CPT Codes to Improve Geriatric Care

JILL YOUNG, CPC, CIMC, CEDC

YOUNG MEDICAL CONSULTING, LLC

EAST LANSING, MICHIGAN

Disclaimer

This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational a guide and should not be considered a legal/consulting opinion

Agenda

Chronic Care Management

Complex Chronic Care Management

Transitional Care Management

Advance Care Planning

Annual Wellness

Psychiatric Collaborative Care Services

INR Monitoring

Codes

CPT CODES

Current Procedural Terminology

Copy written by AMA

Anyone can submit request for code

Although a code may exist insurances, including Medicare, may not pay for it

HCPCS CODES

Healthcare Common Procedure Coding System

Created by CMS

Temporary* codes

Usually a Medicare specific service

May be pre-curser to CPT code

Define the “Who” can Perform

CPT Definition – Clinical Staff

“A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed, **by law**, regulation **and** facility policy to perform or assist in the performance of a **specified** professional service, but who does not individually report the professional service. Other policies may also affect who may report a specific service”

Clinical Staff – WPS Medicare – J8

"The clinical staff providing the service is an individual acting under the supervision of a physician or other practitioner, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician or other practitioner or the same entity that employs or contracts with the physician or other practitioner and meets any applicable requirements to provide the services, including licensure, imposed by the state in which services are being furnished "

Defining the “Who” can Perform

Comprehensive medical evaluation requirement limits other nonphysician practitioners or limited-license practitioners

- Optometrists, Podiatrists, Doctors of Dental Surgery or Dental Medicine

State scope may also limit/restrict them from providing service required element

Chronic Care Management

Chronic Care Management - 99490

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.

Assumes 15 minutes of work by billing practitioner per month

Complex Chronic Care Management - 99487

Complex chronic care management services, 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
- 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

Complex Chronic Care Management Add on code +99489

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)

Care Management Codes

CCM and Complex CCM

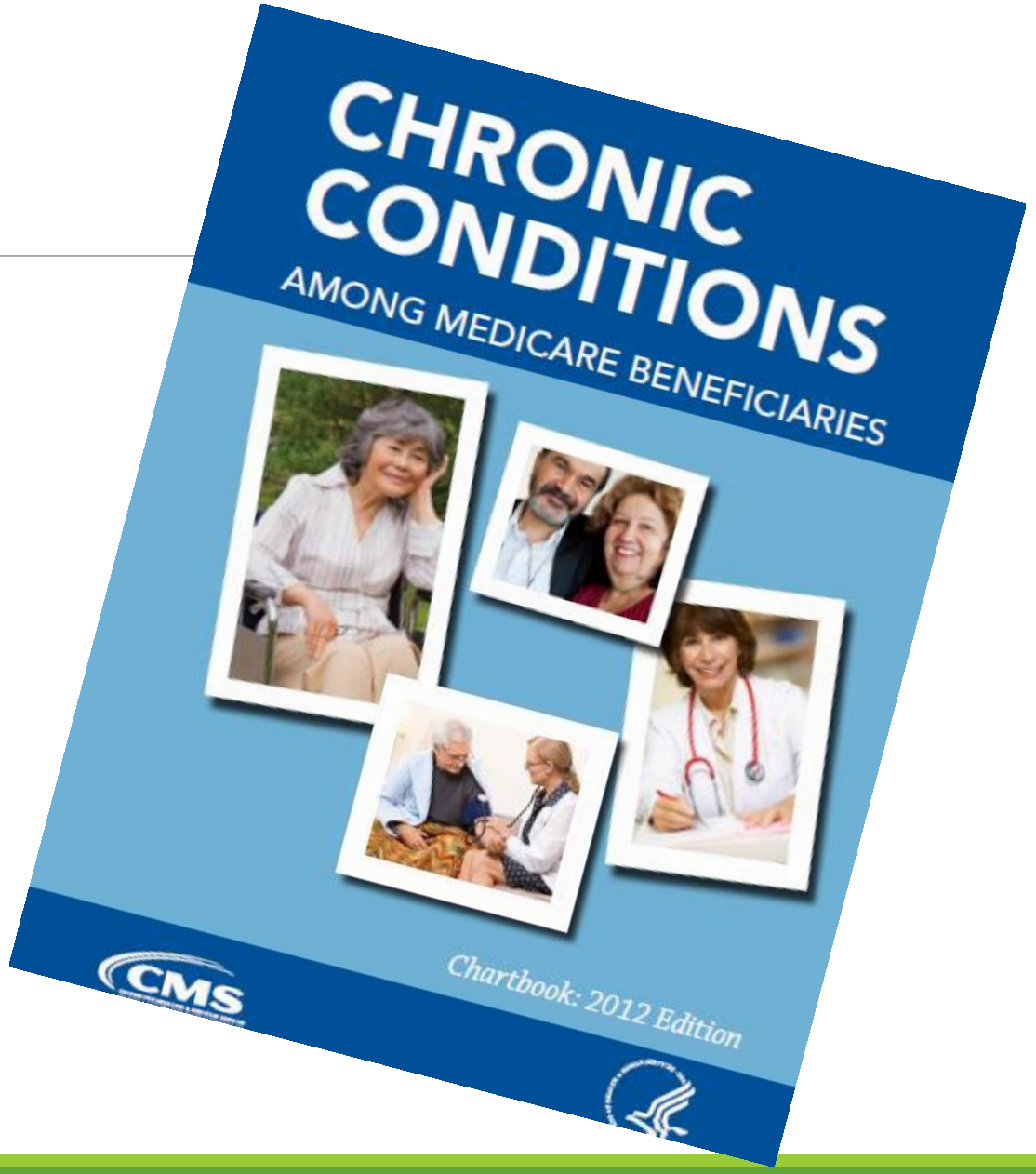
- Differ
  - The amount of clinical staff service time provided
  - The involvement and work of the billing practitioner
  - The extent of care planning performed
- Share
  - A common set of service elements

