Medicare Care Management Services

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Richelle Marting is an attorney, registered health information administrator, and certified coder who focuses on healthcare coding, billing, and reimbursement issues. She has practical, in-the-trenches experience with coding and billing issues. She has served as an outpatient multi-specialty surgery coder, hospital-based outpatient coder and a compliance coordinator for a large multi-specialty medical group. As an attorney she advises clients proactively on complex reimbursement questions and has guided multiple clients through extensive Medicare and OIG audits and investigations.
Overview

Care Management, Defined

- Care Plan Oversight
- Transitional Care Management
- Chronic Care Management
- Complex Chronic Care Management
- Behavioral Health Integration
- Psychiatric Collaborative Care Management

Resources
Services at least partially in the absence of a face-to-face service between a provider and a patient to provide ongoing care of a patient between visits

Care Management, Defined
A comprehensive plan of care for health problems is based on a physical, mental, cognitive, social, functional, and environmental evaluation.

Comprehensive Plan of Care

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive assessment
- Functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and other health care professionals and others, as necessary
- Summary of advance directives
Patient access, care coordination, and clinical integration are key features of practices providing care management services.

**Practice Capabilities**

- 24/7 access to physicians or other qualified health care professionals or clinical staff
- Continuity of care with a provider patient can schedule successive routine appointments
- Timely access and management for follow-up after an emergency department visit or facility discharge
- EHR
- Standard method to identify patients requiring care management
- Internal care management process/function so identified patients start receiving services in a timely manner
- Standardized documentation form and format
- Engage and educate patients
- Coordinate care
- Billing providers oversees care team
- Clinical integration
General Care Management Requirements

• Initiating visit for new patients (CPT) or patients not seen within 1 year
  • Can be E/M, IPPE, AWV, TCM face-to-face
  • Billed separately

• Consent
  • May be verbal or written
  • Must be documented
  • New consent if provider changes
  • Record date of revocation

• DOS: When requirements are met in a month, or end of month; date of face to face visit for TCM
• POS: Report where provider would ordinarily bill face-to-face service
Those care management services permitted to be delivered under general supervision

Designated Care Management
<table>
<thead>
<tr>
<th>Service</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Plan Oversight (CPO) (also referred to as Home Health Supervision, Hospice Supervision) (HCPCS Codes G0181, G0182)</td>
<td>Supervision of home health, hospice, per month</td>
</tr>
<tr>
<td>ESRD Monthly Services (CPT Codes 90951-70)</td>
<td>ESRD management, with and without face-to-face visits, by age, per month</td>
</tr>
<tr>
<td>Transitional Care Management (TCM) (adopted in 2013) (CPT Codes 99495, 99496)</td>
<td>Management of transition from acute care or certain outpatient stays to a community setting, with face-to-face visit, once per patient within 30 days post-discharge</td>
</tr>
<tr>
<td>Chronic Care Management (CCM) (adopted in 2015, 2017, 2019) (CPT Codes 99487, 99489, 99490, 99491)</td>
<td>Management of all care for patients with two or more serious chronic conditions, timed, per month</td>
</tr>
<tr>
<td>Advance Care Planning (ACP) (adopted in 2016) (CPT Codes 99497, 99498)</td>
<td>Counseling/discussing advance directives, face-to-face, timed</td>
</tr>
<tr>
<td>Behavioral Health Integration (BHI) (adopted in 2017) (CPT Codes 99484, 99492, 99493, 99494)</td>
<td>Management of behavioral health conditions(s), timed, per month</td>
</tr>
<tr>
<td>Assessment/Care Planning for Cognitive Impairment (adopted in 2017) (CPT Code 99483)</td>
<td>Assessment and care planning of cognitive impairment, face-to-face visit</td>
</tr>
<tr>
<td>Prolonged Evaluation &amp; Management (E/M) Without Direct Patient Contact (adopted in 2017) (CPT Codes 99358, 99359)</td>
<td>Non-face-to-face E/M work related to a face-to-face visit, timed</td>
</tr>
<tr>
<td>Remote Physiologic Monitoring (adopted beginning 2018 with CPT Code 99091; in 2019, added CPT codes 99453, 99454, 99457; for CY 2020, will add CPT code 99458)</td>
<td>Analysis of patient data used to develop and manage a treatment plan</td>
</tr>
<tr>
<td>Interprofessional Consultation (adopted in 2019) (CPT Codes 99446, 99447, 99448, 99449, 99451, 99452)</td>
<td>Inter-practitioner consultation</td>
</tr>
</tbody>
</table>
### Designated Care Management Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99457</td>
<td>Rem physiol mntr 1st 20 min</td>
</tr>
<tr>
<td>99458</td>
<td>Rem physiol mntr each addl 20 min</td>
</tr>
<tr>
<td>99484</td>
<td>CM BHI clinical staff minimum 20 min</td>
</tr>
<tr>
<td>99495†</td>
<td>TCM moderate complexity F2F w/in 14-day disch</td>
</tr>
<tr>
<td>99496†</td>
<td>TCM high complexity F2F w/in 7-day disch</td>
</tr>
<tr>
<td>99490</td>
<td>CCM clinical staff minimum 20 min</td>
</tr>
<tr>
<td>99439</td>
<td>CCM add to 99490 clinical staff addl 20 min</td>
</tr>
<tr>
<td>99487</td>
<td>Cmplx CCM clinical staff minimum 60 min</td>
</tr>
<tr>
<td>99489</td>
<td>Cmplx CCM add to 99487 clinical staff addl 30 min</td>
</tr>
<tr>
<td>99X24</td>
<td>PCM clinical staff minimum 30 min (previously G2065)</td>
</tr>
<tr>
<td>99X25</td>
<td>PCM add to 99X24 clinical staff addl 30 min</td>
</tr>
<tr>
<td>G2086</td>
<td>Office-based opioid tx CM min 70 min cal month</td>
</tr>
<tr>
<td>G2087</td>
<td>Office-based opioid tx CM addl 60 min subsequent cal month</td>
</tr>
<tr>
<td>G2088</td>
<td>Office-based opioid tx CM month addl 30 beyond first 120 min</td>
</tr>
<tr>
<td>G2214</td>
<td>Init/sub psych collaborative care first 30 min cal month</td>
</tr>
</tbody>
</table>

