Beat those Code Blues!
CPT Coding in the Nursing Home

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Disclosures

- Dr. Zorowitz is an employee of Optum and a stockholder of UnitedHealth Group
- Otherwise no conflicts/disclosures

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Learner Objectives

- Understand the use of cognitive codes available to report services provided in the nursing home
- Understand the basic requirements for documentation and reporting Chronic Care Management Services, Transitional Care Management Services, Prolonged Non-Face-to-Face Services and other recently introduced codes
- Recognize the controversies and opportunities in reporting services not originally intended for the nursing home setting
- Know where to find further information on reporting services performed in the nursing facility

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Which service(s) cannot be reported in the nursing facility?

a) Transitional Care Management Services
b) Chronic Care Management Services
c) Cognitive Impairment Assessment and Care Plan Services
d) Advance Care Planning Services
e) a and c
f) b and c

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Which subject interests you the least?

a. Nursing Facility E&M Coding
b. Advance Care Planning Services
c. Non-Face-to-Face Prolonged Services
d. Chronic Care Management (CCM) Services
e. Behavioral Health Integration Services

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But Bob, I'm not going to remember a blasted thing you say!

The 1995 and 1997 Evaluation and Management Guidelines:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html

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http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html

https://paltc.org/product-store/guide-post-acute-and-long-term-care-coding-reimbursement-and-documentation

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What do payors want?

Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided. They may request information to validate:

- **the site of service;**
- **the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or**
- **that services provided have been accurately reported.**

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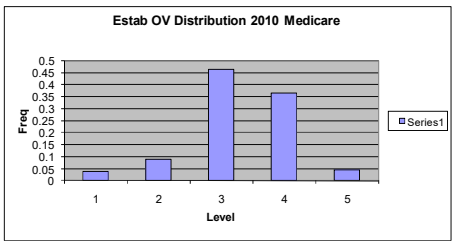
Profiling Pattern



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Coding is based not only on what you do, but what you DOCUMENT

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CPT Codes take into account:

- Work
- Practice expense
- Malpractice insurance expense

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Evaluation/Management (E&M) Codes:

- Initial Nursing Facility Care (New OR Established Patient)
  - 99304
  - 99305
  - 99306
- Subsequent Nursing Facility Care 99307
  - 99308
  - 99309
  - 99310
- Nursing Facility Discharge Services
  - 99315
  - 99316
- Annual Nursing Facility Assessment
  - 99318

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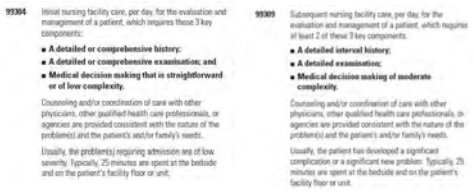
Sample nursing facility codes



99304 Initial nursing facility care, per day, for the evaluation and management of a patient, which requires those 3 key components:

- **A detailed or comprehensive history;**
- **A detailed or comprehensive examination; and**
- **Medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- **A detailed interval history;**
- **A detailed examination;**
- **Medical decision making of moderate complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.

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Work activities incorporated into E&M codes:

- History
- Examination
- Medical-Decision Making

- To a lesser extent
  - Nature of presenting problem
  - Counseling
  - Coordination of care
  - Time

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Number of work activities required

- For assessment codes 99304-99306
  - All 3 work activities
- For subsequent care codes 99307-99310
  - 2 out of 3 work activities
- For Nursing Facility Discharge Services, codes 99315 and 99316
  - Governed by TIME

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Work Activities

- History
- Examination
- Decision-Making (Assessment and Plan)

- NOTE THAT FULL DOCUMENTATION IS A "SOAP" NOTE. NOTES SHOULD BE WRITTEN IN THIS FORMAT

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Initial NF Services and NPP

(Note correlation in MDM and NPP)

Code (3/3)	Nature of Presenting Problem
99304 *(D,D,SF or Low)*	Low severity ("Level 2")
99305 *(C,C, Mod)*	Moderate severity ("Level 3")
99306 *(C,C,High)*	High severity ("Level 4 or 5")

