Proper Care, Proper Pay: Working with TCM, CCM, and ACP

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Learning Objectives

1. Integrate practice changes to incorporate CCM/TCM, and ACP programs.
2. Define requirements of Advance Care Planning documentation.
3. Identify patterns and effectiveness of CCM and TCM delivery.
4. Calculate practice impact of initiating TCM, CCM, and ACP services.

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Audience Engagement System

Step 1 Step 2 Step 3

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My practice provides and bills the following:

A. Transitional Care Management (TCM)
B. Chronic Care Management (CCM)
C. Advance Care Planning (ACP)
D. A&B
E. B&C
F. A&C
G. All three

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The Case for Transitional Care Management (TCM)

- 90% of readmissions within 30 days of discharge are unplanned
- 1/5 of Medicare patients re-hospitalized within 30 days of discharge
- 60% experience medication errors
- Contributes to deterioration of function, reduced symptom-free days and decreased satisfaction with health care

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Positive Outcomes of 9 TCM Studies

- 8 of 9 reduced all cause readmission for at least 30 days after discharge
- 3 of 9 reduction effect lasted 6-12 mo.
- 2 studies reported cost savings per Medicare patients of $3,000 at 6 months and $5,000 at 12 months

Naylor, Mary; Aiken, Linda; et al, “The Importance of Transitional Care in Achieving Health Reform,” Health Affairs, Vol. 30 no. 4, 746-754, April 2011

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Transitional Care Management (TCM) Services

- Services required during transition to the community following certain discharges
- No gap in care provided during transition
- Moderate or high complexity decision making
- Can be used for new or established patients

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Who may provide TCM service

- Physicians (any specialty)
- Non-physician practitioners (NPP)
  - Physician assistants
  - Nurse practitioners
  - Clinical nurse specialists
  - Certified nurse-midwives

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Transitional Care Management Services include discharges from all of the below except:

1. Inpatient Acute Care Hospital
2. Emergency Room
3. Inpatient Rehab Facility
4. Hospital Outpatient Observation
5. Skilled Nursing Facility

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Patients at Highest Risk of Readmission

- >80 y/o with other factors
- Moderate to severe functional deficits
- Inability to manage daily tasks or self-care
- Depression
- 4 or more active coexisting health conditions
- 6 or more prescribed standing medications

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Patients at Highest Risk of Readmission

- 2 or more hospitalizations within the past 6 months
- Hospitalization within the past 30 days
- Baseline dementia
- Treatment during hospitalizations for delirium
- Lack of family caregiver support
- Low health literacy
- Social issues

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99495: Moderate Complexity

- MODERATE complexity medical decision making
- **2 business days** communicate post discharge
- 14 **calendar days** post discharge with face-to-face visit
- **30 days** post discharge ongoing care management

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99496: High Complexity

- HIGH complexity medical decision making
- **2 business days** communicate post discharge
- 7 **calendar days** post discharge with face-to-face visit
- **30 days** post discharge ongoing care management

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Post Discharge Communication Within 2 Days of Discharge

- Must be interactive: direct contact, telephone, electronic
- Document patient or caregiver's response
- Can be face-to-face or non-face-to-face
- Voicemail not adequate

DOCUMENT

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Medication Reconciliation and Management

- Furnished no later than the date of the Face-to-Face Visit

DOCUMENT

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Items to include in Initial Transitional Care Contact Note (within 2 Business Days)

- Date of Contact
- Date of Discharge
- Discharge Facility
- Diagnoses, Problems, Procedures
- Medicine Reconciliation
- Pending referrals, studies, results, reports
- Scheduled visit

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Clinician's Face-to-Face Visit Note

- Timing of initial contact
- Date of face-to face visit
- Complexity of medical decision making
- Medication Reconciliation if not done
- Care plan

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After face to face visit

- Nurse care manager needs to document ongoing care management activities and ideally time spent doing care coordination/managing activities.
- Note needs to be sent to clinician to review

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TCM: An Example from Residency

- **Location:** UMC
- **Clinic:** Outpatient
- **Day:** Thursday, a.m.
- **# of Patients:** 5 – 8

