

## 2018 SC Chapter ACP Scientific Meeting

### Correctly Coding the Transition Care Management and Chronic Care Management Services

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## Background

- As part of the ACA, the Hospital Readmissions Reduction Program (HRRP) was created as a way to reduce readmissions.
- TCM was developed by the CMS/AMA in 2012 and rolled out in CPT 2013
- Encourages seamless patient care coordination from an inpatient hospital to the outpatient setting
- Since implementing TCM and other post-discharge initiatives, hospital readmission rates have decreased by 2%

## Objectives

- State the importance of care coordination and understand how to transition from hospital to home to office to home
- Name components specific to the two different Transition Care Management (TCM) codes for 2018
- Understand the three Chronic Care Management Codes to use for patients with multiple chronic conditions
- Understand processes needed to successfully implement these in your practices

## Complex patients need care coordination

- Chronic disease burden affects multiple organ systems and debilitates patients
  - Complicates surgical cases, both planned and unplanned
    - Orthopedic procedures
      - Healing and rehabilitation is difficult
    - General surgical procedures, especially with general anesthesia
  - Routine infections can become more difficult to treat
    - Diabetes
    - Vascular disease, like CAD, PVD
- Transition Care Management codes are not limited to just multi-chronic disease patients
  - All admissions for Medicare Beneficiaries

## Lack of coordination leads to costly care

- Higher re-admission rates
  - 90% are unplanned (AHRQ), usually related to poor care coordination and continuity
    - <50% see a provider prior to the readmission
    - Medication mismanagement is second leader associated with readmits
  - Of the preventable admissions, physicians assigned patient factors in 44 %, clinician factors in 30 % and system factors in 26 %
  - When re-admitted, more costly care with prolonged LOS and complications
    - Cost annually \$26B, \$17B avoidable (CMS, 01/2015)

## 2018 update: Transition Care Management

- One potential solution to prevent readmissions
  - Hospital penalty of up to 3% of Medicare payments began in 2015
  - TCM codes set to apply mostly to primary care practices to help cover the non face-to-face services they offer
  - For TCM codes to be successfully used, we need partnerships
    - Hospital, Hospital-based physician, and primary care physician working as team to interlink with community resources that meet the patient's needs
  - For care transitions to be compliant, we need hard-wired processes
    - Audits confirm the need

## How do we coordinate care?

- Begins in the hospital before discharge
  - Out of hospital services aligned with the patient's needs
    - Home health, rehab services, outpatient ancillary follow-up with dietitians/counseling, etc.
  - Medication reconciliation and education of proper compliance and reasons for medication use
  - Education of the disease(s) and how they caused the hospitalization and self-directed modifications that can be embraced to keep disease state in check
  - Identification of barriers to self-care
- The Global Team is key to re-admission reduction and patient quality of life optimization
- Relay of the information to outside entities is key

## Discharge encounter

- Inclusions for physician/NPP on unit/floor that day
  - The face-to-face examination
    - Review of the hospital course, and discharge instructions
  - Medication reconciliation
  - Paperwork preparation/form fill-out
  - Discharge summary dictation
- Time for completion of this is additive and must be documented

## The discharge from hospital

- Discharge summary review
  - Must be completed timely
    - Even observation services and 1-day stays!!
  - Must be succinct but complete
    - Abbreviated as compared to the admit note
  - Some "musts"
    - Pertinent tests that were negative or positive
      - A1c of 6.4 means something as does an ECHO of 22% EF
    - Procedures re-stated with findings
      - EGD with stricture, etc.
    - Medication list with med changes from admit summarized
      - If meds changed for sake of formulary, consider reverting to admit medication if class of drug or clinical effect not different
    - Needed follow-up tests, office visits, or other appointments
      - "recheck potassium at ov in 1wk and get a fu ECHO in 4wks"

## Discharge care billable codes

- Inpatient care services
  - 99238 (<30 minutes of time involved)
  - 99239 (>30 minutes of time involved)
- Observation (outpatient) care services
  - 99217 observation discharge (no time)
  - 99234-99236 admit/discharge same day
- Nursing home admission is separately billable even if performed on the same day
  - 99304-99306 (01/2006)

