AMDA- The Society for Post-Acute and Long-Term Care Medicine

Billing and Coding for PA/LTC Provider Somethings Old, Somethings New

Chuck Crecelius, MD, PhD, FACP, CMD

Director Post Acute and Long Term Care, BJC Medical Group, St. Louis, MO
Medical Director, Delmar Gardens
AMDA, Past President, Past Chair Public Policy, RUC & SAGSA Advisor

amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Speaker Disclosures

- Drs. Crecelius has no affiliation with, or financial interest in, any commercial interest that may have direct interest in the subject matter of his presentation.

Newer Codes for Cognitive Services

- **Advance Care Planning codes 99497/99498** January 1, 2016
- Chronic Care Management Codes 99490

- Complex Chronic Care Management Codes 99487/99489 January 1, 2017
- **Non-Face-to-Face Prolonged Service 99358/99359**
- Comprehensive Assessment and Care Planning G0506
- General Behavioral Assessment G0507
- Behavioral Health Integrated Services G0502/G0503/G0504

- ?? Revalued Office E/M January 2020/21?
- ??Code Collapse

amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Why Is CMS Paying for these Codes?

- Short answer – to pay for cognitive services not previously recognized
- Other answers
  - To provide better granularity to the work cognitive physicians do compared to specialist / surgeons with procedural codes
  - To make up for the lost 10% primary care incentive
  - To promote primary care services

amda The Society For Post-Acute And Long-Term Care Medicine™

Advance Care Planning

THE SOCIETY
FOR POST-ACUTE AND
LONG-TERM
CARE MEDICINE™

99497 Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

+ 99498 each additional 30 minutes (List separately in addition to code for primary procedure)

CPT Changes: An Insider's View 2015

CPT Assistant Dec 14:11

(Use 99498 in conjunction with 99497)

amda The Society For Post-Acute And Long-Term Care Medicine™

When will CMS Cover ACP?

- "When the described service is reasonable and necessary for the diagnosis or treatment of illness or injury"
- At present, there is no controlling national coverage policy
- In Missouri, push towards TPOPP may accelerate code use (Illinois has POLST)

amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Are there minimum amounts of time to bill the code

- In the absence of rules otherwise, CMS defers to CPT descriptor language
- According to CPT coding convention, the threshold for minimum time is reached after the midpoint
- For 99497, “first 30 minutes” is reached at 16 minutes
- For 99498, additional 30 minutes is reached at 30 + 16 minutes=46 minutes

amda The Society For Post-Acute And Long-Term Care Medicine™

How often can ACP be billed?

- Per CPT language, there is no limit
- CMS has declined to establish frequency limits at this time
- BUT—if billed multiple times, CMS would expect to see "a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care."

Are there rules governing who may actually perform the service?

- Besides the CPT descriptor, there is no introductory language nor are there explanatory notes governing the performance of the service
- According to the final rule (80 Fed. Reg. 70956), "99497 and 99498 are appropriately provided by physicians or using a team-based approach provided by physicians, NPPs and other staff under the order and medical management of the beneficiary's treating physician."

amda The Society For Post-Acute And Long-Term Care Medicine™

More on who may perform ACP

- CMS expects the billing physician or NPP to "meaningfully contribute to the provision of the services in addition to providing a minimum of direct supervision."
- "Incident to" service rules apply
- All applicable state law and scope of practice requirements must be met

Must the beneficiary be present?

- According to the code descriptor, the service is "face-to-face with the patient, family member(s) and/or surrogate"
- Cannot be reported if performed by phone
- According to CMS, if beneficiary is not present, must document that the beneficiary is impaired and unable to participate effectively
- Must still be face-to-face with family member(s) and/or surrogate

amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Is consent necessary?

- Important, because co-pays and deductibles apply (except in the case of Annual Wellness Visit)
- ACP services are voluntary
- No formal consent is required, but beneficiaries (or family members/surrogates) should be given opportunity to decline or receive ACP services

amda The Society For Post-Acute And Long-Term Care Medicine™

What must be documented?

- No requirements in the CPT code descriptor
- Medicare Administrative Contractors (MACs) have so far not issued guidance
- Recommendations from CMS; document:
  - That participation is voluntary
  - An account of the discussion
  - Who was present
  - Explanation of advance directives, including any completed forms
  - Time spent in the encounter

Can ACP be reported in addition to other services?

- May be reported in addition to E/M codes
  - But need to keep time separate
- May be reported during same service period as Transitional Care Management or Chronic Care Management
- May be reported during global surgical periods
- May not be reported on same date as certain critical case services

amda The Society For Post-Acute And Long-Term Care Medicine™

Are specific diagnoses required?

- No specific diagnoses required
- HOWEVER, as for all services, appropriate ICD-10 code(s) required, preferably that on which the physician is counseling the beneficiary
- May use well exam diagnosis when ACP furnished as part of the Medicare Annual Wellness Visit (AWV)
  - Append modifier -33

amda The Society For Post-Acute And Long-Term Care Medicine™

Do deductibles and copays apply?