CCM aka “Non-complex CCM”

CMS STUDY ON CHRONIC CONDITIONS

Patients with identified multiple chronic conditions are at increased risk for:

- Hospitalizations
- Use of post-acute services
- Emergency department visits



Conditions in Report

Alzheimer's/dementia

Arthritis (including rheumatoid and osteoarthritis)

Asthma

Atrial fibrillation

Cancer (breast, colorectal, lung, and prostate)

Chronic kidney disease

COPD

Depression

Diabetes (excluding diabetic conditions related to pregnancy)

Heart failure

Hyperlipidemia (High cholesterol)

Hypertension (High blood pressure)

Ischemic heart disease

Osteoporosis

Stroke/Transient ischemic attack

Chronic Care Management

Services provided by clinical staff under the direction of the billing practitioner on an “incident to” basis

- As an integral part of services provided by the billing practitioner
- Subject to applicable State law, licensure, and scope of practice
- General supervision is assigned for this code
  - General supervision means when the service is not personally performed by the billing practitioner, it is performed under his or her overall direction and control although his or her physical presence is not require

Chronic Care Management

The clinical staff are either employees or working under contract to the billing practitioner whom Medicare directly pays for CCM.

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 in order to bill CCM services

- Non-clinical staff time cannot be counted

Chronic Care Management

For new patients or patients not seen by the billing practitioner within one year prior to billing CPT code 99091, CMS **requires** initiation of the service during a face-to-face visit with the billing practitioner

- Annual Wellness Visit
- Initial Preventive Physical Exam
- Other face-to-face visit with the billing practitioner

Separately billed

Chronic Care Management

Practitioners may bill G0506 if

- Furnishing a CCM initiating visit
- Personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code
- G0506 is reportable once per CCM billing practitioner, in conjunction with CCM initiation

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

Chronic Care Management

Obtaining advance consent for CCM services ensures the patient is engaged and aware of applicable cost sharing

It may also help prevent duplicative practitioner billing

A practitioner must obtain patient consent before furnishing or billing CCM

Consent may be verbal or written but must be documented in the medical record, and includes informing them about:

- The availability of CCM services and applicable cost-sharing
- That only one practitioner can furnish and be paid for CCM services during a calendar month
- The right to stop CCM services at any time (effective at the end of the calendar month
- Informed patient consent need only be obtained once prior to furnishing CCM, or if the patient chooses to change the practitioner who will furnish and bill CCM

AGREEMENT TO RECEIVE MEDICARE CHRONIC CARE MANAGEMENT SERVICES

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me, including the following:

- Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face means of communication (e.g., email),
- The ability to get successive, routine appointments with my designated primary care physician or member of my care team,
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and settings, including the following:

  Referrals to other health care providers,

  Follow-up after I visit an emergency department,

  Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility),
- Coordination with home- and community-based providers of clinical services.