## TCM Service: 99495/99496

- Provided to patients discharged from
  - Inpatient or Observation status hospital care
  - Skilled Nursing Facilities
  - Partial Hospitalization programs
- NOT to be used
  - Unless physician or NPP accepts the care of the patient post-discharge without a gap and accepts responsibility for patient's care
  - By surgeons in post-hospital global surgical period (90d)
  - By hospitalists who do a one-time f/u visit
  - In hospital → hospital or hospital → SNF transfer
  - By RHC and FQHCs\*
- Established or new patients qualify
- Place of service 11 (office), 12 (pt home), 13 (assisted living)

## TCM for RHC/FQHC as of 2018

- The RHC All Inclusive Rate is TCM reimbursement
  - Co-insurance (20%) and deductibles apply
- The FQHC rate is the lesser of the FQHC charges or the PPS rate
  - Co-insurance (20%) applies

## TCM Service: 99495/99496

- Time period is 30 days (date of discharge and for next 29 days)
- Additional E/M visits outside of the one required are billed separately, even if <30d (but not on the same day)
- Documentation needs:
  - Date of discharge
  - Date of dialogue to assess patient and secure/confirm appointment
  - Minimal content to address hospital course
    - Disease status, medication compliance, f/u interim access
  - Summation of subsequent correspondence that has occurred
  - The E/M note associated with the f/u care (provider exam, A/P)
  - Medication reconciliation completed no later than initial office visit
- Bill for the TCM care (30 day inclusive) is submitted date of post-hospital encounter

## 2018 update: Transition Care Management

- 99495
  - Communication (direct contact, telephone, electronic) with the patient/caregiver (includes home health agencies) within 2 business days by staff
    - Discuss caretaker education, care management, ADLs
    - Assess for support and treatment adherence
    - Identify available community health resources
    - Assist in access to care and other services as needed by family
  - Non face-to-face services provided by physician, or other qualified healthcare provider
    - Discharge summary review
    - Lab f/u issues
    - Contact other providers of care to coordinate healthcare delivery
    - Educational outreach
  - MDM of **moderate** complexity during the service period
  - Face-to-face visit within **14** calendar days of discharge

## 2018 update: Transition Care Management

- 99496
  - Communication (direct contact, telephone, electronic) with the patient/caregiver (includes home health agencies) within 2 business days by staff
    - Discuss caretaker education, care management, ADLs
    - Assess for support and treatment adherence
    - Identify available community health resources
    - Assist in access to care and other services as needed by family
  - Non face-to-face services provided by physician, or other qualified healthcare provider
    - Discharge summary review
    - Lab f/u issues
    - Contact other providers of care to coordinate healthcare delivery
    - Educational outreach
  - MDM of **high** complexity during the service period
  - Face-to-face visit within **7** calendar days of discharge
  - Same rules for billing as for 99495

## The Third Key Component



- History
- Examination
- Medical Decision Making (MDM)**
  - Diagnoses** managed (number and type)
  - Data** reviewed to manage diagnoses of visit
  - Risk** associated with the management plan
- For MDM assessment, need 2 of the 3 to be weighted the same

## TCM: Not Once and Done

- This is a 30 day code, so re-connecting with the patient is expected if there is need
  - Referrals
  - Community resources: Meals on Wheels, Senior Center, AA meetings, etc.
  - Home health initiation and transition
  - Physician/NPP request for close follow-up
    - Review note, how stable is patient
      - Make sure appointments kept and plan of care followed
- Transition to Chronic Care Management if appropriate

## Chronic Care Management

Practical Applications

## Finally, financial freedom...!!!!

- CMS in 2015 stated it was willing to pay physicians for non-face-to-face work done in the care of our patients
- Starting in the fall of 2014, the message was out...  
"The potential payoff to physicians could be tremendous. Practices can earn \$42.60 a month providing care for each patient qualified for CCM. With 500 qualified patients, you could earn an additional \$255,600 annually. For practices with 1000 qualified patients, that could be \$511,200 in additional annual revenue."
- My CFO asked "when can we start billing this?"
- Devil is in the details.....