- YES, except when reported as element of the AWV; use modifier -33
- YES, when reported in addition to Introductory Preventive Physical Examination (“Welcome to Medicare Exam”_
- Recommend that practitioners let beneficiaries know

amda The Society For Post-Acute And Long-Term Care Medicine™

Non-Face-to-Face Prolonged Evaluation & Management (E/M) Services

THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Non-Face-to-Face Prolonged Evaluation & Management (E/M) Services

- In response to comment to the CY 2016 proposed rule, for 2017 CMS established separate payment for non-face-to-face prolonged E/M service codes that are currently considered to be "bundled." The codes are:

  99358 Prolonged evaluation and management service before and/or after direct patient care; first hour

  99359 Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)

NOTE: According to CPT convention, the threshold is reached at the halfway point; e.g. "First hour" is reached at 31 minutes

amda The Society For Post-Acute And Long-Term Care Medicine™

Non-Face-to-Face Prolonged Evaluation & Management (E/M) Services

- Used to report extended non-face-to-face time by physician or other qualified healthcare professional
- Does not overlap with CCM or Behavioral Health Integration codes
- Must be directly related to a face-to-face service
- Can be performed in PA/LTC, AL, outpatient or inpatient POS

Non-Face-to-Face Prolonged Evaluation & Management (E/M) Services

- Requirements much like the Face-to-face Prolonged service, BUT
- May be performed on a different day, so long as it is directly related to the face-to-face service
- Must be performed on one day, and not accumulated over several days (it is a one day service)
- Technically can be performed cumulatively over the entire day – 12:00 midnight to 11:59 pm

amda The Society For Post-Acute And Long-Term Care Medicine™

Possible example of a Non-F2F PA/LTC prolonged E/M service

- 86 year old patient admitted to SNF with paucity of records, seen and H&P done. Extensive old records arrive 2 days later. Reviewed, called previous consultant to confirm details, family called and care plan revised. 45 minutes spent
- CPT 99358 billed as more than halfway point reached (first hour)
- Done on a given date (one day, not a global service)
- Billed on the date of service, not the day of H&P
- Patient not seen

amda The Society For Post-Acute And Long-Term Care Medicine™

Another possible example of a PA/LTC prolonged Non-F2F E/M service

- 88 year old female with acute change of condition seen 5 pm – stat labs ordered, diagnosed with pneumonia and CHF exacerbation, diuretic and IV antibiotics ordered, care discussed with family, 45 minutes on floor 99310 billed
- Next day patient remains tenuous. Physician is off site. Several calls regarding clinical status; lab follow-up; ECHO ordered; old records reviewed; status and advance directives reviewed over phone with family; patient declines rapidly, further conversations result in cessation of restorative efforts and hospice referral. Records kept of time spent, cumulatively equals 40 minutes
- CPT 99358 billed as more than halfway point reached (first hour)

Transitional Care Management Services Codes (99495 and 99496)

- Medicare pays for *combined face to face and non-face to face physician and staff service* of complex patients recently discharged from hospital, LTAC, or skilled nursing facility.
- Medicare will pay between $165 and $232, depending on the complexity of the patient, for care during the 29 days after the discharge date.
- Can bill other medically necessary visits
- The receiving community practitioner and not the discharging practitioner bills for the service. Therefore cannot bill in the SNF/NF, but can bill in AL/residential care

MLN December 2016 Transitional Care Services

amda The Society For Post-Acute And Long-Term Care Medicine™

Transitional Care Management Services Codes

- 99495 - Moderate Complexity Patients
  - A face-to-face visit with the patient is required within 14 calendar days of discharge
- 99456 – High Complexity Patient
  - Face to face visit in 7 days

Both requires physician / staff to make direct contact (phone/electronic) with the patient/caregiver within 2 business days of discharge, and medication reconciliation and care coordination

Only billable by one party (PCP, specialists)

amda The Society For Post-Acute And Long-Term Care Medicine™

Transitional Care Management Services Codes (99495 and 99496)

- Non- face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction:
  - Staff services: medication adherence, education of patients / caregivers e.g. self-management, HHA communication, facilitating access to care.
  - Physician services: discharge information review, diagnostic test follow up, community resources referrals, educating patients / families, interaction with other health professionals

Common Billing and Coding Enigmas

amda
The Society For Post-Acute And Long-Term Care Medicine™

Can an NPP Make the First Visit to a New Patient?

- **YES !!**
- **Definition of Initial Federally Mandated Visit is:**
  - "the initial comprehensive visit during which the physician:
    - completes a thorough assessment,
    - develops a plan of care, and
    - writes or verifies admitting orders for the nursing facility resident."

Carrier Manual Section 30.6.13 A

First Visit continued

- **Prior to/ after Initial Federally Mandated Visit:**
  - "other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit."
  - "Qualified NPP may perform."
  - "Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B."

Carrier Manual Section 30.6.13 A

Do I Charge an Admit Code for a Readmitted Patient?

- **Normally Yes**
  - "A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings."
  - Definition of "readmission" unclear
  - Patient needs to be officially discharged from the facility to be able to use another Initial Visit code, otherwise a Subsequent Visit code should be used
  - Have observation patients been discharged?

Carrier Manual Section 30.6.13 A

Can I Bill Medicare for Forms, or if the Facility Wants to Talk to the Family?

Normally NO

"Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes."

If a medically necessary visit can be tied to the family discussion, then probably can bill

Remember an E/M visit includes the pre-service (1 day) and post service (7 days) work associated with that visit.

Carrier Manual 30.6.13 B

Can I Bill a Discharge Code for a Patient that Dies?

In Rare Cases, Yes

- "may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but *only if the physician or qualified NPP personally performed the death pronouncement.*"

Carrier Manual 30.6.13 I

Can I Bill "Incident To" in the Nursing Home?

NO - and don't try to go there…

Incident To: "the service can be billed under the Physicians UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment."

- "Incident to" E/M visits, provided in a facility setting, are **not payable** under the Physician Fee Schedule for Medicare Part B.
- Where a physician establishes an office in a SNF/NF, the "incident to" services and requirements are confined to this discrete part of the facility designated as his/her office.

How Many Visits Can I Make in a Day?

A Reasonable Number

- "Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits."
- Not quantified, but prosecuted individuals have normally made numbers of visits not possible by time elements
- "The medical record must be personally documented by the physician or qualified NPP who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient."

Carrier Manual 30.6.13 G

Can I Do Split/Shared Visits in the SNF/NF?

