HEALTHCARE REGULATORY ROUND-UP - Episode #58

Care Management and Remote Patient Monitoring

October 11, 2023

Introductions

Martie Ross
mross@pyapc.com

pyapc.com
800.270.9629

Care Management

Chronic Care Management – Clinical Staff

- **CPT 99490** - Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or NPP, 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
- **CPT 99439** – Each additional 20 minutes (up to 2 units)

Chronic Care Management – Physician/NPP

- **CPT 99491** - Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of physician or other qualified healthcare professional time, 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
- **CPT 99437** – Each additional 30 minutes (up to 2 units)

Complex Chronic Care Management

- **CPT 99487** - Complex chronic care management services performed by clinical staff under general supervision of physician or NPP, first 60 minutes per calendar month,
  - Same requirements as CCM + patient's condition must require moderate or high complexity medical decision making
- **CPT 99489** – Each additional 30 minutes (up to 3 units)
- No CPT code (and no separate Medicare reimbursement) for complex CCM performed by physician/NPP
- Reimbursement for CPT 99490 + 2 units of CPT 99439 (60 minutes total) is greater than reimbursement for CPT 99487

Principal Care Management – Clinical Staff

- CPT 99426 -Care management services performed by clinical staff under general supervision of physician or NPP, first 30 minutes per calendar month, for one complex chronic condition that -
  - Is expected to last at least 3 months that places patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death
  - Requires development, monitoring, or revision of disease-specific care plan; frequent adjustments in the medication regimen; and/or management that is unusually complex due to comorbidities
  - Requires ongoing communication and care coordination between relevant practitioners furnishing care
- CPT 99427 – Each additional 30 minutes (up to 3 units)

Principal Care Management – Physician/NPP

- **CPT 99424** –Care management services personally provided by physician or NPP, first 30 minutes per calendar month, for one complex chronic condition that -
  - Is expected to last at least 3 months that places patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death
  - Requires development, monitoring, or revision of disease-specific care plan; frequent adjustments in the medication regimen; and/or management that is unusually complex due to comorbidities
  - Requires ongoing communication and care coordination between relevant practitioners furnishing care
- **CPT 99425** – Each additional 30 minutes (up to 3 units)

General Care Management – RHCs and FQHCs

- **HCPCS G0511** – 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by RHC or FQHC practitioner (physician or NPP) per calendar month
- Bill single unit per month, regardless of total time spent providing services

2021 Traditional Medicare Utilization

Service	# of Practitioners	# of Beneficiaries	# of Services
CPT 99490 (CCM – clinical staff)	25,195	886,895	4,476,813
CPT 99491 (CCM – physician/NPP)	2,942	61,448	163,543
CPT 99487 (Complex CCM)	8,023	115,043	280,198
HCPCS G0264 (predecessor to PCM CPT codes)	179	6,409	19,429

- 35.7 million traditional Medicare beneficiaries in 2021; two-thirds have two or more chronic conditions
  - Less than 5% of potentially eligible beneficiaries receiving CCM services
- Approximately 1 million physicians enrolled in Medicare, of which 360,000 are internal medicine/family practice
  - Approximately 10% of primary care physicians furnishing CCM services

https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners/medicare-physician-other-practitioners-by-geography-and-service

Care Management Reimbursement

Code	Descriptor	2023 MPFS Payment (Non-Facility)	2023 MPFS Payment (Facility)	2023 OPPS Payment
99490	**CCM**, clinical staff, initial 20 min	$62.69	$50.49	APC 5822 = $75.85
99439	**CCM**, clinical staff, +20 min	$47.44	$34.90	N/A
99491	**CCM**, physician/NPP, 30 min	$85.06	$75.57	N/A
99437	**CCM**, physician/NPP, +30 min	$59.98	$50.49	N/A
99487	**Complex CCM**, clinical staff, 60 min	$133.18	$90.82	APC 5823 = $145.70
99489	**Complex CCM**, clinical staff, +30 min	$70.49	$50.15	N/A
99424	**PCM**, physician/NPP, 30 min	$81.33	$73.54	N/A
99425	**PCM**, physician/NPP, +30 min	$58.29	$50.83	N/A
99426	**PCM**, clinical staff, 30 min	$61.34	$49.14	APC 5822 = $75.85
99427	**PCM,** clinical staff, +30 min	$47.44	$34.90	N/A
G0511	**Care mgt.**, RHC/FQHC	$77.24	N/A	N/A

