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Michigan Institute for Care Management & Transformation

MICMT Complex Care Management Course

Sustainability and Billing

Objectives

Relate care manager activities to the tracking and billing codes

Relate caseload and care management activity billing to sustainability

Demonstrate use of billing codes in daily care management work

Key Topics

Describe the payment and value model for care management programs

Review the sustainability model for care management

Describe patient care situations and the corresponding billing codes

Payment and Value Model

The Value of Care Management: a Practice Perspective

- Value
  - Decreased cost and improved patient outcomes
- Success for the practice
  - Making it easier to take care of patients
  - Improving performance on payer quality / utilization programs *(i.e. earning incentive money and being financially sustainable)*

The Value of Care Management: a Payer Perspective

- Payer programs that fund care management use billing codes and outcomes to evaluate the success of care management programs.
  - Billing shows how much of the population we're able to reach
  - Outcomes show the impact of that outreach **(focus on A1c, BP, Inpatient Utilization, and ED Utilization)**

Good news: BCBSM, PH, SIM use the same codes

Face to face w/ patient	• G9001 - Initiation of Care Management (Comprehensive Assessment) • G9002 - Individual Face-to-Face Visit
Group Visits w/ patient	• 98961 - Education and training for patient self-management for 2–4 patients; 30 minutes • 98962 - Education and training for patient self-management for 5–8 patients; 30 minutes
Telephone w/ patient	• 98966 - Telephone assessment 5-10 minutes of medical discussion • 98967 - Telephone assessment 11-20 minutes of medical discussion • 98968 - Telephone assessment 21-30 minutes of medical discussion
Care Coordination on behalf of patient (not with patient or provider)	• 99487 - First 31 to 75 minutes of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month • 99489 - Each additional 30 minutes after initial 75 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. (An add-on code that should be reported in conjunction with 99487)
Provider engaging codes	• G9007 - Coordinated care fee, scheduled team conference • G9008 - Physician Coordinated Care Oversight Services (Enrollment Fee)
Advanced Care Planning	• S0257 - Counseling and discussion regarding advance directives or end of life care planning and decisions

For all BCBSM PDCM codes: Provider liability if patient does not have Provider Delivered Care Management Benefit (BCBSM)

G9001 – Comprehensive Assessment

- BCBSM
  - Individual, face to face (or video for commercial)
  - One per patient per day
- Priority Health
  - Individual, face to face
  - May be billed once annually for patients with ongoing care management
- The goal is to develop a plan of care that is based on how well the patient is able to steward their own care and the provider's care plan goals.
  - Patient self-management goals are an integral piece.

G9001

- The Comprehensive Assessment / G9001 is a face to face meeting that results in a care management plan that all care management team members and the patient will follow.

- The Care Management Plan consists of 2 main things:
    1. Patient-driven goals
    2. Follow up and support plan

G9002 – Face to Face Visit

- BCBSM (Commercial and Medicare Advantage): Quantity Billing
  - Individual, face to face or video
  - If the total cumulative time with the patient adds up to:
    - 1 to 45 minutes, report a quantity of one; 46 to 75 minutes, report a quantity of two;76 to 105 minutes, report a quantity of three;106 to 135 minutes, report a quantity of four

- Priority Health (Commercial, Medicare Advantage, Medicaid): No Quantity Billing
  - In person visit with patient, may include caregiver involvement
  - Used for treatment plan, self management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change

G9001 vs. G9002

- G9001 is used to develop the holistic care management plan that will be followed by you and the patient.

- G9002 is used to discuss specific aspects of a care plan either as part of the follow up steps within a developed care management plan or for the development of a focused care plan in the absence of a comprehensive care management plan.