- **NO**
  - **"A split/shared E/M visit *can not* be reported in the SNF/NF setting."**
- **Definition**
  - "a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service."
  - "The physician and the qualified NPP must be in the same group practice or be employed by the same employer"
  - ***Can*** be used for hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes

Carrier Manual 30.6.13 H

Can I Bill for Seeing the Patient in Multiple Sites on the Same Day? (Same Practitioner)

In One Case Only

- Office/Outpatient/Emergency Department Visit w/Nursing Facility Admission – Only Pays the NF Admit
- Nursing Facility Visit w/ Hospital Visit or Admission - Only Pays the Hospital Visit
- Hospital Discharge Visit and Nursing Home Admission - Pays for BOTH the Hospital Discharge visit (99238, 99239) AND Initial Nursing Facility Care code

Carrier Manual 30.6.7, 30.6.9.1, 30.6.9.2

Do I Have to Examine the Patient in Order to Bill?

It Depends

- Most E&M codes require a face to face contact (Including NF Discharges)
- Physical exam not required for all E&M codes
  - 2 of 3 (Hx, Exam, Medical decision making) for subsequent NF visits
  - Still need face to face contact
  - It never hurts…..

What Documentation Needs to be in a Federally Mandated Visit?

- Not Specified!
- Federally mandated visits are those occurring every 30 days for the first 90 days then every 60 days thereafter (SNF and NF)
- Usually issues affecting the health and function of the resident are addressed
  - Medically necessary issues should be included
  - Chronic diseases, medications, psychosocial issues
  - Discussion with RP ideal but not required if any decline

amda The Society For Post-Acute And Long-Term Care Medicine™

What Code Do I Use if I Assume Care from Another Physician?

Best to Use Subsequent Code

- Need to use appropriate E&M code
- Usually 99309 level
- Need to document appropriately
- Can not use 99304-6 codes unless newly admitted into facility
- Still seeking clarification from CMS – “it depends”

What Code Does the Medical Director Use When Covering a Patient?

Good Question!!

- Regulatory issues – need to have visits performed in timely manner
- Emergency care
- Liability issues – knowledge of patient, malpractice vs. administrative?
- Payment issues – Medical Director not Attending or "Consultant"
- Administrative function covered under contract?

Should I Bill an AWV or Annual Exam?

You can legally bill either

- AWV G0439 is really designed as an outpatient codes but the law states anyone receiving Medicare coverage is eligible. Must meet all requirements of the code.
- AWV pays a little more
- Annual exam 99318 is not required to be billed – value was increased recently

amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

How Often Should I See a Med A POS 31 Patient?

AS OFTEN AS IS MEDICALLY NECESSARY

- All visits except federally mandated visits require medical necessity, an each note should explain why now/today – it is not based on a disease
- Medicare Carriers are not always consistent, but many really start scrutinizing at the 3rd visit
- Practitioner payment = Part B, and facility/LOS = Part A, so effect of one is not always appreciated in the other
- What the usual practitioner does is often considered at any site

amda The Society For Post-Acute And Long-Term Care Medicine™

How Do I Bill a Private Pay Patient in a Med A Bed?

Bill POS 32, NF

- Medicare pays the practitioner for the same POS as the technical component
- POS 31 is only for those patients who are receiving Medicare part A dollars for their facility stay
- 3-Day waiver patients, bundled patients etc are paid under Medicare Part A
- The frequency of visits for both facility (POS 31) and non-facility (POS 32) is dictated by medical necessity
- Since POS 32 NF, NPP can do the initial visit

MLN Matter Number MM7631

amda The Society For Post-Acute And Long-Term Care Medicine™

Are There Federally Mandated Visits in AL?

- **NO**
- AL is a state derived and regulated entity. Each state has their own requirements.
- An admission exam is technically not paid for by Medicare without medical necessity, but this is usually not an issue
- Subsequent visits in AL are based on medical necessity

amda The Society For Post-Acute And Long-Term Care Medicine™

Does the interval for mandated regulatory visits in the LTC/NF setting get reset by medical necessary visits in-between the mandated regulatory visits?

- **YES**
- Regulatory visits do not operate in a vacuum by themselves
- The regulatory visits state the patient must be visited every 30 days for the first 90 days then every 60 days without regard for visit type

amda The Society For Post-Acute And Long-Term Care Medicine™

What do I Bill When the Patient Returns from the ER?

- **DEPENDS**
- First there has to be medical necessity
- The level of the visit depends essentially on the severity of the problem and the level of medical decision making
  - F/U simple suturing would be a low to no level
  - F/U CHF would be complex
  - If a nurse can do it, you don't need to

amda The Society For Post-Acute And Long-Term Care Medicine™

What do I Bill When the Patient Moves from the SNF to the NF or vice-versa

- A Subsequent Code
- Unless there are legally distinct entities involved, and not just a building or floor change, POS 31 and POS 32 are both considered in the same facility and therefore there is no discharge or admit (Discharge = Nursing facility discharge day management")
- CMS often mixes up the term skilled nursing facility, skilled facility and nursing facility. Always have to look at context
- AL to SNF or NF is always an admit - discharge

amda The Society For Post-Acute And Long-Term Care Medicine™

Are Medicare Advantage rules the same as Medicare rules?

