Coding Guidance for HIV Clinical Practices: Care Management Services

HIV medical practices and clinicians provide many services outside of a face-to-face encounter with a patient. Some of these services are on the same day as a visit, and are considered part of the pre-visit work and post-visit work. These include reviewing labs prior to the visit and completing the note. Other services occur days before or after a face-to-face encounter. Some of these occur on a different day. Now, some services provided on a different day may be eligible for payment.

This guide will discuss Transitional Care Management, Chronic Care Management, Care Management for Patients with Behavioral Health Conditions, Advance Care Planning, Certification of Home Health Services, and Non-face-to-face Prolonged Services.

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TRANSITIONAL CARE MANAGEMENT SERVICES

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 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 Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge.

When are they used?

For patients of moderate to high complexity discharged from an inpatient or observation admission, skilled nursing facility or partial hospitalization program.

Who may perform and bill for these services?

A physician or advanced practice practitioner of any specialty may bill for the service. Only one physician/advance practice practitioner may bill for the TCM for any one patient's discharge from the hospital. The physician who discharges the patient may also provide TCM services for that patient, according to Medicare.

The visit requires non-face-to-face work performed by clinical staff or the provider during the 30-day period. Without that, it may not be billed.

Bill TCM codes on the date of service of the E/M visit.

What does the service include?

First, in order to be eligible for the service, the patient's medical and/or social problems must be of **moderate or high complexity, as defined by the E/M Documentation Guidelines**. The service is defined as including the 29 days post discharge. During that time, the clinician or staff must:

- Contact the patient within two business days of discharge, by phone, in person or by email.
- Have a face-to-face service with the patient within the time frames listed for each code above, and this first E/M service is not separately billed. Bill the TCM code the day the patient is seen.

- Medication reconciliation is required no later than the visit.
- Provide non-face-to-face services by the clinical staff during the 29-day post-discharge period that includes some of: communication with the patient, caregiver, family, home health agency and/or other community services involved in the patient's care; education to support activities of daily living; assessment and support of the treatment regimen and medication management; identification of community and health resources and facilitating access to these resources.
- Obtain and review the discharge summary; review the need for pending or follow up diagnostic tests; interact with other healthcare professionals involved in the patient's care; provide education of patient, or family, or caregiver; establish or reestablish referrals and assist in scheduling medical care or community care.
- Document these contacts in phone notes, if your system does not have a care module.

TRANSITIONAL CARE MANAGEMENT SERVICES

Can we bill any services during the 30-day post discharge period?

Yes. Second and subsequent E/M services after the initial bundled E/M service may be reported. Other diagnostic or therapeutic services may be billed.

Anything else we can't report with these codes?

The codes that may not be billed with the TCM codes are Care Plan Oversight (99339, 99340, 99374-99380, G0181, G0182), prolonged services without patient contact (99358, 99359), medical team conferences (99366--99368), education and training (98960-98962, 99441-99443), end stage renal disease services (90951-90970), online medical evaluation (98969, 99444). Preparation of special reports (99080), analysis of data (99090, 99091), complex care coordination services (99487—99489), or medication therapy services (99605—99607) during the time period covered by the TCM codes, which is 29 days after discharge. Of course, many of the codes in the list above are not reimbursed by Medicare.

Date of service	As of Jan 1, 2016, bill TCM codes on date of face-to-face service
Place of service	Place where face-to-face service took place
Who can perform the face to face E/M service	Physician, advanced practice practitioner: someone who is qualified to perform an E/M service within his or her scope of practice.
Is it moderate or high complexity, when?	Any time during the TCM period
What if there are additional office visits?	Report (bill for) other office visits after the first, bundled TCM service.

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.

+**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)

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.

Requirement

- Care provided by a physician or non-physician practitioner and their clinical staff in a calendar month
- Requires use of certified electronic health record
- Patient must have 24-hour-a-day, 7-day-a-week access to address urgent needs (access to the ER alone is not sufficient)
- Continuity of care with a designated physician/non-physician practitioner
- Comprehensive care management and planning
- Coordination with home and community based services
- Enhanced communication such as email
- Management of care transitions within healthcare
- Advance consent — does not need to be in writing starting 2017
- Care management for chronic conditions including 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; and oversight of patient self-management of medications.
- Starting 2017, faxing is allowed as a means to share care plan with other team members
- Give the patient a copy of the care plan

CHRONIC CARE MANAGEMENT

In consultation with the patient, any caregiver and other key practitioners treating the patient, the provider must create a patient-centered care plan.

