2018 NEBRASKA CHRONIC DISEASE SUMMIT

Public Health & Payment for Chronic Care Management

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PYA

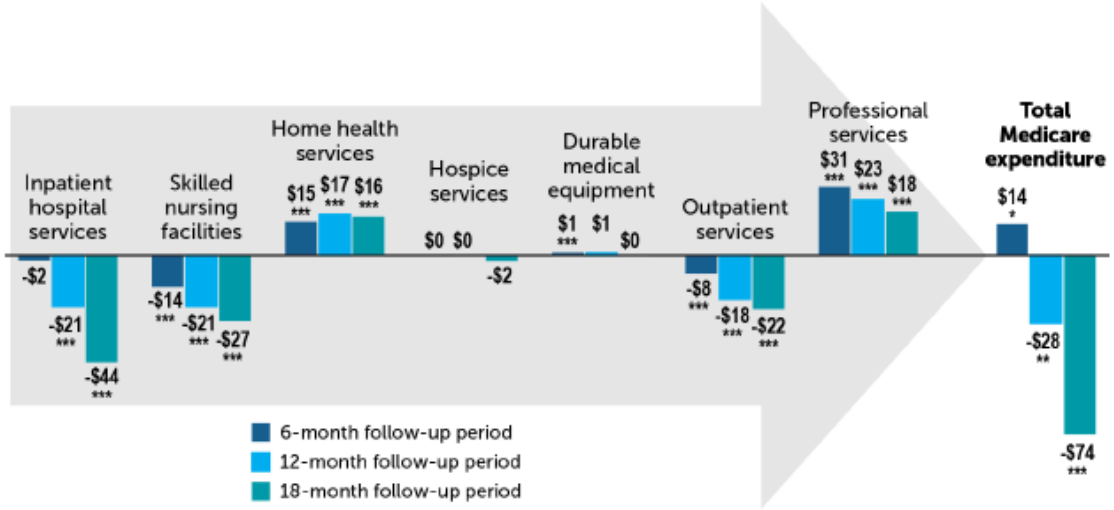
Medicare Billing

Non-Face-to-Face Services

Date	Service	Codes	Nat'l Ave. Payment
01/01/2013	Transitional Care Management	CPT 99495 CPT99496	$167.04 $236.52
01/01/2015	Chronic Care Management	CPT 99490	$42.84
01/01/2017	Complex CCM Care Plan Development	CPT 99487 CPT 99489 G0506	$94.68 & $47.16 $64.44
01/01/2018	RHC & FQHC billing for CCM	G0511	$62.28
01/01/2019 PROPOSED	Remote Patient Monitoring	CPT 990X0 CPT 990X1 CPT 994X9	~$21 ~$69 ~$54

Impact on Total Cost of Care

Figure III.7. Estimated PBPM impact of CCM on total expenditures and by expenditure category: 6-, 12-, and 18-month follow-up periods



Source: Medicare 2014–2016 enrollment and FFS claims data.

CPT 99490 – Long Descriptor

Chronic care management services, 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.

Key Considerations

1. Billing providers
2. Eligible beneficiaries
3. Consent to receive CCM
4. Five specified capabilities
5. Care management services

1. Billing Providers

- Physician (any specialty), APRN, PA, CNS/CNMW
  - Provider who supervises staff providing care management
- Rural Health Clinic
- FQHC

2. Eligible Beneficiaries

- Traditional Medicare
  - Medicare Advantage?
- 2+ chronic conditions
  - No definitive list
- Expected to last at least 12 months, or until the death of the patient; place patient at significant risk of death, acute exacerbation/ decompensation, or functional decline

3. Consent

- Provider cannot bill for CCM unless and until secures beneficiary's consent
  - Documented verbal consent
- If beneficiary revokes consent, cannot bill for CCM after then-current calendar month

Elements of Consent

- Beneficiary must acknowledge provider has explained:
  1. Nature of CCM services and how they are accessed
  2. Only one provider at a time can furnish CCM
  3. Beneficiary may stop CCM services at any time by revoking consent, effective at end of then-current calendar month
  4. Beneficiary responsible for copayment/deductible

4. Five Specified Capabilities

- Provider must demonstrate following capabilities:
  A. Use of certified EHR for specified purposes
  B. Electronic care plan
  C. Beneficiary access to care
  D. Transitions of care
  E. Coordination of care
- Submission of claim = attestation of capabilities

