New Chronic Care Management Coding: Proposed CMS Coding Changes for 2017

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This article is part of a series devoted to hypertension and diabetes in Ohio and the prevalence of these chronic conditions. It addresses changes in coding for Chronic Care Management and Transitional Care Management that CMS is proposing for the 2017 reporting year.

Let me guess: your practice looked at starting a Chronic Care Management (CCM) program. You thought it sounded like it might help with your diabetic patients and those with heart disease and COPD. You even went so far as to review all the technical requirements for starting one. But after you dug in, everyone in the office just rolled their eyes and said "Good idea; hard to execute." Does that sum up your practice's approach to CCM?

> *Well, look again. CMS heard about you and everyone else who hesitated to jump in to set up this brand new program and went back to the drawing board to develop a more user-friendly program.*

We all know CMS is a big proponent of patient-centered care models. The cost of health care in the United States has climbed to $1 trillion. In 2014, almost 30 percent of that cost was attributed to hospital care.[1] Approximately 15 percent of all hospital patients ended up being readmitted during 2014 according to CMS; so any program that can find new and creative ways to keep these hospital admission and readmission rates down receives a lot of attention by CMS. That is why CMS is putting so many eggs in the basket of Chronic Care Management. They can see the benefits and have heard from both practices and patients how great the program can be. But they need to keep tweaking the model to make it easier for practices to understand the requirements and implement it, *and* make it financially worth the practice's efforts to establish such a program. Thus, CMS issued proposed changes to CCM for 2017 in the Physician Fee Schedule regulation.[2]

What Did CCM Look Like Before?

In 2013, CMS began its push to control hospital rates by having ambulatory practices work more closely with the patients once they were discharged from the hospital. This program, called Transitional Care Management (TCM), rewards practices that contact the patient within two days of discharge and schedule an office visit within either seven or 14 days, depending on the severity of the patient's condition. Practices can bill for increased reimbursement for the treating

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html
[2] CMS-1654-P: Physician Fee Schedule for 2017, Federal Register, July 15, 2016

provider using either CPT 99495 (for moderate complexity and seen within 14 days of discharge) or CPT 99496 (for high complexity and seen within seven days of discharge).

In 2015, CMS added CCM, which reimburses practices that devote resources to working with patients outside the office setting. The concept of CCM is that the practice can better help the patient if they work with them on any type of issue that affects their ability to function well with chronic conditions. The original billing code, CPT 99490, allows practices to bill for administrative or clinical staff who work with the patient through both phone or email contacts between visits. These individuals can also include the time they put into contacting other medical practices, social service agencies or clinical sites to help coordinate the patient's care.

CPT Code	Description
99495	**Transitional care management:** condition of at least moderate complexity; patient contacted within 2 days; seen within 14 days.
99496	**Transitional care management:** condition of high complexity; patient contacted within 2 days; seen within 7 days.
99490	**Chronic care management** for clinical or administrative personnel that manage a patient's care outside normal office appointments.

Adoption of CCM

Out of 55 million Medicare beneficiaries, only 275,000 were enrolled in CCM programs in 2015. In addition, only 26 percent of more than 300 hospitals, independent practices *and* multi-specialty groups surveyed had established a CCM program. Why was there so little adoption of such a beneficial program?

According to the National Chronic Care Management Survey, conducted in 2015 and reported by *Healthcare IT News* (November 2, 2015), the problem is three-fold:

1. Insufficient reimbursement for the amount of time required;
2. Limited awareness of the program; and
3. Concerns about how to meet all the specific billing requirements.

CMS reacted quickly and proposed numerous changes through its Physician Fee Schedule proposed rule for 2017. CMS wanted to be as responsive as possible to the concerns around the adoption of CCM so that more practices would adopt the program and use it to manage their patients with chronic conditions.

The following are some of the proposed changes for 2017:

Requirements in 2016 to Bill for a CCM Program	*Proposed Changes for 2017*
Patient must have at least two chronic conditions	No change
Must spend 20 minutes/month performing chronic care management outside an office visit to bill for CPT 99490	Still requires 20 minutes/month but now provides new codes for extended time above 60 minutes
Must have comprehensive E/M visit, annual wellness visit or initial preventive physical exam and written patient consent for the program	Initial visit can be a routine office visit for a current patient (not a Level 4 or Level 5 E/M visit); consent does not need to be signed; no requirement of consent for electronic transmission of protected health information
Structured data must be available in the EHR system to populate care plan, follow-up care	Structured data and care plan must be available in the EHR
Access to record and care plan 24/7	Care plan does not need to be available remotely on a 24/7 basis (but on a timely basis)
Continuity of care by practitioner or member of the team	Continuity of care by any team member
Assessment of needs and development of care plan within EHR. A written copy must be shared with patient as well as available to other providers.	Care plan must be developed; community engagement does not need to be documented in any particular format
Electronic transitions of care or referrals; coordination with community service providers	Electronic transmission to other providers can be by fax

What Are the New Codes and When Can You Use Them?

As part of their overhaul of CCM, CMS is proposing several new codes to address some of the concerns practices have about the program. The new codes allow for billing for increased time spent on managing patients with chronic conditions, both for the treating provider and the clinician or staff member who is working with the patient outside of normal office visits.

In addition to the increased time that CMS will allow practices to bill, it is also proposing new codes for managing patients who have chronic behavioral health conditions or cognitive impairment. CMS is working hard to restructure the CCM program to incorporate patients with more significant needs.

Here are the new codes being proposed by CMS:

CPT Code	Description
99490	Non-face-to-face CCM management support for ≥ 20 minutes/month by clinical staff
99487	60 minutes/month of clinical staff time for complex chronic care management
99489	Each additional 30 minutes/month of clinical staff time for complex chronic care management beyond that billed under *99487*
GPPP7	Charges for additional work of the treating practitioner in personally performing a face-to-face assessment and/or CCM care planning (either face-to-face or non-face-to-face) in the following instances: • Initiating visit is a less complex visit, e.g., a Level 2 E/M visit (problem-focused visit for established patient) or Level 3 E/M visit (expanded problem-focused visit with a review of systems) • Initiating visit is a higher level visit, but practitioner's time exceeds normal effort described by the visit code. • Initiating visit addresses problems unrelated to CCM, but subsequent work is done on care plan, etc.
GPPPX	≥ 20 minutes/month of clinical staff time for care management services for behavioral health conditions
GPPP6	Assessment and care planning by treating practitioner for patients with cognitive impairment; can be billed on same day as CCM staff codes or TCM (different requirements)
99358	Non-face-to-face prolonged evaluation and management service before and/or after direct patient care, 1st hour
99359	Non-face-to-face prolonged evaluation and management service before and/or after direct patient care, each additional 30 minutes

CMS and other payers are building this model of care into new payment reforms. ***However, if your practice is receiving increased reimbursement through a Per Member Per Month (PMPM) additional payment for the management of that patient, then you will most likely not be able to bill under the CCM codes.*** If you are in a new payment model, especially some of those beginning in 2017, check with the payer to see if they will allow you to bill separately for CCM services.

IMPORTANT

These codes are not final until the 2017 Physician Fee Schedule rule is finalized later this year.

This article is supported by Cooperative Agreements #5NU58DP005508 and #6NU58DP004826, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.