** The G9001 doesn't have to be the first code billed on a patient.

98966, 98967,98968 -Phone Service Codes

Call with patient or care giver to discuss care issues, progress towards goals

- 98966 for 5-10 minutes
- 98967 for 11-20 minutes
- 98968 for 21-30 minutes

99487, 99489 – Care Coordination On Behalf of Patient, not with patient

- 99487 – First 31 to 75 minutes of clinical staff time directed by a licensed or unlicensed team member working on behalf of the patient with someone other than the patient or provider
  - Examples:
    - Coordinating DME for a patient
    - Reaching out to a resource to help support a SDOH need
- 99489 – Each additional 30 minutes after 75 minutes per calendar month

G9007 – Team Conference

- PCP and a care team member formally discuss a patient's care plan
- Can be billed once per day per patient regardless of time spent

G9008 – Physician Coordinated Care Oversight Services (Enrollment Fee)

- Physician delivered service
- BCBSM no ***quantity limit*** and can include the following F2F, Video or telephone. This does not include email exchange or EMR messaging
  - Communication with Paramedic, patient, other health care professionals not part of the care team
- Priority Health is a ***one time*** and can include the following F2F
  - Communication with patient and CM

Incentive Programs for Care Management:

BCBSM

- Value Based Reimbursement (i.e. increase on every E&M code and PDCM code)
  - Up to 161% available
  - In 2019:
    - 5% of this is VBR for the billing codes for having 2 touches on 3% of the population
    - 11% is for Quality and Outcomes, focusing on A1c (1.5%), BP(1.5%), IP utilization (6.5%), and ED utilization(1.5%)
    - PCMH Designation 15% through 8/31/20
- Fee For Service on all codes billed
  - **no patient co-pay / provider liability**

Priority Health

- Annual PMPM payment if outreach to up to 5% of the population has 2 billed codes (average $2.64 pmpm)
- Fee For Service on all codes billed
  - **no patient co-pay**

SIM

- $2.75 - $7.00 PMPM care management and care coordination payments on Medicaid patients, assuming the goal of 2.5% eligible patients with a 'billed' code is achieved (reduction by $0.15 if not achieved).
- Incentive payment opportunity in 2019

CPC+ also includes care management, but it isn't so specific in it's funding.

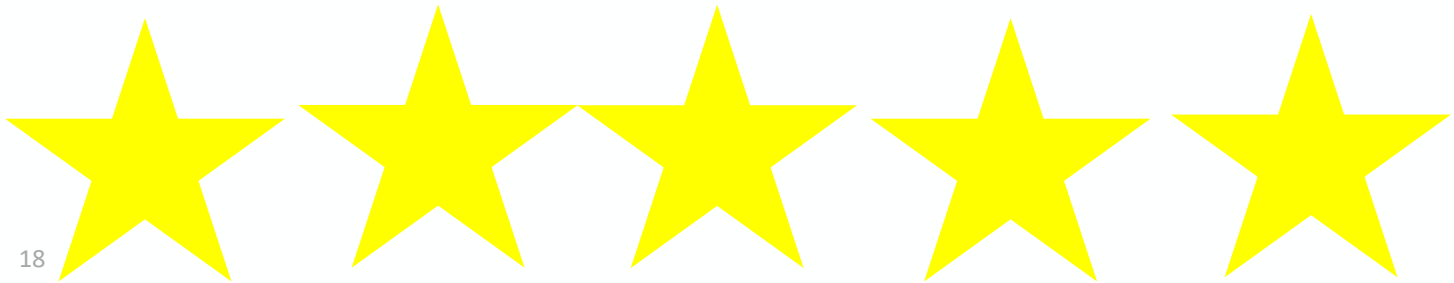
Activity / Billing Progress Reports

- Each Program sets benchmarks for number of patients receiving care management services at the practice level.

- Each program also sends a progress report to the PO; **work with your PO to devise a best strategy for tracking progress towards program goals**.
  - Priority Health sends through Filemart to PO Representatives on a monthly basis.
  - BCBSM sends through the EDDI mailbox on approximately a quarterly basis.
  - SIM program updates through the MDC reports on an approximately monthly basis.

