Care Management: Principal Care and Chronic Care Management Services

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Objectives

- Care Management: Making all-inclusive care plan a reality and by offering these sessions, we hope that our J6 and JK providers have a better understanding on codes available that describe care management

Agenda

- Care Management Continued Series
  - Advanced Care Planning
  - Behavioral Health Integration
  - Cognitive Assessments
  - Principal Care Management/Chronic Care Management
  - Transitional Care Management
- General
- Coding
- Billing
- Resources

Care Management: Principal Care Management (PCM) Services

Principal Care Management Services: General

- Introduced in 2020
- Treatment of beneficiaries with a single, serious, chronic condition
- Diagnosis expected to last between three months and a year or until death of patient
  - May have led to recent hospitalizations
  - Places patient at significant risk of death, acute exacerbation, decompensation or functional decline
- Comprehensive care plan for a single high-risk condition
- Non-face-to face activities

Principal Care Management Services: General

- Benefits
  - Patient-focused care
    - Quality of care with improved outcomes
  - Reduces costs
  - Provides compensation for services previously done at no cost
    - Opportunity for monthly billing per beneficiary

Principal Care Management Services: Coding

- G2064- Comprehensive care management services
  - For a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements
    - One complex chronic condition lasting at least three months, which is the focus of the care plan
    - The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
    - The condition requires development 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

Principal Care Management Services: Coding

- G2065- Comprehensive care management for a single high-risk disease service
  - Principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements
    - One complex chronic condition lasting at least three months, which is the focus of the care plan
    - The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
    - The condition requires development 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

Principal Care Management Services: Billing

- At the initiating visit, obtain patient's verbal or written consent
  - Document in the medical record
  - Educate the patient on PCM
    - Only one practitioner can provide PCM in a calendar month
- Must inform of applicable cost sharing
  - Deductible and coinsurance apply
- 24/7 access to dedicated care team member
- Billing practitioner has to conduct an initial face-to-face visit
  - Annual wellness visit or other separately billable visit
- Develop a comprehensive care plan in the electronic health record
  - Patient's demographics
  - List of medical problems
  - Medications (allergies)

Principal Care Management Services: Billing

- Timed services
  - 30 minutes of clinical staff or physician time performing qualifying activities per month
- Frequent adjustments to medication
- Condition is unusually complex due to comorbidities
- Patient or primary care practitioner may involve another clinician to provide the care
  - Specialist eventually returns patient to primary care practitioner once condition is stable
- Goal is to manage condition benefiting from non-face-to-face services
- Do not report G2065 and G2064 in the same calendar month
- Billing PCM codes requires the practitioner to develop a disease-specific care plan while billing CCM codes requires a comprehensive care plan

Principal Care Management Services: Billing

- Who can bill for PCM?
  - Physicians
  - Certain nonphysician practitioners
  - Physician assistants
  - Clinical nurse specialist
  - Nurse practitioners
  - Certified nurse midwives
  - Rural Health Centers
  - Federally Qualified Health Center
  - Hospitals
  - Critical Access Hospitals

Principal Care Management Services: Billing

- Time accumulates throughout the month
- Once threshold met, claim may be submitted
- Use of EHR technology is required to satisfy certain elements
- PCM codes cannot be billed during same calendar month as
  - CCM (CPT codes 99487, 99489, 99490, 99491 and 99439)
  - Transitional care management (CPT codes 99495–99496)
  - End-stage renal disease services (CPT codes 90951–90970)
  - Supervision of home health care or hospice (HCPCS codes G0181 or G0182)

Principal Care Management: Documentation

- Activities not furnished during face-to-face encounter
  - Telephone calls
  - Review of medical records
  - Clinical staff discussions about patient's care
  - Secure communications
  - Reviewing notes, labs and other tests results
  - Communications with other service providers
  - Medication reconciliation
  - Updating plan of care

Principal Care Management: Documentation

- PCM Care Plan
  - List of patient's problems and conditions
  - Expected outcome and prognosis with measurable treatment goals
  - Cognitive and functional assessments
  - Symptoms management
  - Planned interventions
    - Identification of individuals responsible for interventions
  - Medication management
  - Environmental evaluation
  - Caregiver assessment
  - Coordination with outside resources and providers
  - Requirements for periodic review and revision of plan
  - Referrals applicable to condition
  - Support of referral by creating and exchanging summary of care document

Principal Care Management: References

- Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule - Comprehensive Care Plan

Care Management: Chronic Care Management (CCM) Services

Chronic Care Management Services: General

- In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule for CCM services furnished to Medicare patients with multiple chronic conditions
- CCM service codes provide payment of care coordination and care management for patients with multiple chronic conditions

Chronic Care Management Services: General

- 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
  - Number of illnesses, number of medications, or repeat admissions or emergency department visits
- There is a need to reduce geographic and racial/ethnic disparities in health through provision of CCM services
- The billing practitioner cannot report both complex and regular (non-complex) CCM for a given patient for a given calendar month
  - Do not report 99491 in the same calendar month as 99487, 99489, 99490

Chronic Care Management Services: General

- Examples of chronic conditions include, but are not limited to, the following
  - Alzheimer's disease and related dementia
  - Arthritis (osteoarthritis and rheumatoid)
  - Asthma
  - Atrial fibrillation
  - Autism spectrum disorders
  - Cancer
  - Cardiovascular disease
  - COPD
  - Depression
  - Diabetes
  - Hypertension
  - Infectious diseases such as HIV/AIDS

Chronic Care Management Services: Coding

- 99490 - Chronic care management services
  - Provide 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

