Male with diabetes, claudication and mild congestive heart failure, status post myocardial infarction with mild dementia who had a stent placed 6 weeks ago, lives with his daughter, hospitalized for foot ulcer- treating with two specialist and Primary care physician

Plan of care created and shared with patient and daughter.  
Comprehensive plan for all health problems with person assigned to task/management:

- Problem List
- Expected outcome and prognosis
- Measurable Treatment Goals
- Symptoms Management
- Planned Interventions
- Medication Management
- Social Services ordered

# Advanced Care Planning

99497- 68 year old male with heart failure and diabetes on multiple medications is seen with wife to discuss advance care planning

Documentation to include:

- Cognitive evaluation to determine patient capacity

- Discussion of Risks, benefits and alternatives to the various advance directive planning tools

- Show Patient various forms (blank)

- Discussion of patients personal belief/values/goals

- Discuss palliative care options, ways to avoid hospitalization and the patients desire for care if decision making capacity is affected

- Answer Patient/caregiver questions

99498- 68 year old male with heart failure and diabetes on multiple medications recently discharged from intensive care seen with wife to discuss advanced care planning

Documentation to include the same elements as 99497  
But time spent is 45 minutes  
Additional discussion of patient condition and prognosis, complications in family dynamic,



# Questions



# Thank You!

Michele Olivier  
Director Coding and Audit  
Division

[molivier@askphc.com](mailto:molivier@askphc.com)

303-801-0124



9085 E. Mineral Circle, Suite 110

Centennial, CO 80112

and

204 N. Robinson, Suite 2400

Oklahoma City, OK 73102

(303) 801-0123

**AskPHC.com**