Other Care Management Services

- Transitional care management – CPT 99495-96
- Behavioral health integration
  - Psychiatric Collaborative Care Model – CPT 99492–94, HCPCS G2214
  - General behavioral health integration – CPT 99484
- Chronic pain management (new in 2023) – HCPCS G3002-03
- Community health integration (proposed for 2024) – HCPCS GXXX1-X2
- Principal illness navigation (proposed for 2024) - GXXX3-X4

Billing Rules

1. Consent
2. Established patient
3. Practice capabilities
4. General supervision of clinical staff
5. Care plan
6. Qualifying care management services
7. Double dipping
8. Claim submission

1. Consent

- Must explain following to patient and secure consent
  - Nature of CCM services and how they are accessed
  - Only one provider can furnish CCM at a time
  - Beneficiary may stop CCM services at any time by revoking consent, effective at end of then-current calendar month
  - Beneficiary responsible for copayment/deductible
- Written/verbal consent documented in patient's medical record
- If beneficiary revokes consent (including signing up with new provider), cannot bill for CCM after then-current calendar month

2. Established Patient

- Initiating visit required if new patient or patient not seen within last year
  - Comprehensive E/M visit (Levels 2-5), transitional care management, annual wellness visit, or initial preventive physical exam
    - Must include discussion of CCM
    - Separately reimbursable
      - HCPCS G0506 – add-on code for assessment/care planning
    - May be performed via telehealth if reimbursable service
- Billing practitioner vs. referring practitioner
  - CCM billed under NPI of practitioner providing general supervision of clinical staff
  - Use of case management companies
  - Shared/centralized care management services

3. Practice Capabilities

- Use of certified EHR for specified purposes
  - Structured recording of patient demographic information, problem list, medications/medication allergies
  - Creation of structured summary care record
- Beneficiary access to care
  - Means for patient to access provider on 24/7 basis to address acute/urgent needs
  - Patient's ability to get successive routine appointments with member of care team
- Transitions of care
  - Follow-up after ER visit, provide transitional care management
  - Coordinate referrals and share information electronically with other clinicians
- Coordination of care
  - Coordinate with home and community-based clinical service providers to meet patient's psychosocial needs and functional deficits
  - Document such communications in patient's medical record

4. General Supervision of Clinical Staff

- Clinical staff (CPT definition)
  - "person who works under the supervision of a physician or [NPP] 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."
- Billing practitioner responsibilities
  - Provide oversight and direction for care management program
  - Ensure staff has experience and expertise to perform specified care management activities (delegation of authority)
  - Available to address staff questions and concerns
  - Not required to be physically/virtually present when staff providing services or to review/sign-off on staff documentation

5. Care Plan

- Develop and regularly update electronic care plan
  - Based on physical, mental, cognitive, psychosocial, functional, and environmental assessment of beneficiary's needs
  - Inventory of resources and supports
  - Addresses all health issues (not just chronic conditions)
    - Except PCM care plan focuses on specific condition
  - Congruent with beneficiary's choices and values
- Access to care plan
  - Make paper or electronic copy available to patient
  - Share electronically with other providers involved in patient's care

6. Care Management Services

- Types of services (non-exclusive)
  - Performing medication reconciliation, oversight of beneficiary self-management of medications
  - Ensuring receipt of all recommended preventive services
  - Monitoring beneficiary's condition (physical, mental, social)
  - Addressing social determinants of health (SDOH)
- Documentation
  - Date and time (start/stop?)
  - Person furnishing services (with credentials)
  - Brief description of services

Counting Minutes

- May include face-to-face services (exception, not the rule)
- No requirement for direct interaction with patient (performing services on patient's behalf)
- May include billing practitioner time if not part of separately reimbursable service
- May count time for services furnished on same day as E/M visit, provided time and effort is not counted twice
- Minutes can be aggregated across multiple days but total minutes cannot be rounded up (e.g., CPT 99490 not billed if only 19 minutes)
- May be provided by different individuals, but cannot count time for two staff members providing services at the same time
- If provide services for 2 patients at same time, allocate time between patients