## Basic CCM Details

- Non face-to-face encounter for care coordination
  - Effective 01-2015, updated 01-2017
  - Activities that do not require FTF
    - Review of medical records/reports, Review labs, telephone/email communication, communicate with other providers, health info exchange, etc.
- Medicare patients that have **two or more** chronic conditions
  - Should last >12 months, or death of patient
  - Conditions should be significant enough to place the patient at risk of death, acute exacerbation, or functional decline
    - Possibilities may be: Alzheimer's, OA/RA, Asthma, Afib, Autism spectrum of disorders, Cancer, COPD, Depression, HF, HTN, Ischemic Heart Disease, Osteoporosis, CKD, etc.
    - <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions>

## Basic CCM Details

- Chronic conditions should be managed with the use of a patient-centric care plan that is implemented, revised, or monitored
  - Multiple staff members can participate in the care delivery
- Patient permission is needed before delivery of service
  - Written permission is not required, but verbal consent needs to be clearly documented
  - Beneficiary is responsible for co-insurance and remaining deductible
- One bill per month per provider (practitioner – Part B)

## Expected Included Services

- Use of Certified EMR
  - Need for problems, meds, allergies, but not for other CCM documentation. Faxes count now for care plan sharing
  - After hours CCM team no longer required to have real-time access, need "timely access"
- Designated team member has continuity of care responsibility
- Comprehensive Care Management and Care Planning
  - Coordination with home- and community-based clinical service providers
  - Transition Care Management services
- 24/7 access for urgent needs being addressed
- Enhanced communication (email, etc.)
- Advanced consent from patient can be verbal, no signature needed, but record needs to state info explained to patient

## Who can **initiate** CCM for patients?

- Physicians
- Non-physician practitioners
  - Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, Clinical Nurse Specialists
- Needed for *new patients or patients not seen within one year before CCM commencement*
  - If not in this category, could initiate telephonically
- Not part of CCM, separately billed
  - AWV, IPPE, or other FTF visit with provider who is engaged in management of the chronic conditions
  - During this encounter collection of patient demographics, problems, medications, and allergies as well as a patient-centered Care Plan, AND verbal consent to have CCM

## The Consent Needed to Initiate

- We must educate the patient
- Make the Beneficiary aware that these new services are available, recommended by CMS, as a way of supporting the patient in achieving better health
  - Limit ED use, admits to hospitals, and aids in self management of medical conditions
  - At onset of service, then when change of providers (I recommend yearly, however)
- Service
  - Optional, patient verbally must approve (note in record)
  - Can be canceled (end of that month)
- One provider per month can bill CCM
  - NOT co-pay or deductible waived, but secondary often covers this (and cost savings above may offset this)

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- Needed for new patients or patients not seen within one year before CCM commencement
  - If not in this category, could initiate telephonically
- Not part of CCM, separately billed
  - AWV, IPPE, or other FFF visit with provider who is engaged in management of the chronic conditions
  - During this encounter collection of patient demographics, problems, medications, and allergies as well as a patient-centered Care Plan, AND verbal consent to have CCM
- Providers who furnish CCM initiating visit and personally perform extensive assessment and planning outside of usual effort may bill G0506

## G0506: Comprehensive Assessment and Care Planning

- Billing Provider personally performs extensive assessment and care planning outside the usual effort set forth by the E/M, AWW, or IPPE initiating visit
- Add-on to the above (-25), bill during 99490 (basic) or 99487/99489 (complex CCM) care delivery
- CMS indicated G0506 might be seen with lower level E/M codes (level 2 or 3) but could be seen with higher level services
- Can see this when additional problems unrelated to CCM are addressed
- Only allowed to be billed once per patient by physician

## G0506 ... confusion?

- Do we bill it at EVERY encounter....only level 2/3 E/M ....
  - Get guidance from your MAC
- Consider....
  - Dealing with a condition and you decide CCM is a good option, so address
  - Low level visits (stable f/u and you address)
  - An office visit where you get side-railed and you opt to deploy CCM services to aid in patient care
- No matter, the documentation of that date needs to show reasons why CCM indicated, the verbal OK from patient, and Care Plan (pt. gets)

## The Care Plan "Roadmap"

## The Care Plan "Roadmap"

- Should be "patient centered" and focus on the global patient
  - Physical, mental, cognitive, psychosocial, functional and environmental aspects
  - Evaluate and align resources to address any of the above
  - Patient/caregiver gets at initiation of CCM services
- Should include:
  - Problems, expected outcomes/goals
  - Symptom management (meds and interventions)
  - Coordination of community/social services/specialists
  - Plan to review/revise care plan