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Subsequent NF Services and NPP

Code (2/3)	Nature of Presenting Problem ("Usually")
99307 *(Pf, Pf, SF)*	Minor severity ("Level 1") "Stable, recovering or improving"
99308 *(Epf, Epf, Low)*	Low severity ("Level 2") "Responding inadequately to therapy or minor complication"
99309 *(D, D, Mod)*	Moderate severity ("Level 3") "Developed significant complication or new problem"
99310 *(C,C,High)*	High severity ("Levels 4 or 5") "Unstable or requires immediate physician attention

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Medical Decision-Making Takes into account:

- Number of diagnoses or management options
- Amount and/or complexity of data to be reviewed
- Risk of complications and/or morbidity/mortality

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Need at least two elements to determine level of decision-making:

Type of Decision	Number of Diagnoses and Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Morbidity and Mortality
Straightforward	Minimal (1-2)	Minimal (0-2)	Minimal (1-2)
Low complexity	Limited (1-2)	Limited (1-2)	Low (1-2)
Moderate complexity	Multiple (3-4+)	Moderate (3-4+)	Moderate (3-4)
High complexity	Extensive (3-4+)	Extensive (3-4+)	High (3-4)

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Documentation of Risk

- Comorbidities
- Underlying conditions/diseases
- Invasive Procedures
- Tables of risks

- The highest level of risk in any one category determines the overall risk

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To simplify the MDM Component

(Levenson SR. Practical E/M, 2nd Ed. AMA, 2008)

1. Levels of Risk: SUBJECTIVE
   - Risk of morbidity
   - Risk of mortality
   - Risk of functional impairment
2. Number of diagnoses or treatment options: OBJECTIVE

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Assigning Numerical Values

CPT Description of Amount or Number	Numerical Value
Minimal (Level 1 or 2)	1
Limited (Level 3)	2
Multiple or Moderate (Level 4)	3
Extensive (Level 5)	4 or more

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Assessing Level of Risk

- Only one of three risk categories needs to equal or exceed the severity of risk warranted by the Nature of the Presenting Problem
- Therefore, focus on documenting the risk of the patient's presenting problem(s)

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Level of Risk	*Presenting Problem*	*Diagnositc Procdure(s) Ordered*	*Management Options Selected*
Minimal	•One self-limited or minor problem eg. Cold,insect bite, tinea corporis	•Laboratory tests •Chest x-rays •EKG/EEG •Urinalysis •Ultrasound, eg. Echocardiography •KOH prep	•Rest •Gargles •Elastic bandages •Superficial dressings
Low	•Two or more self-limited or minor problems •One stable chronic illness, eg. Well controlled hypertension, DM, cataract, BPH •Acute uncomplicated illness eg. Cystitis, etc	•Physiologic tests not under stress, eg. PFT •Non-cardiovascular imaging studies with contrast •Superficial needle biopsies •Clinical lab tests requring arterial puncture •Skin biopsies	•Over the counter drugs •Minor surgery with no identified risk factors •Physical therapy •Occupational therapy •IV fluids without additives

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Level of Risk	*Presenting Problem(s)*	*Diagnostic Procedure(s) Ordered*	*Management Options Selected*
Moderate	•One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment •Two or more stable chronic illnesses •Undiagnosed new problem with uncertain prognosis, eg. Lump in breast •Acute illness with systemic symptoms, eg. Pyelonephritis, pneumonitis, colitis •Acute complicated injury, eg. Head injury with brief loss of consciousness	•Physiologic tests under stress, eg. Cardiac stress test •Diagnostic endoscopies with no identified risk factors •Deep needle or incisional biopsy •Cardiovascular imaging studies with contrast and no idetnified risk factors, eg. Arteriogram, cardiac cath •Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	•Minor surgery with identified risk factors •Elective major surgery with no identified risk factors •Prescription drug management •Therapeutic nuclear medicine •IV fluids with additives •Closed treatment of fracture or dislocation without manipulation