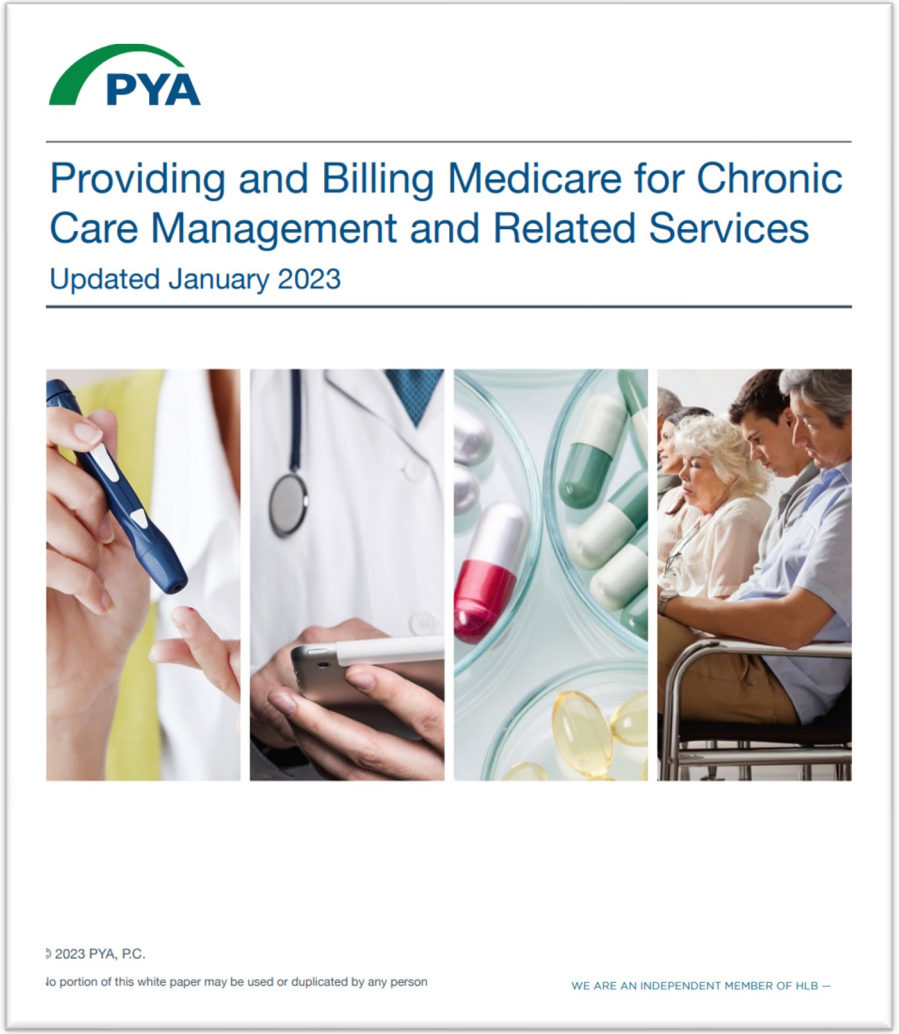
7. Double Dipping

- Only one practitioner can bill for CCM for same patient during same month
  - One practitioner cannot bill CCM and PCM for same patient during same month
  - One practitioner can bill for CCM and another can bill for PCM for same patient during same month (even if both practitioners are part of same group practice)
- Cannot bill CCM/PCM and any of the following during same 30-day period
  - Home health care supervision (G0181)
  - Hospice care supervision (G0182)
  - ESRD services (90951-90970)
- Cannot count time furnishing services if patient is -
  - Hospital inpatient
  - SNF Part A stay
  - Receiving transitional care management services