A. Use of Certified EHR

- Structured recording of the following consistent with 45 CFR 170.314(a)(3) –(7)
  - Patient demographic information
  - Problem list
  - Medications and medication allergies
- Creation of structured summary care record consistent with 45 CFR 170.314(e)(2)
  - Not required to use specific tool or service to transmit summary care record for care coordination purposes

B. Electronic Care Plan

- Maintain regularly updated electronic care plan for beneficiary
  - Based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment of beneficiary's needs
  - Inventory of resources and supports
  - Addresses all health issues (not just chronic conditions)
  - Congruent with beneficiary's choices and values
- Preparation and updating of care plan is not a component of CCM
  - One-time billing for care plan development

Use of Electronic Technology Tool

- "Must electronically capture care plan information"
- "Use some form of electronic technology tool or services in fulfilling the care plan element"
  - "Certified EHR technology is limited in its ability to support electronic care planning at this time"
  - "Practitioners must have flexibility to use a wide range of tools and services beyond EHR technology now available in the market to support electronic care planning"

Access To Electronic Care Plan

- “Must electronically share care plan information as appropriate with other providers” caring for patient
- Provide paper or electronic copy to beneficiary

C. Beneficiary Access To Care

1. Means for beneficiary to access provider in the practice on 24/7 basis to address acute/urgent needs in timely manner
2. Beneficiary's ability to get successive routine appointments with designated practitioner or member of care team
3. Enhanced opportunities for beneficiary-provider (or caregiver-provider) communication by telephone + asynchronous consultation methods (*e.g.*, secure messaging, internet)

D. Transitions of Care

- Capability and capacity to do the following:
  - Follow-up after ER visit
  - Provide transitional care management
  - Coordinate referrals to other clinicians
  - Share information electronically with other clinicians as appropriate
    - Summary care record and electronic care plan
    - No specific manner of transmission required

E. Coordination of Care

- Coordinate with home and community-based clinical service providers to meet beneficiary's psychosocial needs and functional deficits
  - Home health and hospice
  - Outpatient therapies
  - DME suppliers
  - Transportation services
  - Nutrition services

5. Care Management Services

- Types of services (non-exclusive)
  - Performing medication reconciliation, oversight of beneficiary self-management of medications
  - Ensuring receipt of all recommended preventive services
  - Monitoring beneficiary's condition (physical, mental, social)
- Documentation
  - Date and time (start/stop?)
  - Person furnishing services (with credentials)
  - Brief description of services

20+ Minutes

- 20+ minutes non-face-to-face care management services per calendar month
- Furnished by clinical staff under physician/mid-level general supervision
  - No physical presence requirement
  - Not required to sign notes
- 20 minutes can be aggregated but not rounded up
- May be provided by different individuals, but cannot count double for two staff members providing services at the same time

Complex CCM

- Same as CCM except:
  - Beneficiary's condition necessitates moderate-to-high complexity medical decision making
  - 60 minutes per month, plus add-on code for each additional 30 minutes
    - Cannot bill 99490 in same month

Shared Staffing

- CMS acknowledges providers may not have internal capacity to provide CCM
- Arrangements with 3rd parties permitted
  - Sufficient integration (e.g., use of EHR)
  - Responsibility for key components allocated between parties; billing provider ultimately responsible
  - Fee should be consistent with level of work performed

Example

Billing Provider

- Secure patient consent
- Provide LHD with remote access to patient's EHR
- Validate care managers' qualifications and competencies
- Respond to care managers' specific inquiries
- Review/approve patient care plan and any revisions
- Address transitions of care
- Provide coordination of care
- Bill and collect; pay negotiated rate to LHD

LHD Staff

- Provide information sufficient for billing provider to validate qualifications and competencies
- provider's EHR
- Develop draft electronic care plan in provider's EHR
- Deliver ongoing care management services; document in provider's EHR

Proposed RPM Codes

What we know so far…

CPT® 990X0

- Set-up and patient education on

  use of equipment
- No physician work required to bill

Proposed Reimbursement

~$21

CPT® 990X1

- Device supply with daily recordings or programmed alerts transmission, each 30 days
- No physician work require to bill

Proposed reimbursement

~$69

CPT® 994X9

- Remote physiologic monitoring treatment management services
- May be performed by clinical staff (general supervision)
- Alternative to billing CPT® 99091

Proposed Reimbursement

~$54 (non-facility)