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Transitional care team

- **Transitional care coordinator:** Kim McMillian
- **Nurse**: Amy Yourbrough
- **Social Services**: Robert McKinney
- **Dietitian**: Susan Henson
- **Clinical pharmacology:** Danna Caroll
- **Behavioral medicine fellow**: Calia Torres
- **Residents**: Upper level resident and an Intern
- **Faculty:** Tamer Elsayed, MD

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Our TCM Clinic

- Comprehensive medical management
- Early access: within 2 business days a phone call to check on patient, confirm appointment and assess need for transportation
- Medication reconciliation
- Address cost and affordability of medication
- Psychological and behavioral support

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Our TCM Clinic

- Review of discharge summary
- Follow up on pending tests and labs
- Health education
- 24/7Answering service
- Dedicated transitional care nurse (not her only duty)

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Our TCM Clinic

- Social services: transportation, meals on wheels, home condition, medical supplies, social support
- Community resources utilization: Home health, physical therapy
- Follow up phone call, after visit
- Appointment with PCP within 2 weeks
- Home visit, as needed

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TCM billing must wait until 30 days after discharge

- True
- False

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Billing TCM

Can now bill on day of face-to-face visit!

- Reported once during the TCM period
- Place of service site of face-to-face
- Only one clinician can bill per TCM period
- If readmitted within 30 days, can bill, but cannot bill a second TCM if second discharge within 30 days of first discharge, or
  - Can bill regular E&M for first post discharge visit and restart TCM after the second discharge

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Billing TCM

- Can bill additional E&M services if needed during 30 day period
- Can bill in postoperative global period if clinician did not do the operation
- Cannot do TCM face-to-face visit on same day as discharge
- Cannot bill if patient dies before 30 days

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TCM – RVU's for 2016

- 99495 – Work RVU: 2.11
  - Non Facility RVU: 4.60, Payment $164.81
  - Facility total RVU: 3.11, Payment $111.42
- 99496 – Work RVU: 3.05
  - Non Facility RVU: 6.49, Payment $232.52
  - Facility total RVU: 4.50, Payment $161.23
- For comparison
  - 99214 – Work RVU: 1.50
    - Non Facility RVU: 3.02, Payment $108.20
    - Facility total RVU: 2.21, Payment $79.18

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The Challenges for TCM Billing

- Connecting with the patient within 2 business days
  - If you're discharging, tell them you will be calling
- Billing at time of face-to-face or 30 days
  - Refunds if readmitted
  - Keeping track
- Getting discharge info from admitting service

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Medicare 30 Day Readmission Rate 2013

	With TCM	Without TCM
Unplanned readmission	9.1 %	15.5%
Moderate complexity	7.9 %	
High complexity	10.4%	
ER visits	15.6%	22.0%
Moderate complexity	14.7%	
High complexity	16.7%	

Gillis, Kurt; Early Results on the Use of Transitional Care Management in Medicare, 2016 http://www.ama-assn.org/resources/doc/health-policy/x-pub/prp2016-02tcm.pdf

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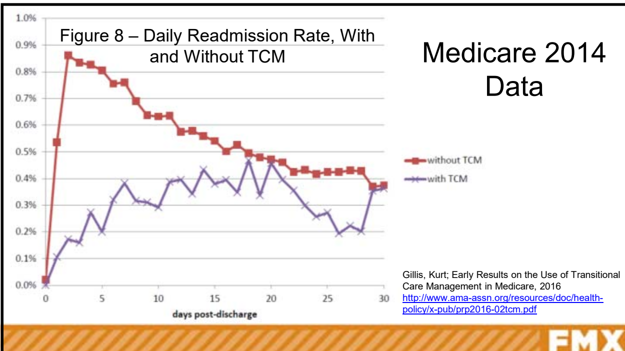

Medicare 2014 Data

Gillis, Kurt; Early Results on the Use of Transitional Care Management in Medicare, 2016 http://www.ama-assn.org/resources/doc/health-policy/x-pub/prp2016-02tcm.pdf

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Chronic Care Management Services (CCM) 99490

"Furnishing care management to beneficiaries with multiple chronic conditions requires multidisciplinary care modalities that involve: regular physician development and/or revision of care plans; subsequent reports of patient status; review of laboratory and other studies; communication with other health professionals not employed in the same practice who are involved in the patient's care; integration of new information into the care plan; and/or adjustment of medical therapy." http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

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99490 Three Key Requirements

- Scanned, signed **patient agreement**
- Patient-centered **care plan**
- Monthly log showing at least **20 min** of staff contact time

Betsy Nicoletti, Fam Pract Manag. 2016 May-Jun;23(3): 30-35. http://www.aafp.org/fpm/2016/0500/p30.html

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What is the minimum number of chronic conditions a patient must have to receive chronic care management services?