## Access to care requirements

- 24/7 access to care management and other needs related to the chronic condition
  - Urgent needs or questions related to care plan, evaluation or other management services
- Continuity of care with a provider in the office on a routine basis
- Enhanced opportunities for communication such as phone, internet portal, secure messaging, or other asynchronous consultation methods
  - Clinical team must be able to have timely access record/care plan to aid in care management
  - HIPAA compliant

## Comprehensive and Transition Care Management

- Assessment of patients medical, functional, and psychosocial needs
- System-based approaches to capture preventive services
- Medication reconciliation
- Care coordination of community resources
- Transitions of care with patient
  - Hospital → home → provider
  - Provider → provider
  - Community-based resources are needed

## What "services"?

- Minimum of 20 minutes of non face-to-face services/month
  - Under direction of Physicians and NPPs via general supervision (not direct) that can be "incident to"
- "Incident to" services
  - Triggered by a Physician/NPP's assessment and order
  - Must be part of the patient's normal course of treatment
  - "Direct" supervision, Physician is in office; "general" supervision, Physician does not have to be (state by state regulations)
  - Service must be an expense to physician (staff cost)

## Clinical Staff

- "Clinical staff" who work for the physician
  - "a person who works under the supervision of the above who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report (bill) that service"...think "licensed" or "certified". But, must be an expense to the physician.
  - MSW, PharmD, CMA, RN, LPN, Rad Tech, Lab Tech, Health Coach, etc. (not front desk secretary, coders, billers – do not count)
  - Can use an outside care management company, clinical staff still required, so ask
- Physicians or NPPs if they perform these services can count that time as well
- Services must pertain to management of chronic condition

## What "services" (20 minutes minimum)?

- Emails with the patient, phone calls
  - A follow-up phone call to the patient after the Care Plan is generated by the Physician to ensure understanding and set up ground rules
- Managing referrals to other providers
  - Call to Heme/Onc to address GI physician's concerns that pt needs IV iron, set up outpatient appointment
- Discussion with pharmacy or time spent counseling the patient on med reconciliation
  - F/U call in one week to make sure new medication is not causing side effects
- Discuss patient with caregivers
  - Pt with wound vac and you speak to husband re: wife's status and if HHN is doing f/u. You call HHN with update.

## What "services"?

- Follow-up after you are notified of any healthcare intervention
  - You find out that the patient went to the ED, you call for f/u and then assess need for the patient to come in for you to see
  - You also spend time in review of the ED (or other consult) note when it comes in.
- F/U of clinically "unstable" patient
  - BS out of control and meds were adjusted with instructions for TID BS checks
- F/U to ensure knowledge of preventive care service appointment or call back with results

## What "services"?

- Transition Care Management
  - f/u from in-hospital care
  - If TCM starts first, then at end of the TCM 30d, address the CCM option with patients and caregivers to set this in motion
- Coordinate care with other providers in community
  - Meals on Wheels, Congregational Nursing, etc.
- Duties performed to assist in chronic care management
  - Handicap sticker, DME, reduced/free medications, pre-authorizations of meds or procedures, etc.

## The CCM Code Set

- As of 01-2017 CCM code set was expanded from the single code to three based on patient's needs
- A given patient can receive regular/"non-complex" CCM or "complex"
- One service (not both) are delivered in a service period (30d period)
  - The difference between complex and non-complex CCM is
    - the amount of clinical staff time,
    - the extent of care planning, and
    - the complexity of the problems addressed by the billing practitioner during the month

## 2018 Coding Summary

TABLE 1. SUMMARY OF 2017 CCM CODING CHANGES

BILLING CODE	PAYMENT (NON-FACILITY RATE)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
CCM (CPT 99490)	\$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised, or monitored	Ongoing oversight, direction, and management Assumes 15 minutes of work
Complex CCM (CPT 99487)	\$94	60 minutes	Established or substantially revised	Ongoing oversight, direction, and management * Medical decision-making of moderate-high complexity Assumes 20 minutes of work
Complex CCM Add-On (CPT 99489, use with 99487)	\$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction, and management * Medical decision-making of moderate-high complexity Assumes 13 minutes of work
CCM Initiating Visit*	\$44-\$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	\$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

