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E/M – Care Coordination/Other CPT Changes

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Presentation Overview

- Chronic Care Coordination Workgroup
- Complex Chronic Care Coordination Services (CCCC)
- Transitional Care Management Services (TCM)
- Observation or Inpatient Care Services
- Pediatric Critical Care Patient Transport Services
- Inpatient Neonatal and Pediatric Critical Care
- Initial and Continuing Intensive Care Services

Chronic Care Coordination Workgroup

- July 19 Proposed Rule for 2012 Medicare Physician Payment Schedule – CMS requested that RUC review all of E/M to ensure that care coordination was appropriately valued
- July 29, 2011 Meeting with Donald Berwick, MD (CMS Administrator) – Doctors Robert Wah (AMA Board Trustee), Peter Hollmann (Chair of CPT) and Barbara Levy (Chair of RUC)

Chronic Care Coordination Workgroup

- Specialty society comments to CMS and AMA's message was consistent: a re-review of E/M would not be productive and would not address CMS stated goals:
  - Incentivize care coordination and improve health care delivery to patients with chronic disease
  - Improve payments to primary care to "shore up primary care and nursing"

Chronic Care Coordination Workgroup

- Informed Doctor Berwick that the CPT Editorial Panel and the RUC would engage in an effort to ensure that the coding and valuation of care coordination are appropriate.
- Created the Chronic Care Coordination Workgroup (C3W) in August 2011.

Chronic Care Coordination Workgroup

- The charge to the C3W was to provide strategic direction to CPT and RUC to address the adequacy of coding and valuation of care coordination services and prevention/ management of chronic disease.
- A request to CMS to immediately implement payment for anticoagulant management, telephone calls, team conferences and patient education was submitted to CMS on October 3, 2011. CMS declined to implement this recommendation.

Chronic Care Coordination Workgroup

- In Fall 2011, the C3W recommended that codes for transitional care management and complex chronic care management be developed for CPT 2013.
- CPT Editorial Panel completed this work in May 2012.
- The RUC submitted recommendations to CMS, October 10, 2012, for consideration in the November 1, 2012 Final Rule.

Chronic Care Coordination Workgroup

The C3W recommendations/minutes are at www.ama-assn.org/go/carecoordination

Complex Chronic Care Coordination Services (CCCC)

Complex Chronic Care Coordination Services are:

- Patient centered management and support services provided by physicians, other qualified health care professionals (QHP), and clinical staff.
- Provided to an individual residing in a home or in a domiciliary, rest home, or assisted living facility.
- A care plan directed by a physician or QHP and typically implemented by clinical staff.
- Services that address the coordination of care by multiple disciplines and community service agencies.

Complex Chronic Care Coordination Services (CCCC)

- The reporting individual provides or oversees the management and/or coordination of services, as needed, for:
  - All medical conditions
  - Psychosocial needs
  - Activities of daily living

Complex Chronic Care Coordination Services (CCCC)

- Patients requiring CCCC may be identified by:
  - Algorithms that utilize reported conditions and services (eg, predictive modeling risk score or repeat admissions or emergency department use)

  OR

  - Clinical judgment

Complex Chronic Care Coordination Services (CCCC)

- CCCC Patients:
  - Typically have 1 or more chronic continuous or episodic health conditions
  - Commonly require the coordination of a number of specialties and services.
  - May have medical and psychiatric behavioral co-morbidities complicating their care.
  - May have social support weaknesses or access to care difficulties.

Complex Chronic Care Coordination Services

- Codes 99487-99489:
  - Are reported **once** per calendar month
  - Include all non-face-to-face CCCC services
  - Include none or 1 face-to-face office or other outpatient, home, or domiciliary visit
  - May only be reported by the single physician or other QHP who assumes the care coordination role with a particular patient for the calendar month.

Complex Chronic Care Coordination Services (CCCC)

- **99487** Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month
- **99488** first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month

Complex Chronic Care Coordination Services

+●**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)

Complex Chronic Care Coordination Services

- CMS currently considering the CCCC services as **bundled** services.
  - Bundled into the services to which they are incident to and are not separately payable.
- CMS will consider payment of the complex care coordination codes developed by the AMA in future rulemaking.
- RUC recommendations are published as requested so others (health plans) could report while CMS considers
  - 99487 RUC recommended work RVU = 1.00
  - 99488 RUC recommended work RVU = 2.50
  - 99489 RUC recommended work RVU = 0.50

Complex Chronic Care Coordination Services

- Two coding Tips have been added to further instruct on the use of these codes.
- Unlike other coding tips throughout the CPT code set, these coding tips are not found in the guidelines.

Complex Chronic Care Coordination Services

Coding Tip

Time of care coordination with the emergency department is reportable using 99487-99489, but time while the patient is inpatient or admitted as observation is not.