I understand that as part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose,

CCM - Scope of Service Elements

Record the patient's demographics, problems, medications, and medication allergies and create structured clinical summary records using certified EHR technology.

Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues).

Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record.

Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service.

Share the care plan electronically outside the practice as appropriate

CCM - Scope of Service Elements

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialists outside the practice will be directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan

CCM - Scope of Service Elements

Access To Care

Provide 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified health care professionals or clinical staff, including providing patients (and caregivers as appropriate) with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week

Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.

Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care. Do this through telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Chronic Care Management Claim Information

Date of service on claim

- Date the minimum 20 minutes of care as defined by the code is achieved

Place of service on claim

- Where face to face service office visit would take place
  - Provider based billing, use hospital outpatient POS code
- Patient cannot be inpatient hospital or SNF inpatient or resident of a facility that receives payment from Medicare for patient.

Chronic Care Management

Services that CANNOT be billed in same month as CCM

- Transitional Care Management
  - 99495-99496
- Home health supervision
  - G0181
- Hospice Care Supervision
  - G0182
- Certain ESRD
  - 90951-90970

Chronic Care Management

Chronic Care Management – 99490

- 1.19 RVU
  - $43.00

Complex Chronic Care Management- 99487

- 2.63 RVU
  - $95.00

Complex Chronic Care Management - +99489

- 1.31 RVU
  - $47.00

Add on to CCM Initiating Visit – G0506

- 1.79 RVU
  - $64.00

Care Management

Care management services such as:

- Systematic assessment of the patient's medical, functional, and psychosocial needs
- System-based approaches to ensure timely receipt of all recommended preventive care services
- Medication reconciliation with review of adherence and potential interactions
- Oversight of patient self-management of medications
- Coordinate care with home and community based clinical service providers.

Transitional Care Management

- Manage care transitions between and among health care providers and settings, including referrals to other providers, including:
- Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.

Transitional Care Management

Transitional Care Management

Can practitioners under contract to the physician billing for the TCM service furnish the non-face to face component of the TCM?

Physician offices should follow "incident to" requirements for Medicare billing. "Incident to" recognizes numerous employment arrangements, including contractual arrangements.

Also there must be appropriate supervision, and state law and scope of practice apply.

Note that for payment of TCM services under the PFS, CMS requires direct supervision for the face-to-face visit but all other TCM services may be furnished under general supervision.

CMS FAQ March 17, 2016

Transitional Care Management

Providing or overseeing the management and coordination of services, as needed

- All medical conditions
- Psychosocial needs
- Activity of daily living supports

Non-Face-to-Face Services by Clinical Staff

Under direction of a physician or other qualified health care professional

Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge. Regarding aspects of care

Communication with home health agencies and other community services utilized by the patient.

Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living.

Assessment and support for treatment regimen adherence and medication management.

Identification of available community and health resources.

Facilitating access to care and services needed by the patient and/or family.

Non-Face-to-Face Services by Provider

Obtaining and reviewing the discharge information (for example, discharge summary, as available, or continuity of care documents).

Reviewing need for or follow-up on pending diagnostic tests and treatments.

Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems.

Education of patient, family, guardian, and/or caregiver.

Establishment or reestablishment of referrals and arranging for needed community resources.

Assistance in scheduling any required follow-up with community providers and services.

Medical Decision Making (MDM)

MODERATE COMPLEXITY

Multiple possible diagnoses and/or the management options

Moderate complexity of the medical data (tests, etc.) to be reviewed

Moderate risk of significant complications, morbidity, and/or mortality as well as comorbidities

HIGH COMPLEXITY

Extensive number of possible diagnoses and/or the management options

Extensive complexity of the medical data (tests, etc.) to be reviewed

High risk of significant complications, morbidity, and/or mortality as well as comorbidities

Transitional Care Management Claim Information

Date of service

- Date of face to face visit

Place of service

- Location of face to face visit

Service code

- Moderate MDM – 99495 (visit <14 days)
- High MDM – 99496 (visit < 7 days)
- Additional E&M services as medically necessary
  - Bill separately

Transitional Care Management Documentation

At a minimum, you must document the following information in the beneficiary's medical record:

- Date the beneficiary was discharged
- Date you made an interactive contact with the beneficiary and/or caregiver
- Date you furnished the face-to-face visit
- The complexity of medical decision making (moderate or high)

Code Descriptors

99495 – TRANSITIONAL CARE MANAGEMENT

Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least *moderate complexity* during the service period; face-to-face visit within *14* calendar days of discharge.