A. 1
B. 2
C. 3
D. 4
E. 5

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99490

- **2 or more chronic conditions** expected to last at least 12 months or until the death of the patient
- **Significant risk** of death, acute exacerbation/decompensation or functional decline

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Practitioner Eligibility

- Physicians (any specialty)
- Non-physician practitioners (NPP)
  - Physician assistants
  - Nurse practitioners
  - Clinical nurse specialists
  - Certified nurse-midwives

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Supervision

- Clinical staff can provide the CCM service incident to the services of the billing physician (or other appropriate practitioner) under the **general supervision** (rather than direct supervision) of a physician (or other appropriate practitioner).

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Visit Requirement Before CCM

- Evaluation and management (E/M) visit (level 2-5), or
- Annual Wellness Visit, or
- Initial Preventive Physical Examination (IPPE), or
- Transitional Care Management Visit

http://blogs.aafp.org/fpm/gettingpaid March 31,2016

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Patient Consent

- **Inform the patient** of the availability of the CCM service
- **Obtain written consent** to have the services provided, including authorization for electronic communication with other treating providers
- **Document the discussion** and note the patient's decision to accept or decline the service
- Explain how to revoke the service
- Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month

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Patient Consent

- Need only be obtained once prior to furnishing the CCM service, or if the patient chooses to change the practitioner who will furnish and bill the service
- Some of the patient agreement provisions require the **use of certified Electronic Health Record (EHR) technology**

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CCM Scope of Service

- Structured recording of patient health information
- Electronic care plan addressing all health issues
- Access to care management services
- Management of care transitions
- Coordinate and share patient information with providers outside the practice

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Care Plan

- **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
- **Care plan available** electronically to anyone within the practice providing the CCM service
- **Share** the care plan electronically outside the practice as appropriate

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Access to Care

- 24/7 access to care management services
- Continuity of care with a designated practitioner for appointments
- Provide enhanced HIPAA compliant opportunities (telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods) for the patient and any caregiver to communicate with the practitioner

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Manage Care

- Assessment of the patient's medical, functional, and psychosocial needs
- System-based approaches for preventive care services
- Medication reconciliation, adherence, interactions
- Care transition management
- Coordinate home health services

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99490 Billing

- **Can only bill once a calendar month**
- Cannot be billed with CPT 99495-99496 (TCM), or CPT 90951-90970 (ESRD)
- Cannot be billed by multiple clinicians in same month
- **Patient must sign written agreement to have services provided, can withdraw at any time**
- Payment $40.84

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Odds and Ends

- Hospital owned practices can bill; paid under facility or non-facility rates as appropriate to practice type
- Can bill 99490 with an E&M visit (with -25 modifier) if clinical staff meet the CCM requirements (possible red flag)
- Can bill 99490 if patient dies during the month but 20 minutes of CCM given during that month

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Odds and Ends

- Can bill 99490 during the same calendar month as TCM, if the TCM service period ends before the end of a given calendar month and at least 20 minutes of qualifying CCM services are subsequently provided during that month
- Cannot double count staff time (2 staff meeting)

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Challenges

- Patient must give signed consent and can withdraw anytime
- Patient will have to pay standard coinsurance (about $8 per 30 days)
- EMR challenges
- Documenting time over 30 days

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Implementing CCM

- Step 1
  - Use EMR to ID patients with **2 or more chronic conditions**
  - **Sort** by physician
  - Physician **reviews** list for patients not appropriate for CCM
  - Initially **focus** on small number of Dx (DM, COPD)
  - Create **log** of participating CCM patients

https://www.acponline.org/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf

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CCM Log

Patient	PCP	Date Enrolled	Care Plan Review Date	Date Terminated	Notes
John	Dr. T.	11/1/30	11/5/15		Needs SW