- **MAYBE, MAYBE NOT**
- Generally have the same general visit frequency rules, but may need authorization to make frequent visits in both SNF and NF. Some may use their own practitioners
- Generally anticipate a more stringent interpretation of medical necessity
- Generally can only make usual 30/90 day visits on NF unless a significant change in condition visit

amda The Society For Post-Acute And Long-Term Care Medicine™

Billing Trends in PA/LTC
2009 - 2015

Charles Crecelius MD PhD FACP CMD

amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Summary, Nursing Facility Family E/M Services 2009-2015

	2009	2011	2013	2014	2015
Number Visits (millions)	22.7	24.8	26.3	27.3	27.6
Increase		9.4%	15.4%	20.2%	21.5%

Source: CMS Website: Research and Statistics, Medicare Part B Utilization,

amda The Society for Post-Acute and Long-Term Care Medicine™

SNF vs. NF 2009-2015
Frequency of Visits

(Thousand of visits)

POS	2009	2011	2013	2015
Total	22,601	24,874	26,295	27,576
SNF	59.3%	58.5%	60.0%	61.3%
NF	40.7%	41.5%	40.0%	38.7%

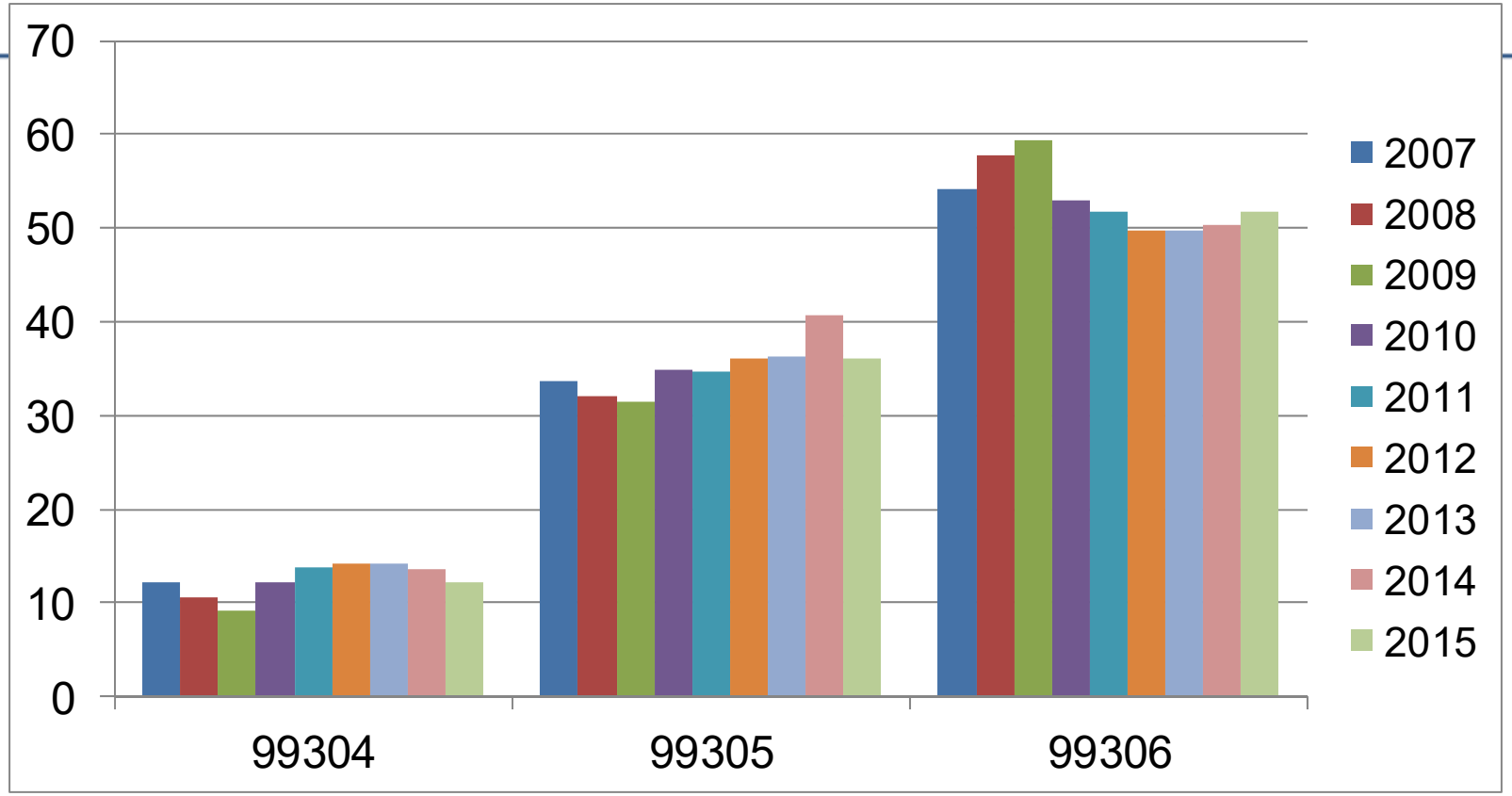
Increase in Total Visits by Specialty 2009-2015

Specialty	2009	2015	% Increase
Int Med	8,042	7,898	-2
Fam Prac	4,643	4,595	-1
Gen Prac	655	358	-45
Geriatrics	708	778	10
NP	3,842	7,477	95
PA	771	1,449	88
PMR	905	1,244	38
Psych	611	942	54
Podiatry	946	1,018	8