99496 – TRANSITIONAL CARE MANAGEMENT

Communication (direct contact, telephone, electronic) with patient and/or caregiver within two business days of discharge; medical decision making of *high complexity* during the service period; face-to-face visit within *seven* calendar days of discharge.

AAFP

Transitional Care Management 30-Day Worksheet

Patient name: _____ DOB: _____

D/C physician: _____ D/C date: _____

Records requested: Records received: Reviewed:

Diagnoses on discharge:	
Date of interactive contact (2 business days post D/C):	☐ Phone ☐ Email ☐ Direct ☐ Other
Date of 7-day or 14-day, face-to-face visit:	
Family and/or caretaker present at visit:	

Medications on discharge	Medication changes/adjustments

Diagnostic tests reviewed/disposition:	
Disease/illness education:	
Home health/community services discussion/referrals:	
Establishment or re-establishment of referral orders for community resources:	
Discussion with other health care providers:	
Assessment and support of treatment regimen adherence:	
Appointments coordinated with:	
Education for self-management, independent living, and activities of daily living:	

TCM.January 2013

SUBMIT BILLING 30 DAYS POST DISCHARGE.

Physician completes colored areas
Staff completes remainder

Transitional Care Management 30-Day Worksheet, continued

Medical Decision Making			
DIAGNOSIS and MANAGEMENT	**QTY**	**POINTS**	**TOTAL**
Self-limited or minor — stable, improv, or prog as expected		1	-
Established prob — stable, improving		1	-
Established prob — worsening		2	-
New prob — no further workup planned		3	-
New prob — additional workup planned		4	-
DIAGNOSIS and MANAGEMENT TOTALS		-	

DATA REVIEWED	
Review/order of clinical lab tests (80000 code series)	1
Review/order of radiology tests (70000 code series)	1
Review/order of medicine tests (90000 code series)	1
Discuss test w/performing or interpreting physician	1
Decision to obtain old records or history from someone other than patient	1
Review and summary of old records and/or ***obtaining*** history from someone other than pt and/or discussion w/another provider **with documentation of findings**	2
Independent visualization of actual image, tracing, or specimen **(not simply review of report)**	2
DATA REVIEWED TOTAL	

TABLE OF RISK		
Moderate	Presenting Problem	1+ chronic ill w/milk exac, prog, or tx side effects, 2+ stable chronic ill, Undx new prob with uncertain prog (lump in breast), Acute ill w/systemic symp (pyeloephritis, Pneumonitis, colitis), Acute comp injury (head inj w/brief loss of consciousness)
	Diag Procedure Ordered	Physiologic tests under stress, Diag endos w/no identified risk, Deep needle or inc bx, Cardio imag w/cont, no identified risk, Obtain fluid from body cavity (lumbar puncture, thoracentesis)
	Mgmt Options	Minor sx w identified risk, Elec major sx (open, perc, endos) w/no identified risk, Rx drug mgmt, Therapeutic nuclear medicine, IV fluids w/additives, Closed treatment of fx or dislocation w/o manipulation
High	Presenting Problem	1+ chr ill w/severe exac, prog, tx side effects; Acute/chr ill or inj posing threat to life/bodily func (trauma, MI, pulm emb, sev resp dist, prog sev rheum arth, psych ill w/pot threat to self or others, renal fail); Sz, TIA, weakness, sens loss
	Diag Procedure Ordered	Cardio img w/cont and risk; Cardio electrophysiological tests; Diag endoscopies w/identified risk factors; Discography
	Mgmt Options	Elective major sx (open, perc, endo w/risk); Emerg major sx; Parenteral cont subs; Rx therapy w/intensive monitoring for toxicity; Decision not to resuscitate or to de-escalate care because of poor prognosis

(2 of 3 elements must be met or exceeded for a level of decision making)

MDM:	SF	Low	Mod	High
DX MGMT Options	0-1	2	3	4+
Data	0-1	2	3	4+
Risk	Minimal	Low	Moderate	High

NOTES:

Physician signature: _____

Staff signature: _____

Staff signature: _____

Staff signature: _____

TCM Documentation and Flow Sheet

TCM Requirements for Post-Discharge Contact Deadlines:

2 days post discharge date ____/____/_____
7 days post discharge date ____/____/_____
14 days post discharge date ____/____/_____

Note: To ensure all required documentation to support TCM services is completed, and so that none of these 4 pages get lost, reproduce this form on the front and back of 11x17 paper and fold it in half to 8 1/2 x 11 booklet size.