Common Outcomes Goals

- ***Quality***
  - Controlled HgA1c
  - Controlled Blood Pressure
- ***Utilization***
  - decrease emergency department visits
  - decrease hospital admissions



Outcomes Goals – Be Part of the Strategy

- Each Care Manager should learn their PO's strategy and which of the core measures the PO is focusing on.
- Then, the Care Manager and office leadership should develop a plan for how they will also impact the selected metrics.

Sustainability Model

What is sustainability?

- Sustainability is how the care manager service in your office maintains itself financially…
  - i.e. it's how you pay for yourself!

How can you help make your service sustainable?

Program Financial Support

Identify which programs your office(s) are in that support care management:

- CMs help achieve program goals, and therefore can increase the program revenue.
- Each CM should track and make sure that the outreach levels dictated by the payer programs are achieved.
  - PO Leads can help provide reports that show progress.
  - Some office managers don't want to share the financial revenue. If that's the case, ask them to work with the PO lead to understand the program revenue coming to their office for care management work.

Billing Revenue

Work with the office manager / PO lead to identify a billing goal based on case mix in your office.

- It's important for everyone to start out with common expectations of a billing goal.
- What is an example of a billing goal?
  - Some start with a minimum of 8-10 billable codes / day or 40-50 billable codes / week. This includes face to faces, team conferences, etc.
- Some offices only allow their care managers to work with patients whose insurance covers the service. Others are more inclusive.

Is a minimum of 8-10 codes in a day feasible??

Many groups don't evaluate on a day to day basis. It's easier to look at a month or a week, as the patient load on a given day is variable.

Review the example to the right for a "day in the life" that shows how you might get up to 10 billable type activities per day or 50 per week.

Week-long review:

- Pre-work (before the week starts):
  - review schedule & identify potential patients based on payer, risk, diagnoses. Send those patients as a list to the provider.
- Scheduled weekly 15 minutes with Provider to review complex patients and face to face patients for that week (10 patients; 10 G9007 codes)*
- Target seeing 1-3 new patients per week and 3-4 existing patients in face to face visits per day
  - 1-3 G9001 codes
  - 15-20 G9002 codes
- Conduct follow up phone call visits; at least 4 phone calls per day
  - 20 phone calls / week (98966 -98968)

That sums to 46 - 53 codes per week.

***Patients must be engaged in care management first**

Billing Examples

Before we start… Activity 7

- The following series of examples are intended to show a couple of common situations for billing codes.
- They are NOT comprehensive.
- The 1st Thursday of every month is a BCBSM Monthly Billing Q&A session at noon (see reference guide for details, or www.micmrc.org/training/care-management-billing-resources)
- If you have questions on specific situations, please reach out to valuepartnerships@bcbsm.com

High Risk Patient

- Patient is flagged as high risk by a payer list.
- Care manager reviews the chart, recent screenings (SDOH, PHQ-9), problem list, medications, and utilization history.
- Care manager sees the patient in a face to face visit and evaluates the patient's current ability to steward their health, identifying strengths, weaknesses, opportunities, and barriers.
- Patient develops a SMART goal, and the care manager connects the patient with various resources that address identified barriers.
- Care manager discusses care plan with the provider. Provider agrees with the care plan.
- Patient and care manager agree on a follow up plan.
- Care manager documents in the chart and adds the appropriate billing codes.

Identify the billing code: G9007, G9001

Face to Face Visit and Follow Up Care Plan

A patient comes into the office to be evaluated by their PCP. After the evaluation the PCP introduces the patient to the care manager (CM).

- During the conversation with the patient the CM assesses that there is not a clear understanding about asthma management.
- CM conducts a medication review, teaches how to use peak flow and keep a log, provides an asthma action plan.
- CM and patient agree to follow up in one week via a phone visit.
- This initial visit with the patient was 60 minutes. PCP and patient agree with the care plan.

Identify the billing code: G9002, G9008

Note how this is different from the G9001!