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Level of risk	*Presenting Problem(s)*	*Diagnostic Procedure(s) Ordered*	*Management Options Selected*
High	•One or more chronic illnesses with severe exacrbation, progression or side effects of treatment •Acute or chronic illnesses or injuries that pose a threat to life or bodily function eg. Multiple traum, acute MI, pulmonary embolus, severe respiratory distress, progressive severe RA, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure •Abrupt change in neurologic stats, eg. Seizure, TIA, weakness, sensory loss	•Cardiovascular imaging studies with contrast with identified risk factors •Cardiac electrophysiologic al tests •Diagnostic endoscopies with identified risk factors •Discography	•Elective major surgery (open, percutaneous or endoscopic) with identified risk factors •Emergency major surgery •Parenteral controlled substances •Drug therapy requiring intensive monitoring for toxicity •Decision not to resuscitate or to de-escalate care because of poor prognosis

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Summary: Initial Nursing Facility Care

Must meet all 3	**Level 1**	**Level 2**	**Level 3**
CPT (E&M) code	99304	99305	99306
History: • HPI • ROS • PFSH	Detailed: • 4 elements • 2-9 Body systems • 1 element (or comprehensive)	Comprehensive • 4 elements • 10 body systems • all 3 elements	Comprehensive • 4 elements • 10 body systems • all 3 elements
Examination	Comprehensive	Comprehensive	Comprehensive
Decision-Making (2 of 3) • Number of diagnoses/options • Data complexity/amount • Risk	Straightforward/low complexity: Minimal-limited 1-2 Minimal-limited 1-2 Minimal-low 1-2	Moderate complexity: Multiple 3 Moderate 3 Moderate 3	High complexity: Mult-ext 3-4+ Mod-ext 3-4+ Mod-high 3-4+

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Summary: Subsequent NF Care (Must meet 2 out of 3 components)

Must meet 2 of 3	**Level 1**	**Level 2**	**Level 3**
CPT (E&M) code	99307	99308	99309
History: • HPI • ROS • PFSH	Problem focused: • 1 elements • N/A • N/A	Exp. Prob Focused: • 1 elements • 1 body systems • N/A	Detailed: • 4 elements • 2-9 body systms • 1 element
Examination	Problem-focused	Exp. Problem-focused	Detailed
Decision-Making (2 of 3) • Number of diagnoses/options • Data complexity/amount • Risk	Straightforward (minimal) Minimal-limited 0-1 Minimal-limited 0-1 Minimal-low 0-1	Low complexity: Minimal-limited 1-2 Minimal-limited 1-2 Minimal-low 1-2	Moderate complexity: Mult-ext 3-4+ Mod-ext 3-4+ Mod-high 3-4+

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Additional Codes

- The "Level 4" code: 99310
  - Comprehensive interval history
  - Comprehensive examination
  - Medical decision making of high complexity
  - Must meet 2 out of 3 components
- Annual Nursing Facility Assessment: 99318
  - Detailed Interval History
  - Comprehensive Physical
  - Medical Decision Making of Low to Moderate Complexity
  - MUST MEET ALL THREE COMPONENTS

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Hints

- You are reimbursed for what you document, not just what you do
- Record must be legible- 3 people must be able to read it
- All encounters must be signed and dated
- All monthly notes must include
  - Medical record review
  - Noting of changes since previous visit
  - Reviewing and signing orders

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CPT Codes for Nursing Facility and Dom/Rest Home/Custodial

Edition/Year: 2019
Publisher: American Medical Association
Card, 3" x 9".
ISBN#: 978-1-62202-756-9
Item#: OP134819
Authors: American Medical Association

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Advance Care Planning Services

- Voluntary—get and document permission/consent
- Billed in addition to other E/M and CPT codes
- No limit on how many times can be billed
- Physician/NPP can bill (incident-to rules apply)
- Must be face-to-face (with either patient or decision-maker)
- Remember 20% copay by beneficiary or secondary insurer
  - Except when doing Annual Wellness Visit, modifier -33, no copay
- Does not require any specific template or completion of any legal documents like **POLST**/AHCD; document time and content
  - For primary care physicians can be an add-on to an Annual Wellness Visit with modifier -33 (in this case no 20% co-pay)

Advance Care Planning Services

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)

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."

