CPT, Transitions of Care, and Other New Services

Robert Carr, M.D.
CPT Advisor, American Academy of Family Physicians
Financial Disclosure Statement and Statement of Unapproved/Investigational Use

I, Robert Carr, DO NOT have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.

I, Robert Carr, DO NOT anticipate discussing the unapproved/investigative use of a commercial product/device during this activity or presentation.
Goals

• Provide a brief overview of the CPT/RUC process
• Discuss development and utilization of Transitional Care Management codes
  – Transition of Care Codes
• As time permits:
  – Discuss Chronic Care Management
  – Other CPT Changes; Future Directions
Steps to a code

CPT  Current Procedural Technology

ONGOING
Applications submitted by any member of the public throughout the year

FEBRUARY
CPT Editorial Panel considers the applications and develops CPT codes

AUGUST
Release of new CPT codes

NOVEMBER 1
CMS announces new Medicare payment rates

MARCH
Specialty societies collect data for new CPT codes

APRIL
RUC considers specialty data and recommendations

JANUARY 1
CPT codes and new Medicare payment rates implemented

RUC  The Relative Value Scale Update Committee

MAY
RUC submits recommendations to CMS
RUC Cycle

CPT Editorial Panel → Level of Interest → Survey → Specialty RVS Committee → The RUC → CMS
RVU Components

- Physician Work (wRVU)
- Practice Expense (PE)
- Professional Liability Insurance (PLI)
- Geographic Practice Cost Index (GPCI)
- Conversion Factor ($35.9335 for 2015)

<table>
<thead>
<tr>
<th>Locality</th>
<th>State/County</th>
<th>Work RVU</th>
<th>PE RVU</th>
<th>RVU</th>
<th>MP RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Connecticut</td>
<td>1.024</td>
<td>1.121</td>
<td></td>
<td>1.232</td>
</tr>
</tbody>
</table>
Example - 99214

• wRVU x GPCI = 1.5 x 1.024 = 1.536

• PE x GPCI = 1.43 x 1.121 = 1.603

• PLI x GPCI = 0.1 x 1.232 = 0.123


3.262

RVU x Conversion Factor = Payment

3.262 x $35.9335 = $117.22
Potentially Misvalued Services

• Periodic Screening of CPT by CMS and RUC:
  – Rapid Growth
  – Change in Practice Expense (e.g. site of service)
  – New Technology
  – Codes Commonly Billed Together
  – High Volume
  – Change in Performing Specialty
  – Bundled Services
Importance of Identifying Misvalued Services

• $100 billion annual Medicare payments
• May distort incentives to perform services
• May affect MD decisions to enter fields that perform undervalued services
• Budget neutrality
CMS Goals (2011 for 2012 Final Rule):

- Incentivize Care Coordination
- Improve Health Care Delivery to Patients with Chronic Diseases
- Improve Payments to Primary Care

Requested RUC to review E/M to ensure appropriate valuation for care coordination
Chronic Care Coordination Workgroup

- Declined to re-review all of E&M
- Developed Chronic Care Coordination Workgroup (C3W)
-Requested that CMS consider paying for CC services with existing codes
- Developed new codes for:
  - Transitional Care Management
  - Chronic Care Management
CPT Category I Codes for Non Face-to-Face E/M Services

99441 **Telephone evaluation and management service** by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99444 **Online evaluation and management service** provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network

99446 **Interprofessional telephone/Internet assessment and management service** provided by a consultative physician including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
Transitional Care Management (TCM) Services

• Follows discharge from inpatient hospital setting:
  – Includes ACH, observation, rehab hospital, SNF

• To community setting
  – Includes home, rest home or assisted living
TCM Services

• Begin on date of discharge
• Continue for next 29 days
• Includes:
  – Initial patient contact within 2 business days
  – One face-to-face visit
  – Non-face-to-face services performed by physician and/or licensed clinical staff under his/her direction
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 **high complexity** during the service period
- Face-to-face visit, **within 7 calendar days** of discharge
Non-FTF Services (Physicians)

- obtaining and reviewing the discharge information (eg, discharge summary, as available, or continuity of care documents);
- reviewing need for or follow-up on pending diagnostic tests and treatments;
- interaction with other qualified health care professionals who will assume or reassume care of the patient’s system-specific problems;
- education of patient, family, guardian, and/or caregiver;
- establishment or reestablishment of referrals and arranging for needed community resources;
- assistance in scheduling any required follow-up with community providers and services.
Non-FTF Services (Staff)

- communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care,
- communication with home health agencies and other community services utilized by the patient,
- patient and/or family/caretaker education to support self-management, independent living, and activities of daily living,
- assessment and support for treatment regimen adherence and medication management,
- identification of available community and health resources,
- facilitating access to care and services needed by the patient and/or family.
Initial Patient Contact

• **Within 2 business days** of discharge
  – Monday through Friday except holidays
  – Irrespective of date of notification
• By physician **or clinical staff**
  – Interactive – addressing status and needs
  – Not just scheduling follow-up
• Two or more separate attempts
## Complexity of Medical Decision Making

<table>
<thead>
<tr>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Complications and/or Morbidity or Mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>minimal</td>
<td>minimal or none</td>
<td>minimal</td>
<td>straightforward</td>
</tr>
<tr>
<td>limited</td>
<td>limited</td>
<td>low</td>
<td>low complexity</td>
</tr>
<tr>
<td>multiple</td>
<td>moderate</td>
<td>moderate</td>
<td>moderate complexity</td>
</tr>
<tr>
<td>extensive</td>
<td>extensive</td>
<td>high</td>
<td>high complexity</td>
</tr>
</tbody>
</table>
99495 or 99496??

<table>
<thead>
<tr>
<th>Type of Medical Decision Making</th>
<th>Face-to-face visit within 7 days</th>
<th>Face to face visit within 8 to 14 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate Complexity</td>
<td>99495</td>
<td>99495</td>
</tr>
<tr>
<td>High Complexity</td>
<td>99496</td>
<td>99495</td>
</tr>
</tbody>
</table>
Documentation
Initial Patient Contact

TCM Phone Screening

TCM Pre-Visit Planning

TCM Phone Screening WCMG:

- Telephone Contact: 1st attempt.
- Communication regarding aspects of care with patient.
- Communication with Home Health Agencies/Community Services: yes.
- Assessment and support of treatment regimen adherence: CHF—Weigh yourself every day on the same scale and write down your weight each day. Call care coordinator if weight increases by 2 pounds overnight or 3-5 pounds in one week. Call care coordinator with symptoms of worsening heart failure such as increased shortness of breath, waking up feeling short of breath, increased ankle swelling, decreased exercise tolerance, excessive and persistent fatigue and/or weight gain as stated. Your may not be back to your normal level of activity. Pace yourself so you do not become overly fatigued. Make healthy food choices such as low salt, low fat meals or as directed by your doctor.
- Medication reconciliation completed with patient: There was a discrepancy regarding the dosage of furosemide. This was discussed with Dr. Carr and clarified for patient to be 40 mg/day. He is also running low on lisinopril and a refill for this was sent to the pharmacy.
- Identification of available Community and health resources: yes. He is interested in meals on wheels, and contact information was provided.
- Facilitating access to care and services: yes. Follow-up appointments were made with Dr. Carr and Dr. Keller (cardiology).
- Other: Contacted VNA nurse (Kimberly) and discussed collaboration and treatment plan.

Signatures
Initial Visit

Discharge Information Reviewed:
- Discharge Summary
- W-10
- Other ___

Reviewed need for, or follow-up on, pending diagnostic tests and treatments:
- Yes
- Not indicated/needed

Communication with other Physicians/Providers:
- Yes
- Not indicated/Needed

Education Provided:
- See “Counseling” below

Referrals +/or Community Resources:
- See Plan Below
- Not indicated/Needed

Assistance in scheduling any necessary follow-ups:
- Yes- see below
- Not indicated/Needed
Subsequent Care

• TCM includes all non-FTF services for 30 days

• During same month, can’t report:

  – *Care plan oversight services, prolonged services without direct patient contact, anticoagulant management, medical team conferences, education and training, telephone services, ESRD services, online medical education services, preparation of special reports, analysis of data, complex care coordination, medication therapy management services*

• **CAN** report additional **FTF** services when indicated.
Billing Tips

• Can only billed by one provider per episode
• Can only be billed once within 30 days
• If FTF visit within 2 business days, this also meets requirement for initial patient contact
• Discharge services may not constitute the required FTF visit
## Payment Comparison