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Step 2

- **Designate personnel** for each patient (primary clinician, nurse, other staff helping with enrollment, consents, scheduling)
- Access to successive routine appointments with designated clinician
- Licensed clinical staff can provide “incident to” services with appropriate supervision

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Step 3

- Design a CCM process and schedule
  - Set up appointment codes for new visits and nurse assessment calls
  - Consider designating specific time frames for visits and calls
  - Assign CCM nurses and staff to assist
  - Consider dedicated phone line answered by designated CCM staff

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Step 4

- Inform the patient
  - Invite patients to participate using an **invitation letter** and **written consent** to participate
  - Example letters at: https://www.acponline.org/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf
  - **Explain process to patients and document in EMR**

Step 5

- Create a Comprehensive Care Plan
- Share plan with other clinicians as appropriate

Step 6

- Provide the patient with the written or electronic copy of the comprehensive care plan

Step 7

- Document the time spent
  - Track non-face-to-face services
    - Phone calls and e-mails with patients
    - Time spent coordinating care by phone or electronic with other clinicians, facilities, community resources and caregivers
    - Time spent on prescription management/medication reconciliation

Step 8

- Termination from program
  - Document death, transfer of patient to another clinician, or termination from the CCM plan for any reason.
  - Example letter at: https://www.acponline.org/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf

Implementing CCM – Plan B

- Contract with independent vendor to provider service for a PMPM payment
  - May loose nuances in communication

Http://blogs.aafp.org/fpm/gettingpaid/entry/survey_many_physicians_still_unaware

CCM Utilization

- *National Chronic Care Management Survey 2015*
  - Only 26% of respondents have started CCM
  - Median of 35 minutes of service, not 20
  - 23% contemplating starting

http://info.pyapc.com/hubfs/White-Papers/National-Chronic-Care-Management-Survey-2015-PYA.pdf

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Cost/Benefit Analysis

- Assume 48 min total per month per patient
- 480 min in a work day: Can do 10 a day
- 50 a week
- 200 a month
- @$40.84 per patient per month
- $98,000 per year

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Advanced Care Planning (ACP)

- 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 healthcare professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate. **16 minutes qualifies**
- 99498
  - each additional 30 minutes

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True or False: Advance Care Planning Never has a Co-Pay

- True
- False

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Advanced Care Planning (ACP)

- If the discussion takes place during the annual wellness visit, it is considered a preventive service and the patient's coinsurance and deductible are waived
- Payment started 2016
- No frequency limits
- No specific diagnosis code required

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Advanced Care Planning

- An advance directive (a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time) is **not required** for ACP billing
- When using these codes, no active management of the problem(s) is undertaken during the time period reported
- Can be reported with another E&M code on the same day Use modifier -25

http://blogs.aafp.org/fpm/gettingpaid/entry/cms_answers_questions_on_advance

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Advanced Care Planning Payment

- 99497 (30 minutes of ACP)
  - RVU: 2.40
  - Facility: $79.54
  - Non-facility: $85.99
- 99498 (Additional 30 minutes)
  - RVU 2.08
  - About $75

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Questions

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Proper Care, Proper Pay: Working with TCM, CCM, and ACP

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AAFP Resources

- CCM
  - http://www.aafp.org/fpm/2015/0100/p7.pdf
  - http://www.aafp.org/fpm/2015/0500/p7.html
  - Patient Plan: http://www.aafp.org/fpm/2015/0100/fpm20150100p7-rt1.pdf
  - Consent Form: http://www.aafp.org/fpm/2015/0100/fpm20150100p7-rt2.pdf
  - CCM Services Log Excel Spreadsheet:
    - http://www.aafp.org/fpm/2015/0100/fpm20150100p7-rt3.xlsx

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Additional Information

- CMS website at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- Acknowledgements: Illustrations by Presentermedia

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Practice Recommendations

- TCM decreases readmission rates and improves patient's health
- Annual Wellness Visit can be gateway to CCM and ACP.
- Financially feasible
- Staff can do most of the work

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Interested in More CME on this topic?
aafp.org/fmx-practice-management

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