† The face-to-face visit included in the service is not assigned general supervision.
CARE PLAN OVERSIGHT:
The supervision of patients under Medicare-covered home health or hospice care requiring complex multidisciplinary care modalities, including regular development and review of plans of care

G0181 Home health supervision
G0182 Hospice care supervision

Coverage Requirements

30+ minutes per calendar month (threshold)
Furnish face-to-face within 6 months before month when CPO is first billed
Not a Designated Care Management Service

Must be the only service on the claim
Bill after end of calendar month
HHA's or hospice's NPI, as appropriate, in loop 2300, ref segment, with qualifier 1J

Hospice CPO
Physician
Physician: The physician who signs the plan of care
Cannot be the medical director or employee of the hospice and may not furnish services under an arrangement with the hospice

HHA CPO
Physician, NPP (APRN, PA, CNS)
Cannot have significant ownership in, or financial/contractual relationship with HHA
NPP:
• Has seen and examined the patient
• Is not functioning as a consultant whose participation is limited to a single medical condition rather than multi-disciplinary coordination of care
• Integrates his or her care with that of the physician who signed the plan of care
• NPP and physician are 1) in the same “group practice”; or 2) doc and NPP have collaborative practice/supervision agreement
TRANSITIONAL CARE MANAGEMENT

Medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living).

99495 TCM with communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; moderate complexity decision-making; AND face-to-face within 14 days of discharge

99496 TCM face-to-face within 7 days of discharge

Provider Services
• Review discharge information
• Review pending/needed diagnostics
• Coordination with providers to assume or reassume care
• Education
• Referrals and community resources
• Scheduling with providers

Important Coverage Rules
Face-to-face is not billed separately
Med reconciliation and management no later than date of face-to-face
Follow CPT MDM guidelines
1 per patient per discharge
Discharge service doesn’t count as face-to-face
Date of discharge + next 29 days
TELEHEALTH APPROVED
RHC/FQHC can be stand-alone

Clinical Staff Services
• Communication regarding aspects of care
• Communication with community services utilized by the patient
• Education to support self-management, ADLs
• Assessment for med management and treatment compliance
• Identification of available community and health resources
• Facilitating access to needed care and services
Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer’s disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS
CHRONIC CARE MANAGEMENT

+ G0506 Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services

99490 CCM, Two+ chronic conditions with comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

+ 99439 each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

  Maximum of two (2) units per month

  Chronic care management services of 60 minutes or more and requiring moderate or high complexity medical decision making may be reported using 99487, 99489

99491 CCM, Two+ chronic conditions with comprehensive care plan established, implemented, revised, or monitored personally provided by physician or qualified health care professional, 30 minutes per calendar month

Clinical staff are employees or contractors working under general supervision of physician or other QHP
CHRONIC CARE MANAGEMENT