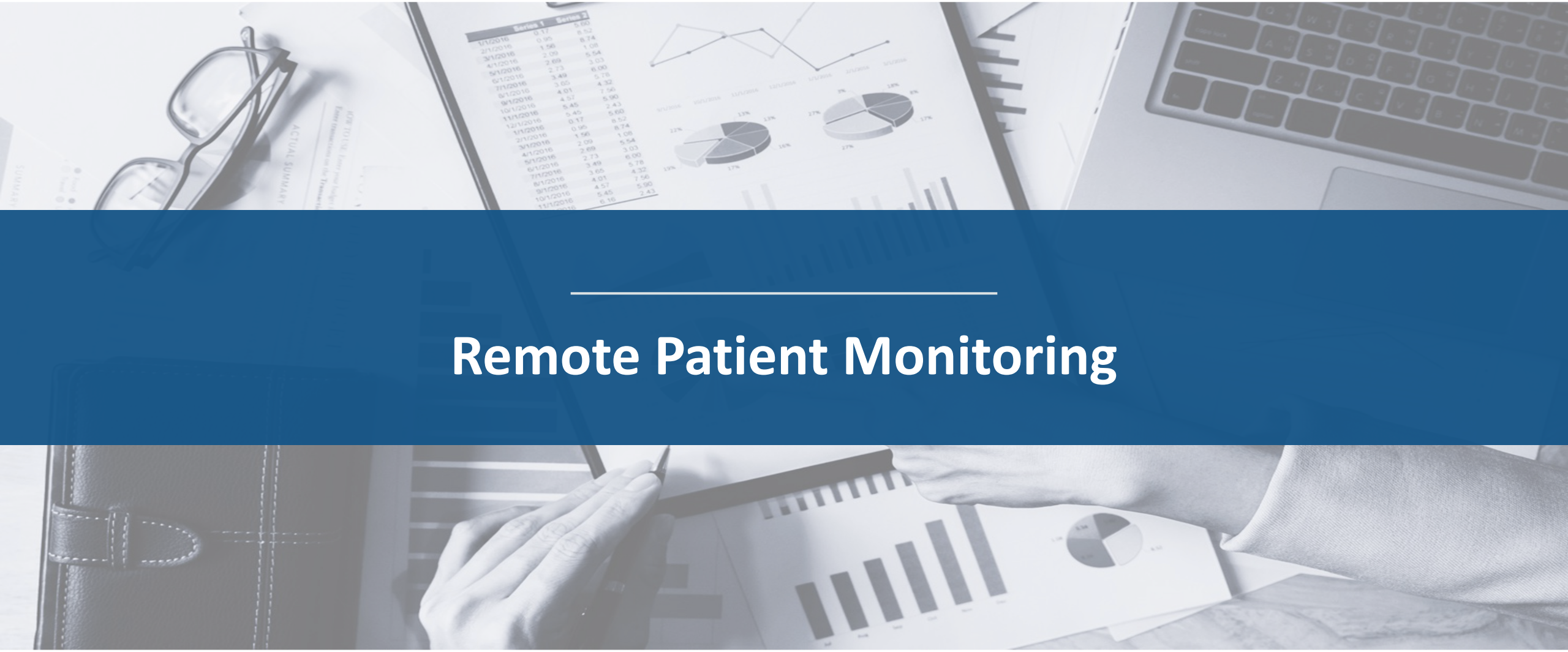
7. Claim Submission

- Bill under NPI of practitioner providing general supervision of clinical staff
- Place of service = where face-to-face visit normally would occur
    - Although ‘incident to’ billing not applicable in hospital outpatient department, practitioner reimbursed for supervision of hospital staff furnishing care management services
- Date of service = any date within calendar month after minimum time threshold is satisfied
    - Codes for additional units of time billed on same data as initial unit of time (e.g., if 60 minutes of CCM in calendar month, bill CPT 99490 and two units of CPT 99439 with same DOS)
- CMS maintains it does not have authority to waive copayment for care management services

For More Information



https://www.pyapc.com/wp-content/uploads/2022/03/Providing-and-Billing-Medicare-for-CCM-PYA-012523.pdf



Remote Patient Monitoring

Remote Physiologic Monitoring

- Collect and analyze physiologic data relating to patient's chronic and/or acute illness or condition to be used in developing and managing treatment plan relating to such illness or condition
- Device requirements
  - Meet definition of "medical device" under the Federal Food, Drug and Cosmetic Act
  - Automatically upload patient physiologic data (i.e., data not self-recorded and/or self-reported by patient)
  - Be capable of generating and transmitting either (a) daily recordings of the beneficiary's physiologic data, or (b) an alert if the beneficiary's values fall outside pre-determined parameters