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Coordination of Care

- Care manager contacts the home health agency to schedule in-home visits and conduct a safety assessment.
- In addition a call was made to the DME provider to arrange for delivery of home O2.
- Time spent coordinating care was 35 minutes.

Identify the billing code: 99487

Gaps in Care

- RN notices during chart review that several of the patients who are in his/her patient population have not received their cancer screenings, even though the RN and provider reminded them.
- RN shows the list to the Medical Assistant.
- Medical Assistant calls the patient to discuss gaps in care and facilitate closing the gaps.

Identify Billing Code: 98966

Interdisciplinary Team

- Patient with diagnosis of diabetes, COPD and HTN. Patient screens positive for SDOH – food insecurity, struggling to afford medications, lacks caregiver support.
- An interdisciplinary team conference was held with the Clinical Pharmacist, SW CM and PCP to modify the plan and discuss the initial plan of care with the team, which includes:

  - The SW CM schedules a virtual face to face visit with the patient regarding the lack of caregiver support and social isolation, which is linked with admissions.
  - The Clinical Pharmacist follows up on the ability to afford medications and the chronic diseases, conducting a comprehensive assessment of the patient.
  - Both SW CM and Clinical Pharmacist follow up with the team at their regular huddle.

Identify billing code: G9007, G9001, G9002

Advance Directives

- CM conducts a 20 minute in person* meeting with a patient regarding their advance directives.
- During the discussion information is given to the patient to review regarding advance directives.
- Discussion includes:
  - how the patient prefers to be treated
  - what the patient wishes others to know
- CM and patient agree to follow up via a phone call in 2 weeks.

Identify the billing code: S0257
* Note: this code allows for phone visit and meeting may be with the patient, care giver, or family member.

Reducing ED visits

- Proactive patient education to consider the PCMH practice first for acute healthcare needs, suggesting nearby urgent care, or ED for true emergency.

- Follow up each ED visit with a call to identify issues, coordinate follow up care, and encourage seeking care through the practice rather than the ED when appropriate. Often, this can be performed by a medical assistant.

- Medical assistants, operating under a protocol, may call patients, ask if the ED physician recommended follow up care, coordinate the needed care, transfer to clinician for issues requiring immediate medical assessment or guidance, encourage the patient to bring in all medications, etc.

Identify Billing code: 98966

Phone Service

CM speaks with a patient via the telephone.

- CM reviews the patient's asthma action plan and reviews the symptoms that indicate worsening symptoms and asthma exacerbation.
- Also reinforces when to call the office.
- In addition, CM asks the patient about interest in attending an asthma Group Visit. Patient indicates interest and CM provides the information regarding the asthma Group Visit.

CM and patient agree on follow up in one week via in person visit at the office.

This meeting takes 20 minutes.

Identify the billing code: 98967

Patient Visit – Face to Face

The patient returns to the office one week later to meet with CM:

- During the visit CM and patient discuss symptoms, medications, SMART goals.
- Patient states he/she has not needed to use the rescue inhaler and feels they now have a better understanding of how to care for his/her self. You again review the action plan and state you will follow up in one month.

Identify the billing code: G9002

G/CPT Billing Code Resources – Care Management Services

Billing resources – Michigan Care Management Resource Center website

- BCBSM - PDCM Billing online course, PDCM Billing Guidelines for Commercial and Medicare Advantage
- Priority Health
- State Innovation Model
- Centers for Medicare & Medicaid – Transitional Care Management, Chronic Care Management, Behavioral Health Integration

Additional Billing resources: https://micmrc.org/training/care-management-billing-resources

Appendix

Medicare Billing

- We are not able to advise you on Medicare billing practices due to nuances in financial structure.

- However, the following slides contain information regarding “incident to” billing, which your practice may want to explore further for Pharmacist billing.