• Record the patient’s demographics, problems, medications, and medication allergies using certified Electronic Health Record (EHR) technology. This means a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year

• A person-centered, electronic 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, with particular focus on the chronic conditions being managed)

• Provide the patient and/or caregiver with a copy of the care plan

• Ensure the electronic care plan is available and shared timely within and outside the billing practice to individuals involved in the patient’s care

• **RHC/FQHC Covered, G0511**
COMPLEX CHRONIC CARE MANAGEMENT

Similar to chronic care management, plus moderate/high complexity decision making and higher time requirements

99487 Complex CCM **first 60 minutes** of clinical staff time directed by a physician or other qualified health care professional, per calendar month

99489 each additional 30 min

**Adult Patient Profile**
- 3+ Prescriptions
- Therapeutic Interventions

**Typical Patient Needs**
- Coordination among several specialties and services
- Impaired cognition, ADLs
- Psychiatric, medical comorbidities
- Social support
- Improved access

**Pediatric Patient Profile**
- 3+ Interventions such as medications, nutrition, therapy support

Patients who require complex chronic care management services may be identified by practice-specific or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for a caregiver, and/or repeat admissions or emergency department visits.
BEHAVIORAL HEALTH INTEGRATION

Care Team Members

- **Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (PA, NP, CNS, CNM); typically primary care, but may be of another specialty (for example, cardiology, oncology, psychiatry).

- **Beneficiary** – The beneficiary is a member of the care team.

- **Potential Clinical Staff** – The billing practitioner delivers the service in full or uses qualified clinical staff to deliver services using a team-based approach. Clinical staff includes contractors who meet the qualifications for the CoCM behavioral health care manager or psychiatric consultant.
BEHAVIORAL HEALTH INTEGRATION

- Initial assessment by primary care team (the billing provider)
- Administration of validated rating scale(s)
- Care planning by primary care team
- Facilitation and coordination of behavioral health care
- Not limited to behavioral health providers

ELIGIBLE CONDITIONS
Any mental, behavioral health, or psychiatric condition treated by the billing practitioner, including substance use disorders
RHC, FQHC Covered G0511
BEHAVIORAL HEALTH INTEGRATION

- Generally performed by clinical staff incident-to provider’s services
- Incident-to typically requires direct supervision
- BHI is a designated care management service, general supervision
- Assessment and treatment plan does not have to be comprehensive
- Could be reported with chronic care management for different conditions
- Clinical staff time spent coordinating care with the emergency department may be reported using 99484, but time spent while the patient is inpatient or admitted to observation status may not be reported using 99484

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 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
- continuity of care with a designated member of the care team
PSYCHIATRIC COLLABORATIVE CARE MANAGEMENT

Care Team Members

- **Treating (Billing) Practitioner** – A physician and/or non-physician practitioner (physician assistant or nurse practitioner); typically primary care, but may be of another specialty (for example, cardiology, oncology)

- **Behavioral Health Care Manager** – A designated individual with formal education or specialized training in behavioral health (including social work, nursing, or psychology), working under the oversight and direction of the billing practitioner

- **Psychiatric Consultant** – A medical professional trained in psychiatry and qualified to prescribe the full range of medications

- **Beneficiary** – The beneficiary is a member of the care team
PSYCHIATRIC COLLABORATIVE CARE

- Initial assessment by primary care team (the billing provider)
- Administration of validated rating scale(s)
- Care planning
- Behavioral health care manager performs proactive, systematic follow-up using validated rating scales and a registry
  - Assesses treatment adherence, tolerability, and clinical response using validated rating scales;
  - Delivers brief evidence-based psychosocial interventions such as behavioral activation or motivational interviewing
- Regular case load review with psychiatric consultant:
  - The primary care team regularly (at least weekly) reviews the beneficiary’s treatment plan and status with the psychiatric consultant
  - The primary care team maintains or adjusts treatment, including referral to behavioral health specialty care, as needed

- RHCs/FQHCs report with G0512; rev code 052X and no modifier CG
PSYCHIATRIC COLLABORATIVE CARE

G2214 Initial or subsequent psychiatric collaborative care management, **first 30 minutes** in a 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.

99492 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.

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.

+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.

G0512 FQHC/RHC – Psychiatric Collaborative Care Model services: Minimum of **70 minutes** in the **first** calendar month and at least **60 minutes** in subsequent calendar months.
Resources

- **RHC/FQHC**: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf)
- **BHI FAQ**: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Behavioral-Health-Integration-FAQs.pdf)
- **TCM FAQ**: [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf)
Questions?

Available Through Heartland Telehealth Resource Center for Technical Assistance
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