See CPT book for description of care plan.

Requires an initiating face-to-face visit for new patients, or patients not seen within a year.

However, CMS recommends an initiating visit for established patients. It gives the opportunity for informed consent and development of the care plan.

The initiating visit could be a welcome to Medicare visit, annual wellness visit, or E/M service 99212—99215, or the post-discharge service provided as part of Transitional Care Management.

The physician or non-physician practitioners may bill an add-on code (G0506) once at the time of the initiating visit, starting January 2017.

+**G0506** Comprehensive assessment of, and care planning for, patients requiring chronic care management services (list separately in addition to primary monthly care management service)

- Billing practitioner personally performs extensive planning, separate from the work of the E/M service or wellness visit
- Pays for the assessment and planning for CCM
- May only be billed once, at the initiation of CCM

CPT bundling

Look in your CPT book for long list of bundled codes — most are not payable under the physician fee schedule. Per CMS, do not report with Care Plan Oversight G0181, G0182.

Key Points

- Requires care plan development for a chronically ill patient at an initial visit
- The initiating visit and an add-on code may be billed at the start of CCM
- Clinical staff, under the general supervision of a physician or a non-physician practitioner provides and documents non-face-to-face care coordination during a calendar month
- Requires 24/7 access for urgent care needs
- Patient must consent to the service, and there is a patient due co-pay
- While typically non-face-to-face services, there may be educational or motivational counseling that is provided face-to-face and this may be included in the clinical staff time
- Time may never be counted twice to report two different services

CPT defines a clinical staff member as "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 that professional service."

CMS assumes the billing practitioner will spend time in the CCM services, but the billing practitioner times in the chart above do not need to be tracked or documented. Track and document clinical staff time.

Date of service and clinical staff

Services are for a calendar month. Bill on the date when the time threshold is met, or at the end of the month.

From CMS's Chronic Care Management Services Changes for 2018				
Code	**National payment, non-facility rate**	**Clinical staff time**	**Care planning**	**Billing practitioner work**
99490	$43	20 minutes	Established, implemented, revised or monitored	▪ Ongoing oversight, direction and management
99487	$94	60 minutes	Established or substantially revised	▪ Ongoing oversight, direction, and management ▪ Medical decision making of moderate-high complexity
+99489	$47	30 minutes	Established or substantially revised	▪ Ongoing oversight, direction, and management ▪ Medical decision making of moderate-high complexity
+G0506	$64	Not applicable	Established	▪ Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

Clinical staff, per CMS: “Practitioners should consult the CPT definition of the term “clinical staff.” And “If the billing practitioner provides the clinical staff services themselves, the time of the billing practitioner may be counted as clinical staff.”

CARE MANAGEMENT FOR BEHAVIORAL HEALTH

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; and
- Continuity of care with a designated member of the care team.

To be eligible, patients must have an identified psychiatric or behavioral health condition that requires assessment, planning and treatment. These conditions may be pre-existing or newly diagnosed. Patients may have other medical conditions, but this isn’t a requirement for the use of the code. The service is billed by the physician or non-physician practitioner for the work done by clinical staff for a patient with behavioral health problems, including substance abuse. According to CPT, there must be a treatment plan. Documentation should include what was done.

The CPT coding tip states that if the physician or other qualified health care professional /non-physician practitioner personally performs these activities, their time may be used to meet the 20-minute threshold, as long as the time isn’t counted towards another reimbursable service. That is, you can’t get paid for the same service, twice.

The reporting professional must have E/M services within his/her scope of practice. That limits the reporting of these services to physicians and advanced practice practitioner. The service is reported and supervised by the physician or non-physician practitioner, but the work is done by clinical staff. Even if a licensed social work is doing the work, do not use the social worker’s NPI to report the service. This code may be reported in the same month as CCM, as long as we aren’t double counting the time or services of one for the other.

The 20-minute threshold may be met by time spent by the physician/non-physician practitioner or by the clinical staff, under the direction of the physician/non-physician practitioner.