Chronic Care Management Services: Coding

- 99439 - 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
  - 2021 Final Rule from CMS replaced G2058 with 99439
  - List separately in addition to code for primary procedure
  - Use 99439 in conjunction with 99490
  - Report additional 20-minute increments of service time (maximum of 60 minutes total)
  - Do not report 99439 for care management services of less than 20 minutes additional to the first 20 minutes of CCM services during a calendar month
  - Do not report 99490, 99439 in the same calendar month as 99487, 99489, 99491

Chronic Care Management Services: Coding

- 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

Chronic Care Management Services: Coding

- 99487 - Complex chronic care management services
  - 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

Chronic Care Management Services: Coding

- CPT 99489- Complex chronic care management services
  - 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
  - CCM (sometimes referred to as “non-complex” CCM) and complex CCM services share a common set of service elements. They differ in the amount of clinical staff service time provided; the involvement and work of the billing practitioner; and the extent of care planning performed.

Chronic Care Management Services: Billing

- Practitioner must obtain patient consent before furnishing or billing CCM
  - Ensures patient is engaged, aware of applicable cost sharing, and will prevent duplicative practitioner billing
- Consent may be verbal or written, but shall be documented in medical record, and includes
  - Availability of CCM services and applicable cost sharing
  - Informs that only one practitioner can furnish and be paid for CCM services during a calendar month
- Patient's right to stop CCM services at any time
  - Effective at the end of the calendar month
- Patient consent obtained once prior to furnishing CCM, or if patient chooses to change the practitioner who will furnish and bill CCM

Chronic Care Management Services: Billing

- Medicare requires new patients or patients not seen within one year prior to the commencement of CCM, initiation of CCM services during a face-to-face visit with billing practitioner
  - Annual wellness visit
  - Initial preventive physical exam
  - Other face-to-face visit with billing practitioner
- Initiating visit is not part of CCM service and is separately billed

Chronic Care Management Services: Billing

- 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
  - 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

Chronic Care Management Services: Billing

- Physicians and the following nonphysician practitioners may bill CCM services
  - Certified Nurse Midwives
  - Clinical Nurse Specialists
  - Nurse Practitioners
  - Physician Assistants
- 99491 includes only time that is spent personally by the billing practitioner
  - Clinical staff time is not counted towards the required time threshold for reporting this code
- 99487, 99489, and 99490 – 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
- CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the direction of the billing practitioner on an "incident to" basis

Chronic Care Management Services: Billing

- Concurrent Billing Reminders
  - CCM cannot be billed during same service period by same practitioner as
    - Home health care supervision hospice care supervision (G0181, G0182)
    - Certain end-stage renal disease services (90951–90970)
    - Transitional care management service (99495, 99496)
    - Complex CCM and prolonged E/M services cannot be reported same calendar month by same practitioner
  - Time reported under or counted towards the reporting of CCM service code cannot also be counted towards any other billed code

Chronic Care Management Services: Billing

- Place of Service
  - CCM is priced under physician fee schedule in both facility and non facility settings
  - Billing practitioners report the POS for location where s/he would ordinarily provide face-to-face care

Chronic Care Management Services: Documentation

- Comprehensive Care Management
  - Systematic assessment of patient's medical, functional, and psychosocial
  - System-based approach to ensure timely receipt preventive care
  - Medication reconciliation review of potential interactions
  - Oversight of patient self-management of medications
  - Coordinating care with home/community-based clinical service providers
  - Manage transitions between/among health care providers and settings
    - Referrals to other clinicians, follow-up after emergency department visitor facility discharge
  - Timely create and exchange/transmit continuity of care document(s) with other practitioners

Chronic Care Management Services: Documentation

- Comprehensive Plan of Care
  - Health issues focus on chronic conditions being managed
    - Patient-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources
    - Provide patient and/or caregiver with copy of plan of care
  - Make sure electronic care plan is available and shared timely within and outside billing practice to individuals involved in patient's care

Chronic Care Management Services: Documentation

- Comprehensive Care Plan Check List
  - Problem list
  - Expected outcome and prognosis
  - Measurable treatment goals
  - Symptom management
  - Planned interventions and identification of individuals responsible
  - Medication management
  - Community or social services ordered
  - Description of how services of agency and specialists outside practice are coordinated
  - Schedule periodic review and revision of plan of care

Chronic Care Management Services: Documentation

- CCM is extensive and includes
  - Structured recording of patient health information
  - Maintaining comprehensive electronic care plan
  - Managing transitions of care
  - Care management services and coordinating
  - Sharing patient health information timely within and outside practice

Chronic Care Management Services: Documentation

- CCM services typically provided outside face-to-face visits
  - Continuous relationship with designated member of care team
  - Patient support for chronic diseases to achieve health goals
  - Patient access 24/7 to care and health information
  - Delivery of preventive care
  - Patient and caregiver engagement
  - Timely sharing and use of health information

Chronic Care Management Services: Documentation

- Structured Recording Using EHR
  - Promoting interoperability
  - Record patient's
    - Demographics, problems, medications and medication allergies
  - Using
    - Certified EHR acceptable under the EHR Incentive Programs as of December 31st of calendar year preceding each Medicare PFS payment year

Chronic Care Management: References

- MLN® Booklet: *Chronic Care Management Services*
- Chronic Care Management
  - Outreach Campaign on Geographic and Minority/Ethnic Health Disparities
- Chronic Conditions in Medicare
- Chronic Conditions Data Warehouse

Chronic Care Management: References

- MLN Matters® *MM11560: Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Services List, CT Modifier Reduction List, and Preventive Services List*

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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