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Care Management: Chronic Care Management

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Today's Presenters

- Lori Langevin
  - JK Provider Outreach and Education, Consultant

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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.

Care Management Team

- Provider Outreach and Education Consultants
  - Care Management Team
    - Carleen Parker
    - Christine Obergfell
    - Jennifer Lee
    - Lori Langevin
    - Michelle Coleman
    - Nathan Kennedy

Agenda

- Care Management Continued Series
  - Chronic Care Management
- General
- Coding
- Billing
- Resources

Care Management: CCM Services

Chronic Care Management Services: General

- CCM service codes provide payment of care coordination and care management for patients with multiple chronic conditions
  - 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
- CCM services can also help reduce geographic and racial or ethnic health care disparities

Chronic Care Management Services: General

- 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
- The billing practitioner cannot report both complex and noncomplex 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

- Physicians and the following NPPs 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 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: 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 (CMS 2021 Final Rule 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 "noncomplex" 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
- Patients need to provide informed consent only once unless they switch to a different CCM practitioner

Chronic Care Management Services: Billing

- Medicare requires an initiating visit for new patients or patients who the billing practitioner hasn't seen within one year
  - Annual wellness visit
  - Initial preventive physical exam
  - Other face-to-face visit with billing practitioner
- If practitioner doesn't discuss CCM during initiating visit, then it can't count as the initiating visit
- 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: Concurrent Billing Reminders

- CCM cannot be billed during same service period by same practitioner as
  - Home health care supervision (G0181) or hospice care supervision (G0182)
  - Certain End-Stage Renal Disease services (90951–90970)
- Complex CCM and prolonged E/M services cannot be reported in the same calendar month
- You can report CCM codes 99487, 99489, 99490 and 99491 by the same practitioner for services furnished during the 30-day TCM service period (CPT 99495, 99496)
- 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

OIG Audit Findings

- Overpayments for CCM services costing the Medicare program $1.9 million
- Physician and hospital claims for CCM services for 2017 and 2018 totaled $356 million
- Errors occurred because CMS did not have claim system edits to prevent and detect overpayments
  - Providers billed noncomplex or complex CCM services more than once for the same beneficiary for the same service period
  - Same provider billed for both noncomplex or complex CCM services and overlapping care management services rendered to the same beneficiaries for the same service periods
  - Incremental complex CCM services that were billed along with complex CCM services
- Implement claim system edits to prevent and detect overpayments for noncomplex and complex CCM services

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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