Where can ACP be billed?

- There is no place of service limitation in the CPT code descriptors
- CMS has no place of service limitation in its final rule (80 Fed. Reg. 70956)
- ACP codes may be used in any setting, facility or non-facility (although not in the ICU if critical care codes are used)

Who can submit ACP claims?

- As per CPT coding convention, 99497-8 may be submitted by any "Physician or other qualified health care professional"
- There is no limitation as to physician specialty
- Nonphysician practitioners (NPP), e.g. nurse practitioners, physician assistants, etc., may submit ACP claims

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."

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
  - May be of particular relevance in the NH
- 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 or via telehealth services
- 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

Is consent necessary?

- Important, because copays and deductibles apply (except in the case of Annual Wellness Visit)
  - AWV can technically be done in the NH
- 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, good idea to document

What must be documented?

- No requirements in the CPT code descriptor
- Consult Medicare Administrative Contractors (MACs)
- CMS recommends documentation of:
  - Voluntary participation (consent)
  - An account of the discussion
  - Who was present
  - Explanation of advance directives, including any completed forms
  - Time spent in the encounter *(definitely include this)*

- Completed Advance Directive forms are not, by themselves, sufficient to document the service for the purposes of reporting the ACP code(s)
- Completion of Advance Directive(s) or other documents (e.g., POLST Paradigm forms) is not necessary to report ACP services

Can ACP be reported in addition to other services?

- May be reported in addition to E/M codes, including all nursing facility services
  - 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, including neonatal and pediatric critical care

(Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480)

- Critical care services 99291-99292
- Neonatal critical care services 99468-99469
- Pediatric critical care services 99471-99476
- Neonatal intensive care services 99477-99480

Advance care planning included in the time requirements of these codes, so do not bill ACP

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
- Diagnosis necessary for 99318 annual NF exam
- May use well exam diagnosis when ACP furnished as part of the Medicare Annual Wellness Visit (AWV)
  - Append modifier -33

Do deductibles and copays apply?

- YES, except when reported as element of the Annual Wellness Visit; use modifier -33
- YES, when reported in addition to Introductory Preventive Physical Examination ("Welcome to Medicare Exam")
- Recommend that practitioners let beneficiaries know

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

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)

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
- Adopted as written in CPT

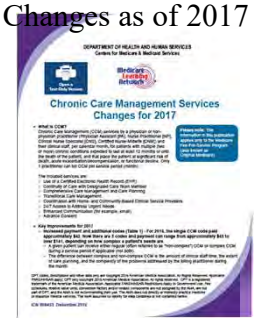
Non-Face-to-Face Prolonged Evaluation & Management (E/M) Services

- 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

National Rates 2018

Code	Short Description/ CMS Posted Typical Time(s)	2018 NF MPFS National Rate
99358	**Prolong service w/o contact** *CMS Posted Typical Time* • Intra-Service 50 min • Total 50 min	$113.76
99359	**Prolong serv w/o contact add** *CMS Posted Typical Time* • Intra-Service 30 min • Total 30 min	$54.72

Chronic Care Management Services: Changes as of 2017



Chronic Care Management (CCM)

- Two or more "significant chronic conditions"
- Non face-to-face work
- Billed no more frequently than once per month per qualified patient
- Started January 1, 2015

Chronic Care Management (CCM)

- 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-hour-a-day, 7-day-a-week access to address a patient's acute chronic care needs
  - Transitional Care Management

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.