Complex Chronic Care Coordination Services

Coding Tip

If the physician personally performs the clinical staff activities, his or her time may be counted toward the required clinical staff time to meet the elements of the code.

Complex Chronic Care Coordination Services

- **What if additional E/M services are provided during the month?**

  Additional E/M services beyond the first visit may be reported separately by the same physician or other QHP during the same calendar month.

- **What if care coordination resumes after a discharge during a new month?**

  If care coordination resumes during a new month, start a new period or report transitional care management services (99495, 99496) as appropriate.

Complex Chronic Care Coordination Services (CCCC)

- The reporting individual provides or oversees the management and/or coordination of services, as needed, by providing first contact and continuous access for:
  - All medical conditions
  - Psychosocial needs
  - Activities of daily living

Transitional Care Management Services (TCM)

The transition in care is **from**:

- an inpatient hospital setting
- partial hospital
- observation status in a hospital
- skilled nursing facility/nursing facility

To the patient's community setting:

- home
- domiciliary
- rest home
- or assisted living

Transitional Care Management Services (TCM)

- CPT TCM are services for an **established patient** whose medical and/or psychosocial problems require **moderate or high complexity medical decision making** during **transitions** in care.
- TCM services address any needed coordination of care performed by multiple disciplines and community service agencies.

Transitional Care Management Services (TCM)

- Codes 99495, 99496 require:
  - A **face-to-face visit** within the specified time frames
  - **Interactive contact** with the patient or caregiver within 2 business days of discharge and may be direct (face-to-face), telephonic, or by electronic means.
  - **Medication reconciliation and management** no later than the date of the face-to-face visit

Transitional Care Management Services (TCM)

- Codes 99495, 99496:
  - Are reported **once** per patient within 30 days of discharge
  - Are selected based on **medical decision making** and the **date of the first face-to-face visit**
  - May only be reported by one individual

Transitional Care Management Services (TCM)

- **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
- **work RVU = 2.11** and 40 minutes intra-service time

Transitional Care Management Services

- **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 high complexity during the service period
- Face-to-face visit, within **7** calendar days of discharge
- **work RVU = 3.05**
  - Adjusted the intra-service time from RUC recommended 60 minutes to **50 minutes**
  - Adjusted the clinical labor time in the direct practice expense inputs from 60 minutes to **70 minutes.**

Transitional Care Management Services

- CMS **accepted** the CPT TCM codes and RUC work RVU recommendations instead of the proposed G code for post-discharge transitional care management

Transitional Care Management Services

- **CMS Modifications:**
- CMS indicated they will modify the prefatory instructions to allow physicians to bill these codes for **new** patients, not only established patients as specified in CPT.
- CMS clarifies post-discharge service period in prefatory language
  - The physician who reports a global procedure should not be permitted to also report the TCM service.
  - "The same individual should not report transitional care management services provided in the post-operative period **for a service with a global period**."

Transitional Care Management Services

- **CMS Modifications:**
- CMS indicated the same physician may bill the discharge day management code for this patient and the TCM code for this patient
  - CMS is concerned about overlap and will monitor

Transitional Care Management Services

- **CMS Modifications:**
- CMS indicated that the same physician can not bill the discharge day management code and the TCM included **E/M visit** on the same day.
  - The E/M visit **is included** in the TCM code, one assumes CMS will monitor when the E/M visit occurred via auditing documentation
- CMS states “We wish to avoid any implication that the E/M services furnished on the day of discharge as part of the discharge day management service could be considered to meet the requirement for the TCM service that the physician or nonphysician practitioner must conduct an E/M service within 7 or 14 days of discharge.”

Transitional Care Management Services

Similar to the CCCC codes:

- Two coding Tips have been added to further instruct on the use of these codes.

- Unlike other coding tips throughout the CPT code set, these coding tips are not found in the guidelines.

Transitional Care Management Services

Coding Tip

If another individual provides TCM services within the postoperative period of a surgical package, modifier 54 is not required.

Transitional Care Management Services

Coding Tip

The required contact with the patient or caregiver, as appropriate, may be by the physician or qualified health care professional or clinical staff. Within two business days of discharge is Monday through Friday except holidays without respect to normal practice hours or date of notification of discharge. The contact must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care. If two or more separate attempts are made in a timely manner, but are unsuccessful and other transitional care management criteria are met, the service may be reported.

CCCC and TCM

- An exclusionary parenthetical note follows the CCCC and TCM codes precluding their use with several codes in both the E/M and Medicine sections.

- These excluded codes are also listed in the guidelines for CCCC and TCM.