Thousands of visits

amda The Society For Post-Acute And Long-Term Care Medicine™

Trends in Initial Visit NH Code Billing Frequency 2006-2015

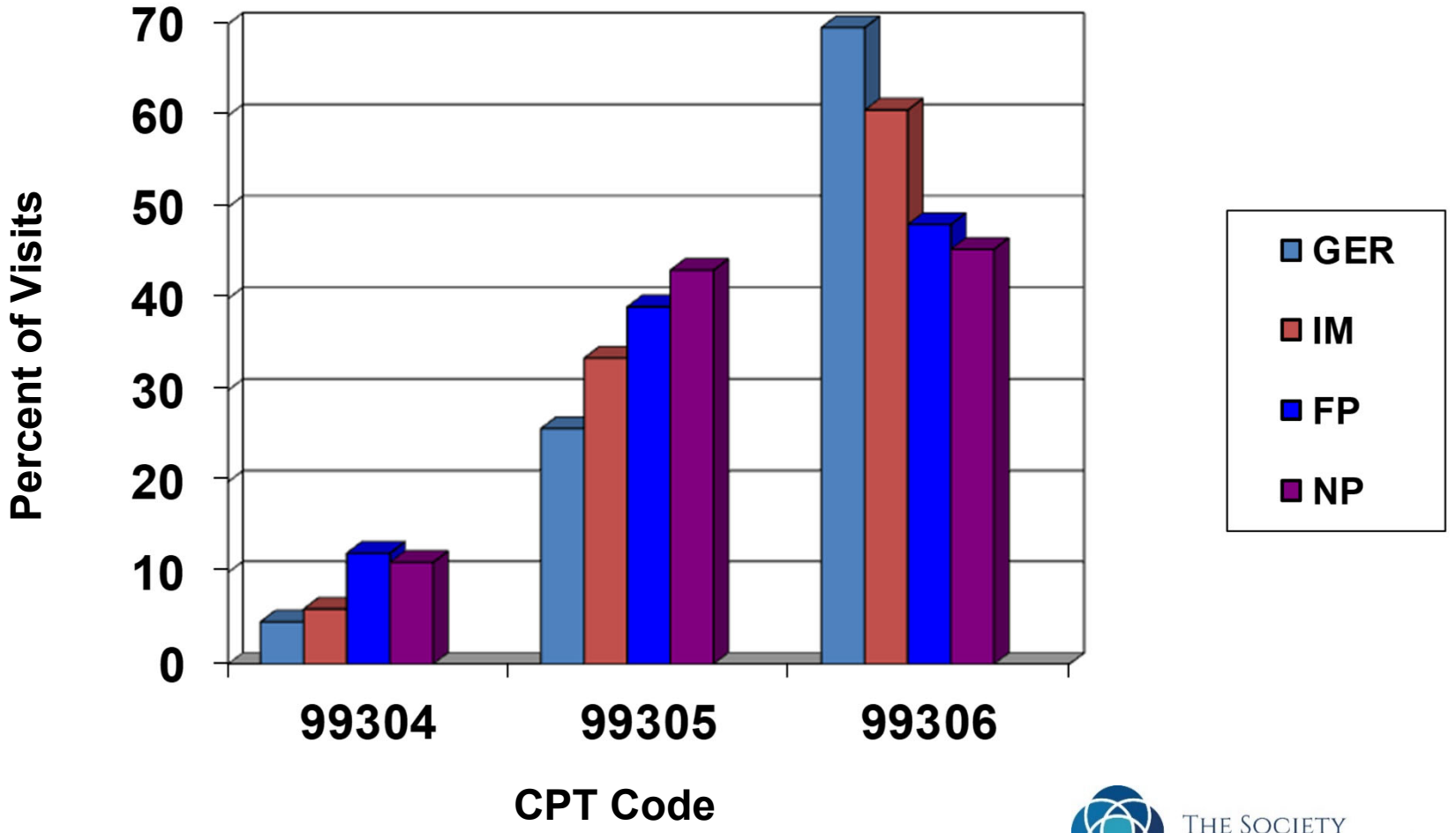


2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
1,907	1,932	1,872	1,877	2,404	2,497	2,561	2,629	2,653	2,784

Visits in thousands

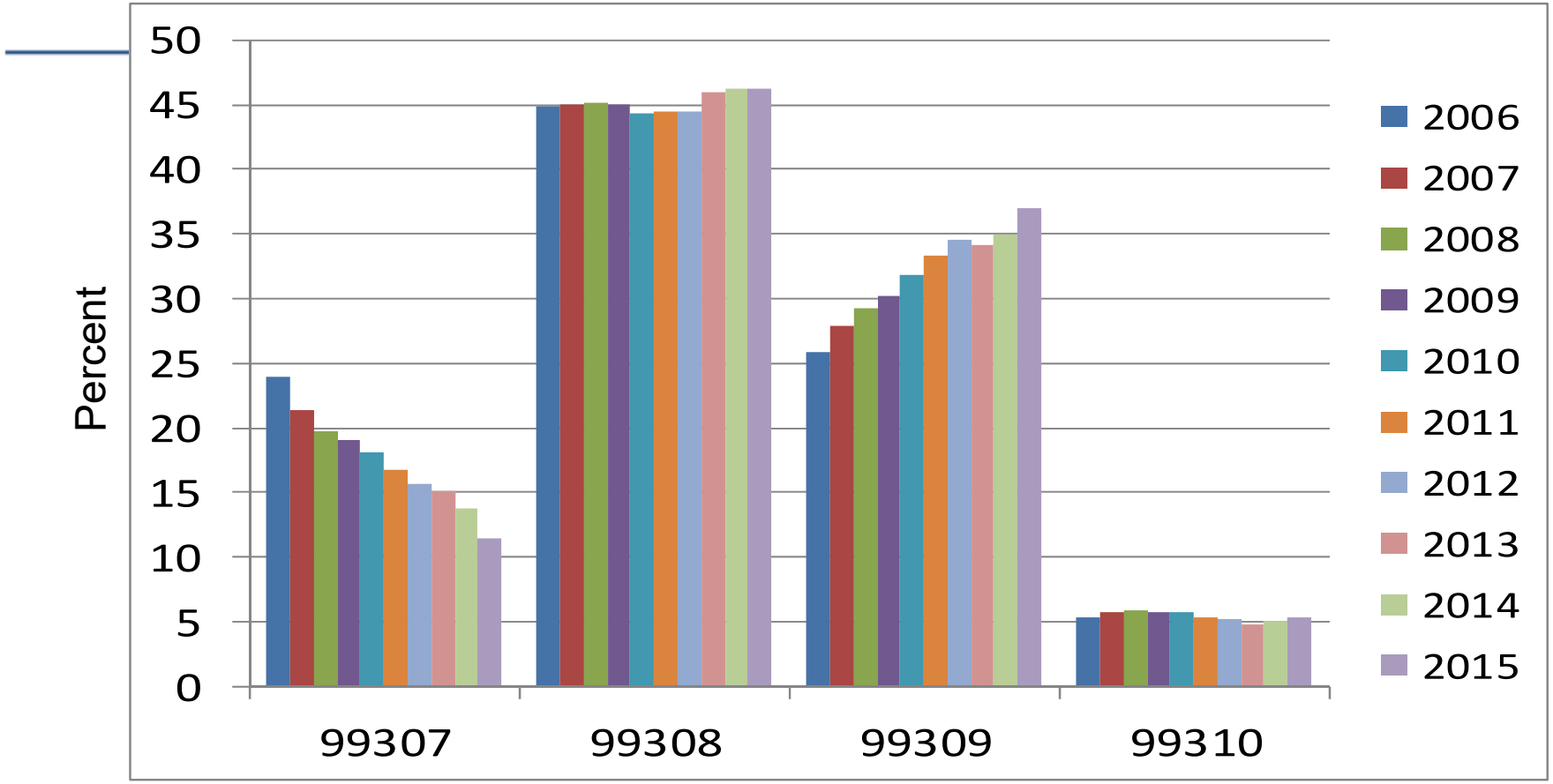
amda FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Distribution of 2015 Initial Nursing Facility Care Visits