Patient Name: _____

Patient DOB: ____/_____/_____ **Discharge Date/Day:**____/_____/_____ ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

Patient's Physician: _____

Reason for Admission: _____

Contact Information: ☐ Patient ☐ Caregiver Name:_____ Relationship: _____

Preferred method of contact: ☐ phone ☐ cell ☐ text ☐ e-mail

Phone: Home: (_____)_____
Cell: (_____)_____
Work: (_____)_____

E-mail address (if applicable): _____

Is Home Health Involved? ☐No ☐ Yes — if yes, please include home health contact information:

Contact person: _____ Company name:_____
Phone: (_____)_____ Fax: (_____)_____
E-mail (if applicable): _____

Discharge Information:

Diagnosis(es) at discharge: _____
Discharging physician (name and phone #): _____

Discharge Information Obtained:

Discharge summary: Date rec'd: _____/_____/_____
Copies of discharge instructions: Date rec'd: _____/_____/_____
Most recent diagnostic test results: Test name: _____ Date rec'd: _____/_____/_____
Test name: _____ Date rec'd: _____/_____/_____
Test name: _____ Date rec'd: _____/_____/_____

Patient Current Location:

☐ Home ☐ Family member home ☐ Non-family member home ☐ Assisted living facility ☐ Rest home
☐ Other: _____

Initial Communication Post-Discharge:

First 2 attempts must be within 2 business days of discharge (see discharge date at top of page).
Continue attempting to reach the patient, even if the attempts during the first 2 days are unsuccessful.

1st attempt: Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____

2nd attempt: Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____

Add'l attempts: Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____
Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____
Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____
Date: ___/___/____ Time: ____:_____ □ am □ pm Method: ☐ call ☐ fax ☐ e-mail ☐ mail Initial: _____

*** Once you reach patient or caregiver go to page 2.*

TCM Documentation and Flow Sheet

Patient Name: _____ DOB: ____/____/_____ Discharge Date: ____/____/_____

Initial Communication Post-Discharge section continued ...

Disposition: _____
_____
_____
_____
_____ initial: _____ date: _____

Summary of nursing/licensed clinical staff member's discussion with patient/caregiver during initial post-discharge communication:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____ initial: _____ date: _____

First Face-to-Face Follow-up Visit:

First face-to-face follow-up visit must be no longer than 14-days post-discharge to qualify for TCM.

Review progress notes in patient's record for information:

First face-to-face visit occurred on: Date: ____/____/_____ Time: _____:_____ ☐ am ☐ pm

Location of visit: ☐ Office ☐ Home ☐ Rest Home ☐ Other_____

Number of calendar* days since discharge: ☐ 7 or fewer ☐ 8-14 ☐ 15 or more

Medication reconciliation performed? ☐ No ☐ Yes (If yes, date: ____/____/_____)

Level of medical decision-making : ☐ High ☐ Moderate ☐ Low/Straightforward

Face-to-face visit performed by (provider name and credentials): _____

Progress notes signed by the treating provider for the above date of service? ☐ Yes ☐ No

** Calendar days include weekends and holidays.*

Summary of recommendations: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____ initial: _____ date: _____

Patient Name: ____ DOB: ____/____/______ Discharge Date: ____/____/______

Additional Non-Face-to-Face Services:

Additional non-face-to-face services provided within 30 days post-discharge must be performed by licensed clinical staff members, or personally performed by physician or qualified NPP. ***Initial and date each entry below, including licensure initials.***

Examples of Additional Non-Face-to-Face Services

Review discharge information:

- Document provider name, date and findings.
- Pending diagnostic tests and treatments: Document if nothing pending or list of pending tests and treatments, action recommended for each, dates and results received for each.

Communication with other providers involved in patient's care:

- List each provider communicated with, date of each communication, and findings and results from each communication. Document if no communication required.

Education: (*patient, family, guardian, and/or caregiver*):

- Date of education, who was educated (and if applicable their relationship with the patient), who provided education, topic of education, results and follow-up. Document if no education required.

Community resource arrangement(s):

- Document resources required, who arranged each resource, date each resource arranged, result of each resource. Document if none needed.

Assess and support treatment regimen adherence and medication management:

- Document date, topic, result and name of staff providing support. Document if none needed.