<table>
<thead>
<tr>
<th>wRVU</th>
<th>PE RVU</th>
<th>PLI RVU</th>
<th>Total RVU</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td>1.50</td>
<td>1.43</td>
<td>0.10</td>
<td>3.03</td>
</tr>
<tr>
<td>99495</td>
<td>2.11</td>
<td>2.38</td>
<td>0.14</td>
<td>4.63</td>
</tr>
<tr>
<td>99215</td>
<td>2.11</td>
<td>1.82</td>
<td>0.16</td>
<td>4.09</td>
</tr>
<tr>
<td>99496</td>
<td>3.05</td>
<td>3.26</td>
<td>0.19</td>
<td>6.50</td>
</tr>
</tbody>
</table>
Primary Care Only?

• Intended primarily for use by primary care, but not strictly limited

• Must include provision or oversight

  “for all medical conditions, psychosocial needs and activity of daily living support by providing first contact and continuous access.”
Summary

• Transitions from inpatient to outpatient setting
• First contact within 2 business days
• MDM at least moderate complexity
• FTF visit within 7-14 days
• Includes all non-FTF services for 30-day period
Transitional Care Management Services: New Codes, New Requirements

Two new codes will help you get paid for managing a patient’s transition from the inpatient to outpatient setting, but they come with new expectations.

Jacqueline Bloink, MBA, CHC, CPC-I, and Kenneth G. Adler, MD, MMM

On Jan. 1, 2013, the much anticipated transitional care management (TCM) codes arrived. These codes can be found in the evaluation and management (E/M) section of the 2013 CPT manual. They have potential benefits not just for you, the physician, but also for your patients and your local hospitals.

Transitional care management addresses that period of handoff between an acute care setting and the outpatient setting. Commonly the patient has just experienced a medical crisis, had a change in therapy, or received one or more new diagnoses and is now expected to follow-up with his or her primary care physician, as well as previous or new specialists. The risk for medical error and readmission during this period is high, especially among older patients. The 30-day readmission rate for Medicare patients with primarily medical admissions was 16 percent in 2010. Many of these readmissions are felt to be preventable with better primary care follow-up after discharge, which is how the TCM codes were introduced to promote.

Seeing a patient through this transition is often time-consuming. The new codes recognize the extra work with higher reimbursement than the usual E/M codes, but they come with new expectations as well. Your office is

About the Authors
Jacqueline Bloink is director of compliance at Arizona Community Physicians, a physician-owned, primary care medical group in Tucson, Ariz., and is a coding and compliance consultant. Dr. Adler is a practicing family physician, a medical director for Arizona Community Physicians, and medical editor for Family Practice Management. Author disclosures: no relevant financial affiliation disclosed.

12 | FAMILY PRACTICE MANAGEMENT | www.aafp.org/fpm | May/June 2013
Questions
Chronic Care Management Services

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.

$46.41
CCM Resources

AAFP

• “Chronic Care Management and Other New CPT Codes, “FPM, January/February 2015. (http://www.aafp.org/ccm)

• “Answers to Your Questions About Chronic Care Management,” FPM, May/June 2015. (http://www.aafp.org/ccm)

CMS

• Chronic Care Management Services (Centers for Medicare & Medicaid Services)

• Frequently Asked Questions about Billing Medicare for Chronic Care Management Services (Centers for Medicare & Medicaid Services)
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf
Advance Care Planning

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 care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

- CPT Changes: An Insider’s View 2015
- CPT Assistant Dec 14:11

99498  each additional 30 minutes (List separately in addition to code for primary procedure)
Prolonged Clinical Staff Service

99415  
Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)

99416  
each additional 30 minutes (List separately in addition to code for prolonged service)
Categories of Telehealth Services

**Codes to describe existing services using remote capabilities**
- Telehealth E/M services (new patient/problem visits, follow up visits, consultations)
- Teleradiology
- Telepathology

**Remote monitoring services (synchronous, asynchronous)**
- Device monitoring
- Patient status monitoring (e.g., blood pressure, HR, weight, glucose, pulmonary artery pressure)
Emerging Issues Workgroup

• Population Health/Registry Management
• Dementia Management
• Inter-Specialty Care Coordination
• Valuation of PCMH
• Cognitive Work
• Social Determinants of Health
• Bundled Payments
Questions