amda The Society For Post-Acute And Long-Term Care Medicine™

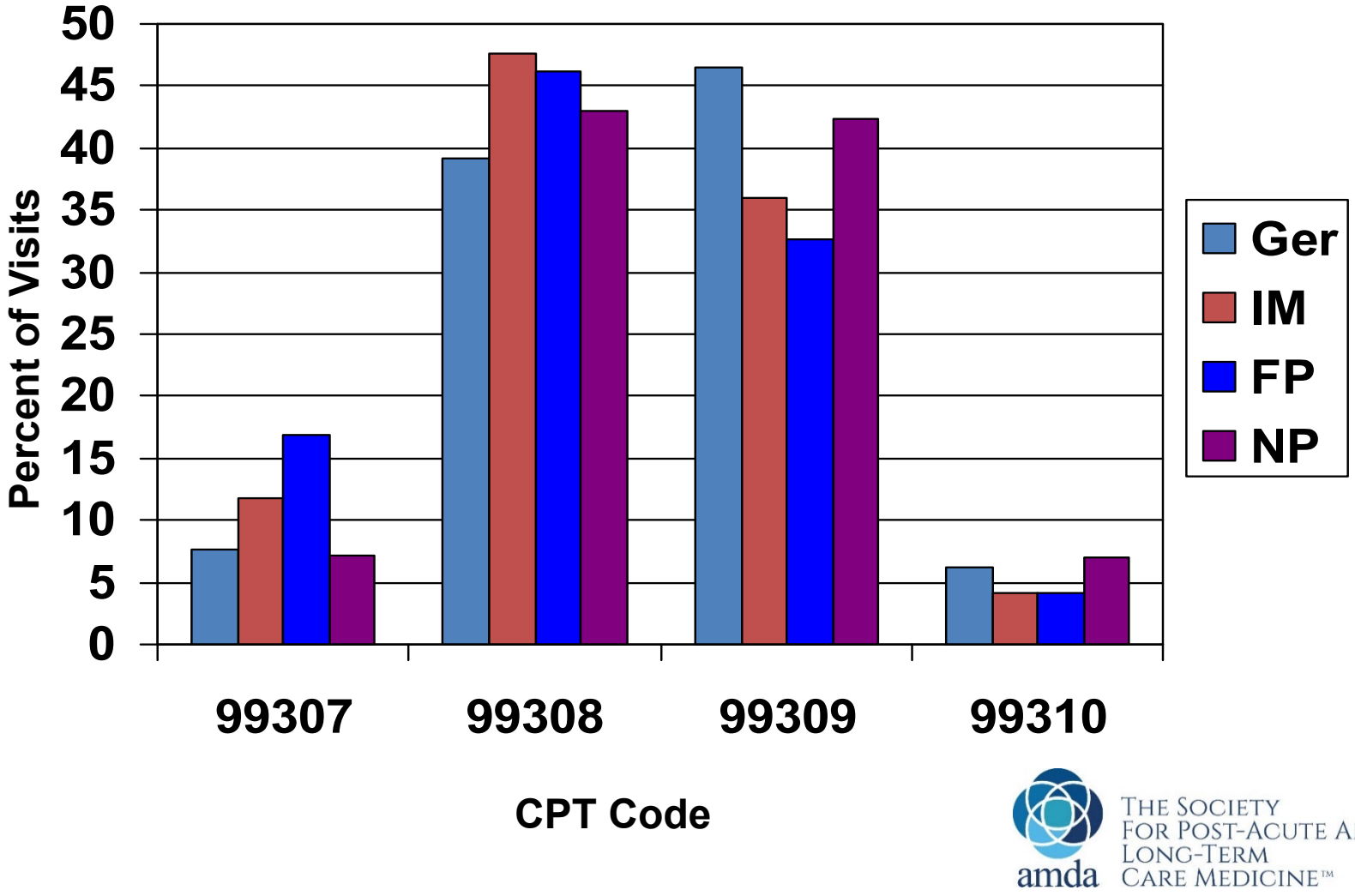
Trends in NH Subsequent Code Billing Frequency



2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
19,096	18,935	19,295	19,825	20,920	21,760	22,269	23,496	23,928	24.015

amda LONG-TERM CARE MEDICINE™

Distribution of 2014 Subsequent Nursing Facility Care Visits



amda The Society For Post-Acute And Long-Term Care Medicine™

Thank you!

"To answer your question, we may or may not be trying to have it both ways."