Patient Non-Face-to-Face Services Documentation Record:	Initial and Date Each Entry:
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

Patient Non-Face-to-Face Services Documentation Record: | **Initial and Date Each Entry:**

___

*__Note__: **The person who signs below and closes this document has NO bearing on whose name the TCM services should be billed under.** CMS states that TCM services should be billed under the physician or NPP who __actually provides the mandatory face-to-face encounter__. Ideally, to ensure continuity of care, it would also be the same person, but this is not required.*

__TCM 30-Day-Period Closure__:

Date range included in this document: Start date: ____/____/______ End date: ____/____/______

Document reviewed and closed by: ____ ____/____/_____

Physician or NPP Signature and Licensure | Date

Transitional Care Management

99495

- 4.64 RVU
  - $167.00

99496

- 6.57 RVU
  - $237.00

Advance Care Planning

Advance Care Planning
2015 New CPT Codes

99497 & 99498 will be separately payable by Medicare beginning **January 2016**

Payable under 2 different circumstances

- #1) When reasonable and necessary for diagnosis and treatment of injury or illness
- #2) Voluntarily, as part of Annual Wellness Visit (AWV)

Advance Care Planning

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;

- 99497 - first 30 minutes, face to face with the patient, family member(s) and/or surrogate
- +99498 - each additional 30 minutes

Advance Care Planning

Involves counseling and discussing advance directives

Certain E/M services performed on the same day may be reported separately including

- Critical care codes
- Neonatal and pediatric critical care codes
- Care management codes
- Chronic care management codes

Advance Care Planning

Note #1)

- Deductible/coinsurance applies when reasonable and necessary for the diagnosis and treatment of an injury or illness
- May be performed the same day or subsequently to an E&M service *

Advance Care Planning

Note #2) Separate payable, voluntary element of Annual Wellness Visit

- Incident to doesn't apply to AWV
- BUT….
  - Physicians or using a team-based approach where, in addition to providing a minimum of direct supervision, the billing physician or NPP manages, participates and meaningfully contributes to the provision of the services.

Advance Care Planning

Who can bill

- Physician or practitioner
- Facility and non-facility settings
- Not limited to particular physician specialties*

Modifier 33

- In conjunction with AWV
- AWV and ACP must be billed on same date on same claim for deductible and coinsurance to be waived *

Modifier 25

- In conjunction with E&M

Annual Wellness Visit (AWV)

Annual Wellness Visit - AWV

Establishes or updates patient's medical and family history

Measures height, weight and Body Mass and blood pressure

Goal is health promotion and disease detection

Fosters coordination of screening & preventive services that may be already covered

Includes Personalized Prevention Plan Services

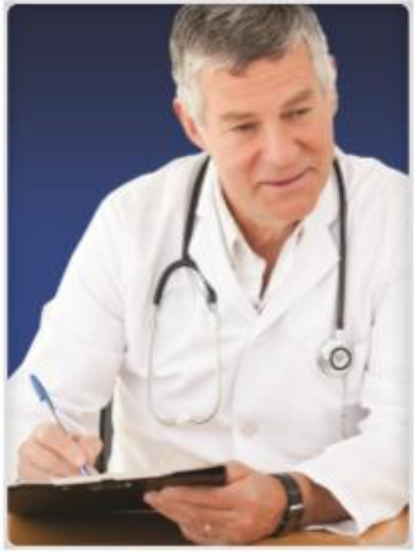
Done on patients who are no longer within the 12 months after the effective date of their Medicare coverage

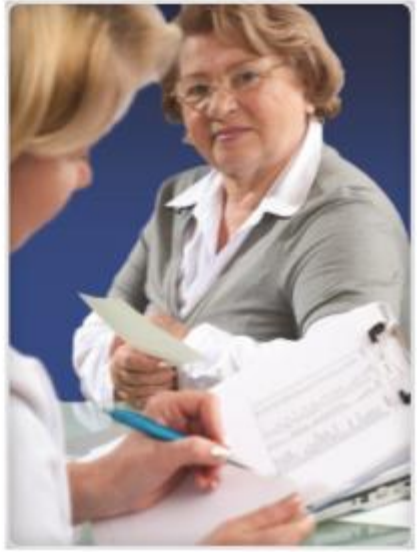
- IPPE

EDUCATIONAL TOOL

KNOWLEDGE • RESOURCES • TRAINING

THE ABCs OF THE ANNUAL WELLNESS VISIT (AWV)





Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare)