Additional Medicare Resources

- Hospital-based Clinic – Pharmacist “incident to” billing
  - Medicare Benefit Policy Manual – Chapter 6, 20.5.2

- Office Based Clinic – 99211 billing
  - Medicare Claims Processing Manual – Chapter 12, 30.6.4

- “Incident to” billing information
  - Medicare Benefit Policy Manual – Chapter 15, 60.1 and 60.3

- “Incident to” Services – Documentation and Correct Billing

- CMS Chronic Care Management Services

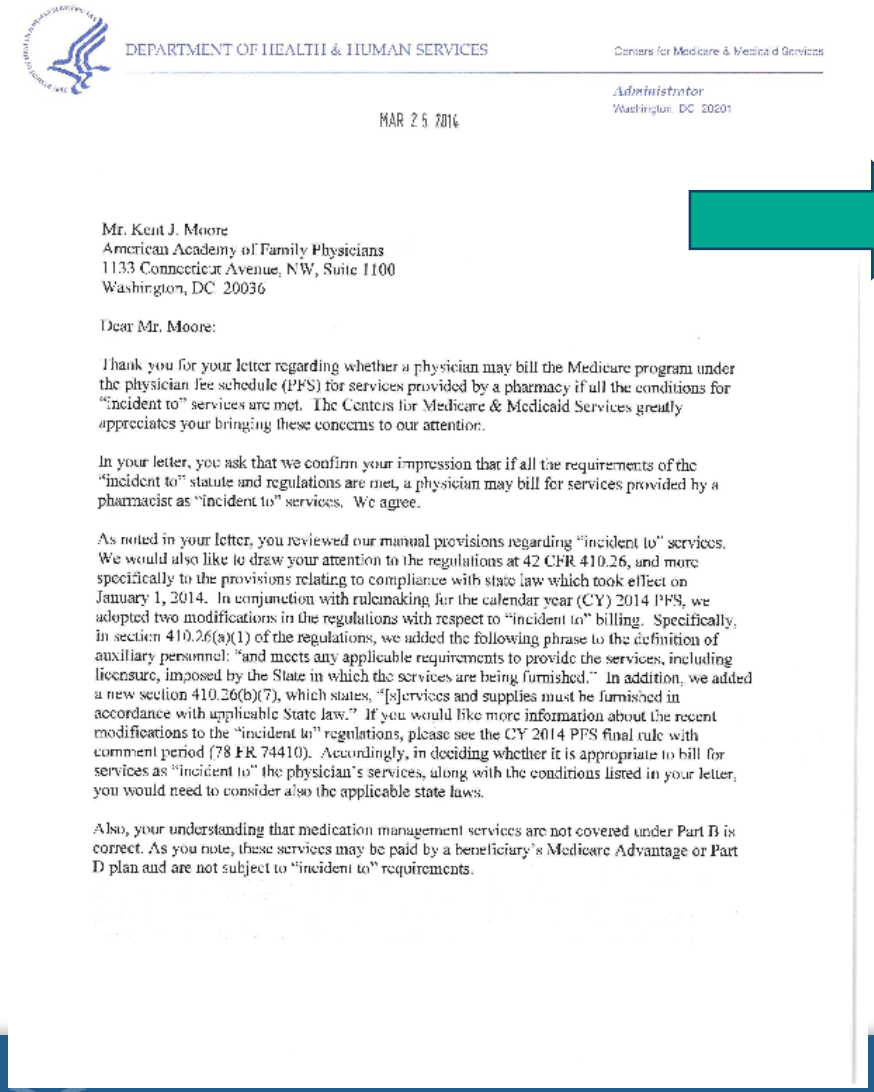
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- CMS Transitional Care Management Services

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

Note: See CCM course resource guide to access the pdf documents

“Incident to” Billing



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAR 25 2014

Mr. Kent J. Moore
American Academy of Family Physicians
1133 Connecticut Avenue, NW, Suite 1100
Washington, DC 20036

Dear Mr. Moore:

Thank you for your letter regarding whether a physician may bill the Medicare program under the physician fee schedule (PFS) for services provided by a pharmacy if all the conditions for "incident to" services are met. The Centers for Medicare & Medicaid Services greatly appreciates your bringing these concerns to our attention.