ADVANCE CARE PLANNING

CMS recognizes and reimburses physicians and non-physician practitioners to provide Advance Care Planning, using CPT codes 99497 and 99498.

- *CPT code 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face- to-face with the patient, family member(s) and/or surrogate); and an add-on CPT code 99498 (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 professional; each additional 30 minutes (List separately in addition to code for primary procedure).*

Keep in mind

- Face-to-face service between a physician or non-physician practitioner and a patient and/or family member or surrogate
- Forms may be completed, but the service may be billed even if forms are completed at the visit
- ACP may be performed on the same day as an E/M service, except for pediatric and adult critical care services
- CMS will waive the co-pay and deductible when it is performed on the same day as an initial or subsequent Annual Wellness Visit (G0438, G0439)
- The service may be performed in the same month as TCM or CCM
- CMS has not instituted a frequency limit on the service
- Although parts of the service may be performed incident to (such as completing forms with a nurse) CMS and CPT say this is a service performed by a physician or non-physician practitioner
- Any specialty provider may perform the service.

These follow CPT rules for time

99497 the first 30 minutes, and **99498** is an-add on code, for each additional 30 minutes.

But, because they follow CPT rules, you need to meet half of the threshold time for each:

Use **99497** for services from 16-45 minutes

Add on code **99498** if the service is 46 minutes or more

	Work	Total Non-facility	Total Facility
99497	1.5	2.31	2.17
99498	1.4	2.02	2.02

HOME HEALTH CERTIFICATION

There are two HCPCS codes that physicians can use to report developing a plan for a Medicare patient to have home health services. The payment isn't for signing the certification. The payment is for developing and monitoring the plan of care for a patient who is receiving Medicare-covered home health services. The physician creates and reviews the plan, verifies it is being implemented and reviews the data sent by the agency. Although the payment is small, it represents work done by physicians. Only a physician may certify home health services and be paid for this.

G0180 Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period.

G0179 Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period.

Key Issues

- G0180 is used to certify the patient for home health care for the first 60 days.
- G0179 may be reported after the initial 60-day period has lapsed for patients still receiving the care.
- The patient must be eligible to receive and require home health services.
- The physician or collaborating advanced practice provider must have seen the patient no more than 90 days prior to the start of home health or within 30 days of the start of the service for a related condition.
- This face-to-face encounter may be performed by the certifying physician or an advanced practice provider who collaborates with the physician.

Code	Description	National payment amount
G0180	Physician certification of HHA plan	54.55
G0179	Physician recertification of HHA plan	41.99

NON-FACE-TO-FACE PROLONGED SERVICES

Starting January 1, 2017 Medicare will recognize and pay for non-face-to-face prolonged services using existing CPT codes.

These codes are for prolonged services by the billing physician/ advanced practice practioner when provided in relation to an E/M service on the same or different day as an E/M service. If the clinician meets half of the threshold time for the prolonged service without face-to-face contact (31 minutes), use 99358.

99358 - Prolonged evaluation and management service before and/or after direct patient care, first hour (National payment of $113.41).

+ **99359** - each additional 30 minutes (List separately in addition to code for prolonged services) (National payment of $54.55).

Key points

- This service may be provided on the same day or on a different day than the face-to-face service.
- Physician/advanced practice practitioner time counts for these codes, not staff time.
- Use CPT time rules and bill 99358 when 31 minutes (over half of stated code time) has been met.
- It is for extensive time in addition to seeing the patient, and must relate to a service for a patient where direct face-to-face patient care has occurred or will occur and be part of ongoing patient management.
- Code 99358 is not an add-on code. That is, it can be reported on the day when no other service is provided.
- Code 99359 is an add-on code to 99358.
- The time during the day a non-face-to-face service does not need to be continuous.
- CPT tells us not to report these services during the same month as complex chronic care management (99487, 99489) or during the service time of transitional care management (99495, 99496).
- You cannot double count the time for these non-face-to-face prolonged services codes and time spent in certain other activities represented by specific CPT codes. However, the list of CPT codes is mostly those which have a status either non-covered or bundled by Medicare. (Care plan oversight: 99339, 99340, 99374-99380; anticoagulant management: 99363, 99364, medical team conferences: 99366-99368, online medical evaluations:
- 99444, or other non-face-to-face services that have more specific codes and no upper limit in the CPT codes.