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

CPT codes, descriptions and other data only are copyright 2016 American Medical Association. All Rights Reserved. Applicable FARS/HHSAR apply. CPT is a registered trademark of the American Medical Association. Applicable FARS/HHSAR Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Annual Wellness Visit - AWV

Minimum requirements for Health Risk Assessment (HRA)

- Collects self-reported information about the beneficiary
- Can be administered independently by the beneficiary or administered by a health professional prior to or as part of the AWV encounter
- Is appropriately tailored to and takes into account the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs
- Takes no more than 20 minutes to complete

Annual Wellness Visit – AWV

The HRA addresses, at a minimum, the following topics:

- Demographic data, including but not limited to:
  - Age,
  - gender
  - race
  - ethnicity
- Self assessment of:
  - health status,
  - frailty
  - physical functioning
- Psychosocial risks, including but not limited to:
  - depression/life satisfaction
  - stress
  - anger
  - loneliness/social isolation
  - pain
  - fatigue
- Behavioral risks, including but not limited to:
  - tobacco use
  - physical activity
  - nutrition and oral health
  - alcohol consumption
  - sexual health
  - motor vehicle safety (seat belt use)
  - home safety
- Activities of daily living, including but not limited to:
  - dressing
  - feeding
  - toileting
  - grooming
  - physical ambulation (including balance/risk of falls)
  - bathing
- Instrumental activities of daily living (IADLs), including but no
  - shopping
  - food preparation
  - using the telephone
  - housekeeping
  - laundry
  - mode of transportation
  - responsibility for own medications
  - ability to handle finances

INITIAL AWV COMPONENTS: APPLIES THE FIRST TIME A BENEFICIARY RECEIVES AN AWV

Acquire Beneficiary Information

Action	Elements

❑ Administer HRA	• Collect self-reported information from the beneficiary
	  ◦ You or the beneficiary can complete the HRA before or during the AWV encounter; it should take no more than 20 minutes
	• Account for and tailor to the communication needs of underserved populations, persons with limited English proficiency, and persons with health literacy needs
	• At a minimum, address the following topics:
	  ◦ Demographic data
	  ◦ Self-assessment of health status
	  ◦ Psychosocial risks
	  ◦ Behavioral risks
	  ◦ Activities of Daily Living (ADLs), including but not limited to: dressing, bathing, and walking
	  ◦ Instrumental ADLs, including but not limited to: shopping, housekeeping, managing own medications, and handling finances

❑ Establish a list of current providers and suppliers	Include current providers and suppliers that regularly provide medical care to the beneficiary

Acquire Beneficiary Information (cont.)

Action	Elements
❑ Establish the beneficiary's medical/family history	At a minimum, collect and document the following: • Medical events of the beneficiary's parents, siblings, and children, including diseases that may be hereditary or place the beneficiary at increased risk • Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments • Use of, or exposure to, medications and supplements, including calcium and vitamins
❑ Review the beneficiary's potential risk factors for depression, including current or past experiences with depression or other mood disorders	Use any appropriate screening instrument for beneficiaries without a current diagnosis of depression, which you may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations
❑ Review the beneficiary's functional ability and level of safety	Use direct observation of the beneficiary, or select appropriate screening questions or a screening questionnaire from various available screening questions or standardized questionnaires recognized by national professional medical organizations to assess, at a minimum, the following topics: • Ability to successfully perform ADLs • Fall risk • Hearing impairment • Home safety

Prolonged E&M Before and/or After Direct Patient Care

Code	Description	Payment	Required Elements	CPT Guide	Service period	Threshold to bill
99358	Prolonged evaluation and management service before and/ or after direct patient care; - first hour	3.16 RVU $114.00	Used to report non-face-to face prolonged service time beyond the usual physician service time.	May be reported on a different date than the primary service to which is it related. Must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management. Does not need to be continuous. Time can not be counted more than once towards the provision 99358 and any other PFS service.	Report only once per date of service.	31 minutes
+99359	- Each additional 30 minutes (List separately in addition to code for prolonged service)	1.52 RVU $55.00			Must be reported with 99358	76 minutes (60 min 99358 +16 min 99359)

Psychiatric Collaborative Care Services (COCM)

Psychiatric Collaborative Care Management Services

CPT codes mirror HCPCS codes of 2017

G0502, G0503, G0504

Services provided under direction of treating physician or other qualified health care professional during a calendar month

Services provide when a patient has a diagnosed psychiatric disorder that required behavioral health care assessment