In your letter, you ask that we confirm your impression that if all the requirements of the "incident to" statute and regulations are met, a physician may bill for services provided by a pharmacist as "incident to" services. We agree.

As noted in your letter, you reviewed our manual provisions regarding "incident to" services. We would also like to draw your attention to the regulations at 42 CFR 410.26, and more specifically to the provisions relating to compliance with state law which took effect on January 1, 2014. In conjunction with rulemaking for the calendar year (CY) 2014 PFS, we adopted two modifications in the regulations with respect to "incident to" billing. Specifically, in section 410.26(a)(1) of the regulations, we added the following phrase to the definition of auxiliary personnel: "and meets any applicable requirements to provide the services, including licensure, imposed by the State in which the services are being furnished." In addition, we added a new section 410.26(b)(7), which states, "[s]ervices and supplies must be furnished in accordance with applicable State law." If you would like more information about the recent modifications to the "incident to" regulations, please see the CY 2014 PFS final rule with comment period (78 FR 74410). Accordingly, in deciding whether it is appropriate to bill for services as "incident to" the physician's services, along with the conditions listed in your letter, you would need to consider also the applicable state laws.

Also, your understanding that medication management services are not covered under Part B is correct. As you note, these services may be paid by a beneficiary's Medicare Advantage or Part D plan and are not subject to "incident to" requirements.

“In your letter, you ask that we confirm your impression that if all the requirements of the "incident to" statute and regulations are met, a physician may bill for services provided by a pharmacist as "incident to" services. We agree.”

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Medicare “incident to” Billing

https://petitions.whitehouse.gov/response/pharmacists-and-social-security-act

Official Centers for Medicare & Medicaid Services Response toRecognize pharmacists as health care providers! This response was published on January 17, 2014.

Pharmacists and the Social Security Act

By Jonathan Blum

Thank you for your petition on recognizing pharmacists as health care providers under the Social Security Act.

As you noted, pharmacists are not recognized in the Social Security Act as health care providers who are authorized to bill and receive payment for their services from Medicare. To do so would require a change to the statute by Congress.

But we recognize and value the trusted role that pharmacists play in the community, and their importance to patient care -- in particular to Medicare beneficiaries who need prescription medications.

The term "provider" is defined in Medicare regulations at 42 C.F.R, §400.202 and includes hospitals, skilled nursing facilities, and home health agencies. That term does not include pharmacists. Moreover, the Medicare law specifically authorizes the health care providers who can bill and receive payment from Medicare. For instance, section 1861(r) of the Social Security Act defines "physicians" under the Medicare program. This definition includes, with various restrictions and exceptions, doctors of medicine and osteopathy, doctors of dental surgery and dental medicine, doctors of podiatric medicine, doctors of optometry, and chiropractors. The statute also authorizes several specific non-physician practitioners including nurse practitioners, clinical nurse specialists, physician assistants, nurse midwives, clinical psychologists, and physical therapists to bill and receive payment from Medicare for their professional services that fall within their State scope of practice.

So while pharmacists are not recognized as "providers" who are authorized to bill and receive payment for their services from Medicare, they can receive payment for their services when furnished to Medicare beneficiaries in certain circumstances. For example, pharmacists can receive payment for furnishing services "incident to" the services of a physician or non-physician practitioner. The requirements under the "incident to" provision must be met, including the supervision requirements. The physician or non-physician practitioner who bills for the "incident to" services that the pharmacist furnished would receive payment from Medicare, and the pharmacist would receive payment from the physician or non-physician practitioner based on the agreement established by the parties involved.

Pharmacists can also be paid under Part D by Medicare prescription drug plans to dispense prescription drugs as well as to provide medication therapy management services to patients to identify problems and perform medication reconciliation.

Please visit CMS.gov for additional information.

Jonathan Blum is the Principal Deputy Administrator at the Centers for Medicare & Medicaid Services.