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

Chronic Care Management (CCM)

- Electronic Care Plan - components
  - 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

Chronic Care Management (CCM)

- Billing
  - The practice must have the patient's consent
  - CPT code **99490** (avg: $43)
  - Co-pays do apply
  - Only one clinician can be paid for CCM services in a calendar month

Chronic Care Management

- Billing
  - The following codes cannot be billed during the same month as CCM (CPT 99490):
    - Transition Care Management (TCM) – CPT 99495 and 99496
    - Home Healthcare Supervision – HCPCS G0181
    - Hospice Care Supervision – HCPCS G9182
    - Certain ESRD services – CPT 90951-90970

Although not intended to be used in nursing facilities, CMS allows the service to be performed and reported in nursing facilities, so long as all the requirements are met and the patient is not on a Part A stay

So what's new since 2017?

- Increased payment and additional codes
- Reduced requirements associated with initiating care, and increased payment when extensive initiation work is necessary
- Significantly reduced administrative burden (reduced payment rules for billing the services)
- General supervision in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

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 26 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 [E/M])

TABLE 2. SUMMARY OF CCM SERVICES CHANGES FOR 2017

CCM Requirement	Changes for 2017
Initiating Visit	• Now only required for new patients or patients not seen within 1 year prior to commencement of CCM • Extra payment for extensive initiating services by the CCM practitioner (G0506)
Certified EHR and other electronic technology requirements	• Certified EHR still required to standardize formatting in the medical record of core clinical information (demographics, problems, medications, medication allergies), but certified technology no longer required for other CCM documentation or transitional care management documents • No specific technology requirements for sharing care plan information electronically within and outside the practice, and fax can count, as long as care plan information is available timely (meaning promptly at an opportune, suitable, favorable, useful time) • Individuals providing CCM after hours no longer required to have access to the electronic care plan, as long as they have timely information • Remove standards for formatting and exchanging/transmitting continuity of care document(s) • Continue to encourage and support the use of certified technology and increased inter-operability, but code-level conditions of Medicare Physician Fee Schedule (PFS) payment may not be the best means of accomplishing this. Practitioners are likely to transition to advanced electronic technologies due to incentives of the Quality Payment Program, independent of CCM rules.
Continuous Relationship with Designated Care Team Member	• Improved alignment with CPT language for administrative simplicity
Comprehensive Care Management and Care Planning	• Improved alignment with CPT language for administrative simplicity and appropriate caregiver inclusion • No longer specify format of the care plan copy that must be given to the patient (or caregiver if appropriate) • Electronic technology use standards relaxed (see above)
Transitional Care Management	• Improved alignment with CPT language for administrative simplicity • Clinical summaries used in managing transitions renamed "continuity of care document(s)" • Electronic technology use standards relaxed (see above)
24/7 Access to Address Urgent Needs	• Improved alignment with CPT language • Clarifying the required access is for urgent needs
Advance Consent	• Verbal instead of written consent is allowed (but must still be documented in the medical record, and the same information must be explained to the patient for transparency)

CCM – New since 2017

- Initiating Visit: now only needed for new or patients not seen >1 year; extra payment for extensive initiating services
- Certified EHR: no longer required for ALL CCM documentation (but stile for SOME); now can fax care plan; coverage no longer needs access to EHR; removed standards for formatting and exchanging continuity of care documents; continue to encourage advanced technology, but acknowledgement that practitioners will increase technology better based on incentives

CCM – New since 2017

- Continuous Relationship with Designated Care Team Member: align better with CPT language
- Comprehensive Care Management and Care Planning: align better with CPT language; no longer specify the format of the care plan copy that must be given to the patient; technology use standards relaxed
- Transitional Care Management: align better with CPT language; clinical summaries for managing transitions renamed "continuity of care document(s)"; technology use standards relaxed

CCM – New since 2017

- 24/7 Access to Address Urgent Needs: align better with CPT language; clarify the required access is for urgent needs
- Advance Consent: verbal instead of written consent allowed

Complex Chronic Care Management Codes 99487 / 89

CMS Recognition of CPT Codes for Primary Care Previously not Paid for

- Requires the patient be at significant risk of death, acute exacerbation/decompensation or functional decline
- Requires the establishment or substantial revision of a comprehensive care plan
- Requires moderate or high complexity medical decision making
- Based on clinical staff time directed by a physician or other qualified health care professional
- 99487 is for the first 60 minutes per month, 99489 is for each additional 30 minutes.

