CCM and ACP in the RHC

By Joanie Perkins, CPC

Jan 1, 2016 RHC's became eligible to be paid for CCM Services

- Qualifying Patients Must have:
  - 2 or more chronic conditions expected to last at least 12 months (or until death) that place the patient at significant risk of death, acute exacerbation/de-compensation, or functional decline.
  - CCM services must be initiated as part of a comprehensive E&M visit, IPPE, or AWV

CCM Payment

- Payment for CCM services is based on the PFS national average when CPT code 99490 is billed – Currently Novitas is paying 39.40
- 99490 may be billed on the UB04 in addition to a qualifying visit code (*I don't recommend it*), or on a stand alone claim under the RHC provider number.
- Face to face requirement is waived

CCM Payment Continued

- Co-insurance and Deductibles do apply
- RHC's cannot bill CCM services during the same service period as Transitional Care Management, or any other management service that provides additional payment for care management services.

Patient Consent Requirements

- Consent should only be obtained once
- Must have documented informed consent including the following:
  - CCM services written agreement authorizing electronic communication of medical information with other treating providers
  - Information that only 1 provider/month can furnish the service
  - How to revoke the service

Patient Agreement Requirements

- Should include a discussion with the patient and/or caregiver about:
  - What CCM Service is;
  - How to access the elements of the Service;
  - How the patient's information will be shared;
  - How Co-pay's and Deductibles are applied
  - How to Revoke the Service

Be sure and document the discussion in the medical record

Structured Data Recording

- Must record structured patient health information data to include:
  - Patient Demographics
  - Problem List
  - Medications
  - Allergies
  - Create structured clinical summary records using certified EHR technology

Comprehensive Care Plan

- The plan must be patient-centered and based on a physical, mental, cognitive, psychosocial, functional and environmental assessment and inventory of resources
- Must provide the patient with a copy of the plan either on paper or electronically and document you gave it to them in the medical record

Comprehensive Care Plan

- Ensure the care plan is available electronically at all times
- Share the care plan electronically outside the practice as appropriate

Typically Included in a Care Plan

- Problem list
- Expected Outcome/Prognosis
- Measurable Treatment Goals
- Symptom Management
- Planned interventions and identify responsible individuals
- Medication Management
- Social Services ordered and how the practice will coordinate them
- Schedule for periodic review/revision

Access to Care

- Patients must have 24/7 access to care management services with means to make *timely* contact with providers who have access to the patients electronic care plan
- Ensure continuity of care with a designated provider (pt is able to get routine appointments)
- Provide enhanced communication for patient and caregivers to the provider

Doing alright?

Care Management Services

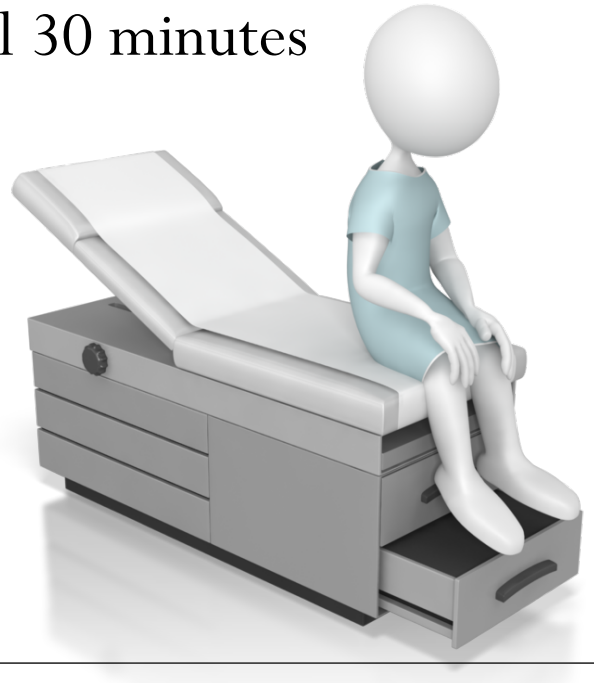
- Systematic assessment of patient's needs (medical, functional, psychosocial)
- System based approach to preventive care services
- Medication reconciliation
- Oversight of self-management of Medications
- Provide follow up care (after ED visit, hospital or other health care facility discharge)

Advanced Care Planning

- In their final rule for the 2016 Medicare Physician Fee Schedule, CMS announced that beginning on January 1, 2016 Advanced Care Planning (ACP) services will be a stand-alone billable visit in a RHC

Bill Code Descriptors

- 99497 ACP including the explanation and discussion of Advanced Directives such as standard forms (with completion of such forms) by the physician or other health care professional first 30 min face-to-face with patient, family member(s) and/or surrogate
- 99498 Each additional 30 minutes



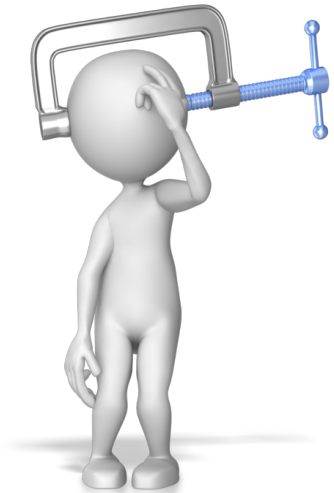
Billing Code Info

- Document total time in your medical record anytime you bill this code
- CMS has not set any frequency limits for these codes
- If you do bill it several times on one patient, CMS would expect to see a change in the patient's status and/or end of life wishes

Billing

- Medicare waives co-pay and deduct for the ACP when:
  - Provided on the same day as a covered AWV
  - Furnished by the same provider as AWV
  - Billed with modifier 33 (prev. services)

Deductible and co-pays do apply when ACP is provided outside the AWV



ACP Example

68 y/o male with CHF and DMII on multiple medications. Routine visit for disease management occurs. In addition to discussing short-term treatment options the provider and patient talk about the possibility of heart transplant if CHF worsens and ACP. It includes talking about the pts. desire for care and treatment if he suffers an event that affects his decision making ability.

Bill E&M service and 99497 (and 99498 if more than 30 min)

Thank you!

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