- Establishing, implementing, revising or monitoring a care plan
- Provision of brief interventions

Psychiatric Collaborative Care Management Services

Services reported by treating physician or other qualified health care professional,

- Include services of treating physician or other qualified health care professional
- Behavioral health care manager
- Psychiatric consultant
  - Contracted directly with treating physician to provide consultation

Psychiatric Collaborative Care Management Services

Patients directed to behavioral health care manager have

- Newly diagnosed conditions
  - May need help engaging in treatment
- Have not responded to standard care delivered in a non-psychiatric setting
- Require further assessment and engagement, prior to consideration of referral to a psychiatric care setting

CPT Guidelines have definitions of

- Health care professionals
- Behavioral health care manager
- Psychiatric consultant

Psychiatric Collaborative Care Management Services

99492 – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities. In consultation with 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 patient directed by the treating physician or other qualified health care professional
- Initial assessment of the patient, including administration of validated rating scales, wit the development of an individualized treatment plan
- Review the psychiatric consultant with modifications of the plan if recommended

Psychiatric Collaborative Care Management Services

99492 required elements: *cont'd*

- 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

Time threshold to bill this 70 minute code is 36 minutes

Psychiatric Collaborative Care Management Services

99493 – 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

Psychiatric Collaborative Care Management Services

99493 *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

Time threshold to bill this 60 minute code is 31 minutes

Psychiatric Collaborative Care Management Services

+99494 - 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)

General Behavioral Health Integration Care Management

Services reported by supervising physician or other qualified health care professional

Services performed by clinical staff for patient with behavioral health (including substance abuse) condition that required care management services of 20 minutes of more in a calendar month

A treatment plan as well as specified elements of service description are required

Only for patients with behavioral health and psychiatric diagnoses

General Behavioral Health Integration Care Management

Assessment and treatment plan is not required to be comprehensive and the office/practice is not required to have all the functions of chronic care management

May be used in any outpatient setting

- Reporting professional must have an ongoing relationship with the patient & clinical staff
- Clinical staff must be available for face to face service with the patient

General Behavioral Health Integration Care Management

Reporting professional must be able to perform evaluation and management (E&M) services of an initiating visit

These services and Chronic Care Management may be reported in the same month

May not be reported in the same month with Behavioral Health Integration Care Management

May not be reported in the same month with Psychiatric Collaborative Care Management

General Behavioral Health Integration Care Management

99484 – 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 of follow-up monitoring, including 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, pharmacotheraphy, counseling and/or psychiatric consultations
- Continuity of care with designated member of care team

INR Monitoring

Home and Outpatient International Normalized Ratio (INR) Monitoring Services

93792 – Patient/caregiver training for initiation of home international normalized ration (INR) monitoring under the direction of a physician or other qualified health processional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results and documentation of patient's/caregiver's ability to perform the testing and report results.

E&M Same day reportable with modifier 25

- When significantly separate enough to warrant additional service

Home and Outpatient International Normalized Ratio (INR) Monitoring Services

93792 used to report all training and instruction needed for the patient or caregiver to allow initiation of the home and outpatient INR monitoring service

This includes training on use and care of the monitoring device and on obtaining the blood sample, instructions for reporting test results and documentation of the patient's/caregiver's ability to perform testing and report the results.

Provision of the test materials and equipment is reported separately from hone and outpatient INR services

- 99070
- Other appropriate supply code

Home and Outpatient International Normalized Ratio (INR) Monitoring Services

93793 – Anticoagulant management for a patient taking warfarin, must include review and interpretation for a new hope, office or lab international normalized ratio (INR) test result, patient instructions, dosage adjustments (as needed) and scheduling of additional test(s) when performed

Report code only once per day regardless of the number of tests reviewed

Home and Outpatient International Normalized Ratio (INR) Monitoring Services

93793 Used to report the management services needed to treat the patient

This includes review of the home and outpatient INR test results, patient instructions, adjustment of dosages (as needed) and any additional testing or scheduling necessary for management

Anticoagulation management service references have been deleted along with their codes

Home | About CMS | Newsroom Center | FAQs | Archive | Share Help Print

CMS.gov
Centers for Medicare & Medicaid Services

Learn about your health care options

Search

Medicare | Medicaid/CHIP | Medicare-Medicaid Coordination | Private Insurance | Innovation Center | Regulations & Guidance | Research, Statistics, Data & Systems | Ou Educat

THANK YOU!!

youngmedconsult@gmail.com

Questions????