Total Duration of Staff Care Management Services	Complex Chronic Care Management
Less than 60 minutes	Not reported separately
60 to 89 minutes (1 hour - 1 hr. 29 min.)	99487
90 - 119 minutes (1 hr. 30 min. - 1 hr. 59 min.)	99487 and 99489 X 1
120 minutes or more (2 hours or more)	99487 and 99489 X 2 and 99489 for each additional 30 minutes

From AMA, CPT Professional 2018

Chronic Care Management (CCM)

- Resources
  - 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.

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National Rates 2018

Code	Brief Description	2018 NF MPFS National Rate
99490	Chron care mgmt srvc 20 min	$42.84
99487	Cmplx chron care w/o pt vsit	$94.68
99489	Cmplx chron care addl 30 min	$47.16
G0506	Comp asses care plan ccm svc	$64.44

Behavioral Health Integration Care Management

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 or 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.

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

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.

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.

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;

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

To find the Medicare physician fee schedule look-up:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSLookup/index.html?redirect=/pfslookup/02_pfssearch.asp

Other Common Services

Code	Brief Description	2018 F MPFS National Rate	Bill in NF?
G0402	Welcome to Medicare Visit (IPPE)[1]	$129.60	Yes
G0438	Annual wellness exam[2], initial	$175.32	Yes
G0439	Annual wellness exam, subseq.	$119.16	Yes
99318	Annual nursing fac assessmnt	$97.92	Yes

[1]https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf

[2]https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf

Where can I bill these codes?

Description	LTC	Ambulatory	Home
CCM (Chronic Care Management), 20-59 min	Yes	Yes	Yes
CCCM 60 minutes	Yes	Yes	Yes
CCM, each additional 30 minutes to 99487	Yes	Yes	Yes
CCM initial care plan creation	Yes	Yes	Yes
TCM - 14 days (Transitional Care Management)	No	Yes	Yes
TCM - 7 days	No	Yes	Yes
ACP - 1st 30 min (Advance Care Planning)	Yes	Yes	Yes
ACP - each additional 30 min	Yes	Yes	Yes
Home Care Re-certification	No	Yes	Yes
Home Care Certification	No	Yes	Yes
CPO (Care Plan Oversight)	No	Yes	Yes
CPO-hospice	No	Yes	Yes
Prolonged Service non F2F with E/M , 1st 60 min	Yes	Yes	Yes
Each additional 30 min	Yes	Yes	Yes
Behavioral Health Integration Care Management	Yes	Yes	Yes
Psychiatric Collaborative Care Management Services	Yes	Yes	Yes
	Yes	Yes	Yes
	Yes	Yes	Yes
Cognitive assessment, outpatient	No	Yes	Yes
New, outpatient	No	Yes	Yes

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Which service(s) cannot be reported in the nursing facility?

a) Transitional Care Management Services
b) Chronic Care Management Services
c) Cognitive Impairment Assessment and Care Plan Services
d) Advance Care Planning Services
e) a and c
f) b and c

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Name of Service	Where to find the information
Chronic Care Management Services	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3678CP.pdf
Cognitive Assessment and Care Services	https://www.alz.org/careplanning/downloads/cms-consensus.pdf
Advance Care Planning Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf
Non-Face-to-Face Prolonged Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm5972.pdf
Care Management Services in Rural Areas	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Name of Service	Where to find the information
The Initial Preventive Physical Exam ("Welcome to Medicare Visit")	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MPS_QRI_IPPE001a.pdf
Annual Wellness Exam (AWV)	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/awv_chart_icn905706.pdf
Transitional Care Management Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
Behavioral Health Integration Services	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf

Thank you!

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