CCCC and TCM

For example:

99366 Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional

►(Do not report 99366 during the same month with 99487-99489)◄

►(Do not report 99366 when performed during the service time of codes 99495 or 99496)◄

CCCC and TCM

- The CCCC and TCM codes include:
  - Care Plan Oversight Services
  - Prolonged Services Without Direct Patient Contact
  - Anticoagulant Management
  - Medical Team Conferences
  - Education and Training

CCCC and TCM

- The CCCC and TCM codes include:
  - Telephone Services
  - End Stage Renal Disease Services
  - On-Line Medical Evaluation
  - Preparation of Special Reports
  - Analysis of Data
  - Medication Therapy Management
  - TCM (when reporting CCCC)
  - CCCC (when reporting TCM)

CCCC and TCM

- Parenthetical notes have been added following many of these E/M and Medicine section codes excluding the CCCC and TCM codes from being reported in conjunction with these services.

Observation or Inpatient Care Services (Including Admission and Discharge Services)

- Typical times have been added to codes 99234-99236.

- RUC surveys were used to obtain the data of typical times used to perform these services.

Pediatric Critical Care Patient Transport

Two codes 99485 and 99486 have been established to report non-face-to-face physician supervision of interfacility pediatric critical care transport, 24 months of age or younger.

Pediatric Critical Care Patient Transport

#• **99485** Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 months of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report; first 30 minutes

- CMS indicated this service is **bundled** and not separately payable under Medicare
- RUC recommended work RVU = 1.50

Pediatric Critical Care Patient Transport

#💻• **99486** each additional 30 minutes (List separately in addition to code for primary procedure)

► (Use 99486 in conjunction with 99485) ◄

- CMS indicated this service is **bundled** and not separately payable under Medicare
- RUC recommended work RVU = 1.30

Pediatric Critical Care Patient Transport

- ► (For physician direction of emergency medical systems supervision for a pediatric patient older than 24 months of age, or at any age if not critically ill or injured, use 99288) ◄
- ► (Do not report 99485, 99486 with any other services reported by the control physician for the same period) ◄
- ► (Do not report 99485, 99486 in conjunction with 99466, 99467 when performed by the same physician) ◄

Inpatient Neonatal and Pediatric Critical Care

Guideline revisions only including:

- Codes 99471-99476 are used for a critically ill infant or young child from 29 days of postnatal age through **less than 6 years of age.**
- Services for critically ill or critically injured child **6 years of age or older** would be reported with critical care codes 99291, 99292

Inpatient Neonatal and Pediatric Critical Care

- Revisions to guidelines to clarify reporting of services when a neonate or infant becomes critically ill and the patient is transferred to a critical care level of care provided by a different individual in a different group.
- The reporting for the **transferring** and **receiving** individual is as follows:

Inpatient Neonatal and Pediatric Critical Care

- The **transferring** individual reports **one** of the following depending on the service performed:
  - Time-based Critical Care (99291, 99292)
  - Intensive care services (99477-99480)
  - Hospital care services (99221-99233)
  - Normal newborn service (99460, 99461, 99462)

Inpatient Neonatal and Pediatric Critical Care

- The **receiving** individual reports initial or subsequent inpatient neonatal or pediatric care 99468-99476, as appropriate based upon the patient's age and whether this is the first or subsequent admission to the critical care unit for the hospital stay.

Inpatient Neonatal and Pediatric Critical Care

- Further guideline revisions for the same patient on the same day:
  - Time based critical care services (99291, 99292) are not reportable by the same or different individual within the same group when neonatal or pediatric critical care services 99468-99476 are reported.

Initial and Continuing Intensive Care Services

- Guideline revisions only including:

  Codes 99464 or 99465 may be reported in addition to the initial hospital care code 99477 when the physician or other qualified health care professional is present for the delivery (99464) or resuscitation (99465) is required.

Initial and Continuing Intensive Care Services

- Revisions to guidelines to clarify reporting of services when a neonate or infant becomes critically ill on a day when initial or subsequent intensive care services (99477-99480) have been reported by **one** individual and the patient is transferred to a critical care level of care provided by a **different** individual from a **different** group, as follows:

Initial and Continuing Intensive Care Services

- The **transferring** individual reports **one** of the following depending on the service performed:
  - Time-based Critical Care (99291, 99292)
  - Intensive care services (99477-99480)

Initial and Continuing Intensive Care Services

- The **receiving** individual reports initial or subsequent inpatient neonatal or pediatric care 99468-99476 based upon the patient's age and whether this is the first or subsequent admission to critical care for the same hospital stay.

Initial and Continuing Intensive Care Services

- Further guideline revisions clarify reporting of services when a neonate or infant becomes critically ill on a day when 99477-99480 have been performed by the **same** individual or group:
- Report only initial or subsequent inpatient neonatal or pediatric critical care 99468-99476 depending on the patient's age and first or subsequent admission to critical care for the same hospital stay.