\*Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management (TCM), or Other Qualifying Face-to-Face Evaluation and Management (EAM)

## What is the code?

- 99490 (Basic CCM)
  - Bill one unit per month that the 20 minutes of non face-to-face services are delivered by provider or clinical staff
  - YOU cannot bill another "time-based" code\*\*
    - Home health certification/recertification
    - Hospice Care
    - Care plan oversight
    - Transition Care Management
    - ESRD services (90951-90970)
    - Prolonged E/M service codes
    - Remote patient monitoring (99090/99091) are bundled in
      - As long as not the only work performed, can count as time for CCM
  - ~\$43/month
    - Recall co-pay and deductible (so after deductible, ~\$8)
    - Secondary insurance companies kick in, case-by-case

## What is the code?

- 99487 (Complex) CCM
  - As with Basic, see 2 or more chronic conditions
  - Establishment or substantial revision of the care plan
  - Moderate or High medical decision making
    - New problem management, OR
    - Two conditions with at least one out of control, OR
    - Three chronic conditions that require care management issues
  - 60 minutes of clinical staff time under direction of the provider per calendar month

## 99487 clinical case

- 67 year old HTN, IGT/BMI 38 with new anemia (7.8 grams)
  - Initiated at the 99214 visit, add-on code G0507 due to the anemia.
  - Appointment with GI.
  - Call to GI physician after seeing that scope negative
    - Time for call and for review of endoscopy notes and call to patient for plan to come back for labs – all time additive for month
  - Call to review labs (Hgb 8.2), plan to refer to Hematology.
  - Physician calls Hematology, then patient who also asked for provider to call his daughter in next state who has many questions. 20 minute call with daughter. She now gets f/u call after every appointment her Father has.
  - 67 minutes for the month.....bill 99487 (> 60 min)

## 99489

- Each additional 30 minutes of clinical staff time directed by a physician or qualified provider

## Counting the time

- When doing work on care management and coordination, does time count.....?
  - Yes
    - When calling a patient regarding med reconciliation after a visit
    - When talking to a son about coordination of his Mother's care
    - When the patient is discussed in a complex case management conference to optimize her care
  - No
    - When running a report to see who needs a mammogram this month
    - When doing a group visit diabetes education session and your patient shows up
    - When the billing staff talks to you about how to code and document the patient's CCM or when the front desk secretary calls the patient to remind her of her next appointment

## CCM for RHC/FQHC as of 2018

- Services billed prior to 01/01/2018, the 99490 (20 min CCM) code is paid as per schedule
- After 01-01-2018, the 99490 code is denied
- After 01-01-2018, the G0511 code is to be used
  - Payment is set based on a blend of
    - 99490
    - 99487 (60 min complex CCM)
    - 99484 (20 min behavioral health integration)
  - 2018 rate is \$62.28
- Co-insurance (20%) and any deductibles apply

## Show Me The Money

- Is this the cash cow many CFOs dreamed would answer their every financial wish.....?
  - No
- Difficult to do?
  - Must document, track staff time, etc.
- Difficult to sell?
  - Wish it were co-pay/deduct waived....but secondary insurance picks this up often
- Difficult to operationalize?
  - May be better suited for system-based chronic disease management with care teams for many sites
- BUT, this CAN be operationalized in both small and large practices when we have populations that fall in this category

## Resources

- Care Planning Tools
  - <http://go.cms.gov/ccm>
  - <https://integrationacademy.ahrq.gov/playbook/develop-shared-care-plan>
  - <http://www.ihl.org/resources/Pages/Tools/MySharedCarePlan.aspx>
  - <http://catalyst.nejm.org/making-the-comprehensive-shared-care-plan-a-reality/>
- Medicare Learning Network publication on Chronic Care Management
  - ICN 909188, December 2016
- Connect with your MAC
  - <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map>

## Remember.....TCM

- Check the boxes, document the checks
  - 99495: 2.11 wRVU (\$111)
    - Moderate MDM
    - < 14 days to be seen
  - 99496: 3.03 wRVU (\$160)
    - High MDM
    - < 7 days to be seen (best practice)
- 30 day codes, drop bill on date of ov
  - Do not combine with other 30 day codes
    - CPO, Hospice care, ACP, etc.
    - CCM is OK with TCM if ends and CCM continues

## Connect with me....

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