Chuck Crecelius MD, PhD, CMD

c_crecelius@msn.com

amda The Society For Post-Acute And Long-Term Care Medicine™

Appendix

amda The Society For Post-Acute And Long-Term Care Medicine™

Behavioral Health Integration Care Management

amda THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Behavioral Health Integration Care Management

- Established for care management of behavioral health conditions
- Similar in structure to Chronic Care Management
- Does not require comprehensive care plan, but requires initiating E/M visit
- Does not require all the practice attributes of 99490 Chronic Care Management
- Uses same simplified consent

Behavioral Health Integration Care Management

G0507 Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician other qualified health care professional, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

amda The Society For Post-Acute And Long-Term Care Medicine™

Question

- Q: Can the same provider report CCM (99490) and Behavioral Health Integration Care Management (G0507)?
- A: Yes. CMS advises selecting the most appropriate code, but if they are each independently eligible to be reported, they both may be reported in the same month. CMS will be monitoring utilization.

Psychiatric Collaborative Care Management Services

THE SOCIETY FOR POST-ACUTE AND LONG-TERM CARE MEDICINE™

Psychiatric Collaborative Care Management Services

In February 2016, the CPT Editorial Panel created three new codes to describe a model for providing psychiatric care in the primary care setting. This code set is one of several in response to a request from CMS to facilitate appropriate valuation of the services furnished under the Collaborative Care Model (CoCM).

CoCM is used to treat patients with common psychiatric conditions in the primary care setting through the provision of a defined set of services which operationalize the following core concepts:

1) Patient-Centered Team Care/Collaborative Care;
2) Population-Based Care;
3) Measurement-Based Treatment to Target; and
4) Evidence-Based Care.

amda The Society For Post-Acute And Long-Term Care Medicine™

Psychiatric Collaborative Care Management Services

- Involves a primary care physician working with
  - Behavioral health manager
  - Consulting psychiatrist
- CMS opted to provide a ‘G’ code for reporting the service in 2017
- In 2018, it presumably will be replaced by CPT codes

Psychiatric Collaborative Care Management Services

G0502 Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;
- initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- review by the psychiatric consultant with modifications of the plan if recommended;
- entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

amda The Society For Post-Acute And Long-Term Care Medicine™

Psychiatric Collaborative Care Management Services

G0503 Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- tracking patient follow-up and progress using the registry, with appropriate documentation;
- participation in weekly caseload consultation with the psychiatric consultant;
- ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;

amda The Society For Post-Acute And Long-Term Care Medicine™

G0503, Subsequent psychiatric collaborative care management (Cont'd.)

- additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

Psychiatric Collaborative Care Management Services

G0504 **Initial or subsequent psychiatric collaborative care management**, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional

(List separately in addition to code for primary procedure)

(Use G0504 in conjunction with G0502, G0503)

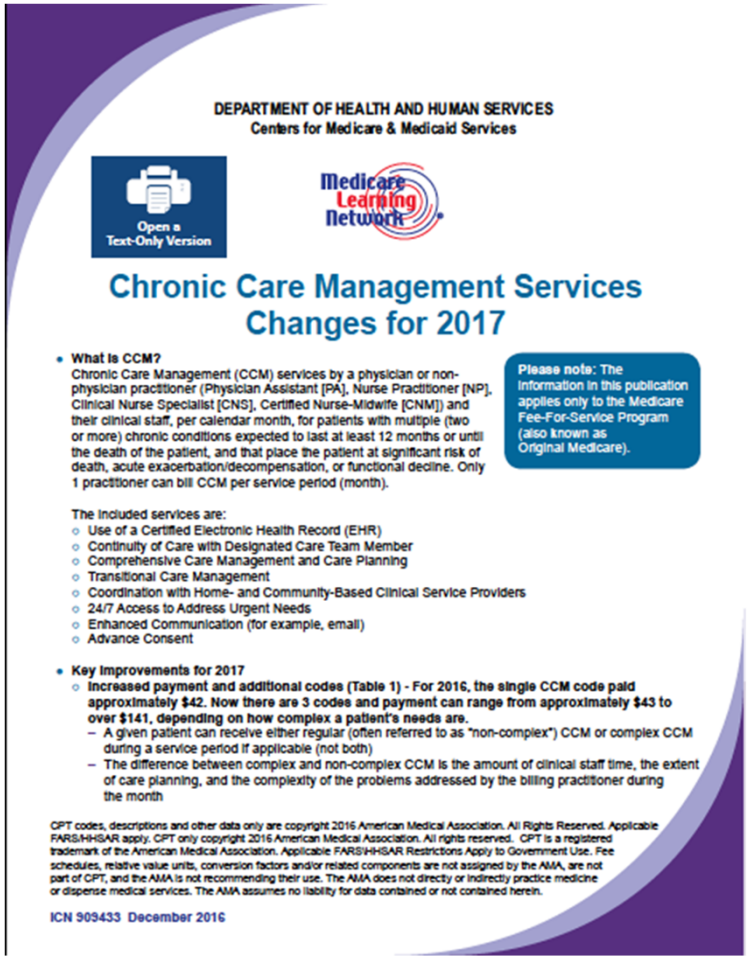
Payment for New Behavioral Health Codes

HCPCS Medicare Payment Summary

HCPCS	Description	Payment/Pt (Non-Fac) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
G0502	Initial psych care mgmt, 70 min - CoCM	$142.84	$90.08
G0503	Subsequent psych care mgmt, 60 min - CoCM	$126.33	$81.11
G0504	Initial/subsequent psych care mgmt, additional 30 min CoCM	$66.04	$43.43
G0507	Care mgmt. services, min 20 min – Other models of care	$47.73	$32.30

amda The Society For Post-Acute And Long-Term Care Medicine™

Chronic Care Management Services: Changes for 2017



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Open a Text-Only Version

Medicare Learning Network

Chronic Care Management Services Changes for 2017

- **What is CCM?**
  Chronic Care Management (CCM) services by a physician or non-physician practitioner (Physician Assistant [PA], Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Certified Nurse-Midwife [CNM]) 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 the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only 1 practitioner can bill CCM per service period (month).

  Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

  The included services are:
  - Use of a Certified Electronic Health Record (EHR)
  - Continuity of Care with Designated Care Team Member
  - Comprehensive Care Management and Care Planning
  - Transitional Care Management
  - Coordination with Home- and Community-Based Clinical Service Providers
  - 24/7 Access to Address Urgent Needs
  - Enhanced Communication (for example, email)
  - Advance Consent

- **Key improvements for 2017**
  - **Increased payment and additional codes (Table 1) - For 2016, the single CCM code paid approximately $42. Now there are 3 codes and payment can range from approximately $43 to over $141, depending on how complex a patient's needs are.**
    - A given patient can receive either regular (often referred to as "non-complex") CCM or complex CCM during a service period if applicable (not both)
    - 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

ICN 909433 December 2016

amda The Society For Post-Acute And Long-Term Care Medicine™

Chronic Care Management (CCM)

- Two or more “significant chronic conditions”
- Non face-to-face work – 20 minutes time staff
- Billed no more frequently than once per month per qualified patient
- Services covered include
  - Regular development and revision of a electronic plan of care using certified EHR
  - Communication with other treating health professionals Medication management
  - 24/7 access to address a patient’s acute chronic care needs
  - Transitional Care Management

amda The Society For Post-Acute And Long-Term Care Medicine™

Chronic Care Management (CCM)

- Services covered include
  - Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
  - Care management for chronic conditions including systematic assessment and development of a patient centered plan of care.
  - Management of care transitions within health care.
  - Coordination with home and community based clinical service providers.
  - Enhanced opportunities for a patient to communicate with the provider through telephone and secure messaging, internet or other asynchronous non face-to-face consultation methods.

amda The Society For Post-Acute And Long-Term Care Medicine™

Chronic Care Management (CCM)

- Electronic Care Plan - components
  - establish, implement, revise, or monitor and manage an electronic care plan that addresses the physical, mental, cognitive, psychosocial, functional and environmental needs of the patient
  - maintain an inventory of resources and supports that the patient needs
  - The practice must use a certified EHR to bill CCM codes.
  - The care plan must be available to anyone providing CCM services in a timely fashion
  - A copy of the electronic care plan must be provided to the patient

amda The Society For Post-Acute And Long-Term Care Medicine™

Chronic Care Management (CCM)

- Billing
  - The practice must have the patient's consent (verbal OK)
  - CPT code **99490** (avg: $43), and co-pays do apply
  - Only one clinician can be paid for CCM services in a calendar month
  - Billed at the end of the month, so SNF utility very limited.
  - CMS originally did not pay in PA/LTC, but now allows if all requirements met. Can be difficult to do as requires use of physician and not facility staff
  - Cannot bill the following codes in the same month: Transition Care Management, Home Healthcare Supervision, Hospice Care Supervision , Certain ESRD services

amda The Society For Post-Acute And Long-Term Care Medicine™

Possible Example of Chronic Care Management in PA/LTC

82 year old man with moderate dementia and behavioral disturbances and heart failure who has had 2 episodes of decompensated heart failure treated in the facility in the last year. *Physician's clinical staff* coordinates visits by cardiologist and psychiatrist, providing prior history and goals of care. Care planning includes 3X week weights with parameters for extra diuretic and physician notification, regular lab test monitoring, restorative therapy, regular assessment of cardiopulmonary status and parameters for reporting changes. A care plan for behavioral symptoms is instituted as well. These elements are included in the facility care plan and shared with the authorized decision-maker. EHR is utilized for all electronic and telephonic encounters of physician and clinical staff clearly documented. Cumulative time for all encounters by clinical staff amounts to 25 minutes for that calendar month and is clearly documented

More Examples of Physician Employed Staff Activities that Would Lend Themselves to CCM

- Physician employed staff reviews latest Oscar report for all physician patients who trigger late-loss life ADL, falls, antipsychotic use, hypnotic use, UTI, depressive behaviors and pain, collates report and identifies high risk patients who trigger 3 or more who would benefit from an intensive physician review
- Physician employed staff reviews all physician patient's advance directives, hospitalizations in the last year, functional status, runs prognostic scale (e.g. Porock or Flacker), reviews last facility care plans and runs report for physician to identify patients needing family discussion / education on advance directives, referral to palliative care services

Possible example of complex chronic care management in PA/LTC

83-year-old male with moderate dementia with paranoid / depressive features, CHF, DM with peripheral neuropathy who has recurrent falls due to combined physical and mental incapacities with minor to moderate associated injuries to date. Care planning includes frequent monitoring of multiple aspects including: medications used to treat his medical and psychiatric status; non-pharmacologic behavioral interventions; fall interventions with the interdisciplinary team; vital signs, physical and psychosocial status with pertinent call parameters for his medical diagnosis; and regular communication with a consulting psychiatrist. These elements are included in the facility care plan. EHR is utilized with all electronic and telephonic encounters of physician and the *physician's clinical staff* clearly documented and time elements summed to more than 60 minutes per month

What is the Best Use Of CCM in PA/LTC

- More appropriate for LTC than SNF
- Very appropriate for AL
- The Society is working with providers to get examples of CCM/CCCM billings to review and try to provide members with more concrete examples of best practices
- The OIG is reviewing CCM this year, but the exact focus is unclear. Suspect outright fraud and "cookie-cutter" CCM without substance offered by third parties

amda The Society For Post-Acute And Long-Term Care Medicine™

Help with Chronic Care Management

- Medicare MLN
  - **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf**
- Medicare MLN Connects: National Provider Call
  - **http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-02-18-Chronic-Care-Presentation.pdf**
- ACP – toolkit
  - **https://www.acponline.org/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf**
- AAFP
  - Moore, K: Chronic Care Management and Other New CPT Codes. *Fam Pract Manag.* 2015 Jan-Feb;22(1):7-12.