Ordering and Consent

- Must be ordered and billed by **eligible practitioner -**
  - ✓ Physicians and NPPs eligible to bill for E/M services
  - X Independent Diagnostic Testing Facilities
  - X Rural Health Clinics/Federally Qualified Health Centers (CMS proposes to include RHCs and FQHCs beginning in 2024)
- Must have **established patient** relationship
  - Distinct from CCM's initiating visit requirement
  - Definition used to determine whether to bill new patient E/M codes (i.e., received professional services from practitioner or another practitioner in same group/same specialty within prior 3 years)?
  - Referring practitioner vs. billing practitioner
- Must obtain **consent** prior to or at initiation of service
  - Acknowledgment of responsibility for co-payment or deductible
  - May be verbal - but must be documented in medical record

CPT 99453 - Service Initiation

- Report for device set-up and patient education
  - Practice expense only; no assigned work RVUs
- Report only once for each episode of care even if multiple devices are provided to beneficiary
  - Per CPT Guidelines, episode of care “begin[s] when the remote monitoring physiologic service is initiated, and ends with attainment of targeted treatment goals”
  - Only one provider can be reimbursed for CPT 99453 for same patient during same time period
- Collection/transmission of 16 days of data in 30-day period is pre-condition for billing CPT 99453
  - Count 30-day period from date on which data is first collected

CPT 99454 - Data Transmission

- Report for provision and programming of device for daily recording or programmed alert transmissions over 30-day period
  - Data must be transmitted automatically (not patient reported)
  - Practice expense only; no assigned work RVUs
- Can only be billed once per 30-day period even if multiple devices utilized
  - Only one provider will be reimbursed for CPT 99454 for same patient during same time period
- Collection/transmission of 16 days of data in 30-day period is pre-condition for billing CPT 99454

CPT 99091 - Data Analysis and Interpretation

- "[A]fter the data collection period for CPT 99453 and 99454, the physiologic data that are collected and transmitted may be analyzed and interpreted as described in CPT 99091…."
  - Minimum of 30 minutes of time in 30-day period; no add-on code for additional time
- Performed by physician/NPP or by clinical staff if "incident to" requirements are met
  - Requires direct (not general) supervision by billing practitioner
    - Direct supervision is permitted via interactive audio/visual real-time communications technology through 12/31/23 (CMS proposes to extend to 12/31/24)
- *Appears* collection/transmission of 16 days of data in 30-day period is pre-condition for billing CPT 99091

RPM Treatment Management Services

- **CPT 99457** - At least 20 minutes per calendar month of clinical staff time under general supervision of physician or NPP
  - Must involve “live interactive communication” with patient
    - “real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission”
    - Not required for full 20 minutes
  - *Appears* collection/transmission of 16 days of data in 30-day period is pre-condition for billing CPT 99457
  - Only one provider will be reimbursed for CPT 99457 for same patient during same time period
  - May bill CPT 99457 and care management code(s) for same patient for same time period, provided documentation supports distinct service
- **CPT 99458** – Each additional 20 minutes (up to 3 units)

CPT 99457 and 99091: Separate…but Together?

- According to CPT Codebook, CPT 99091 and 99457 cannot both be billed for same time period for same beneficiary
- However, CMS has determined that "in some instances when complex data are collected, more time devoted exclusively to data analysis and interpretation by a [practitioner] may be necessary such that the criteria could be met to bill for both CPT codes 99091 and 99457 within a 30-day period."
  - CMS cautions that one cannot use same time to meet criteria for both CPT 99091 and 99457

RPM Reimbursement

CPT Code	Service Description	2023 MPFS Payment (Non-Facility)	2023 MPFS Payment (Facility)	2023 OPPS Payment
99453	Service Initiation	$19.32	$0	APC 5012 = $120.86
99454	Data Transmission	$50.15	$0	APC 5741 = $35.00*
99091	Data Analysis/Interp	$54.22	$54.22	N/A
99457	Treatment Mgmt (20 min)	$48.80	$30.16	N/A
99458	Treatment Mgmt (+20 min)	$39.65	$30.16	N/A

* Assigned Status Indicator Q1

Remote Therapeutic Monitoring vs. RPM

- Both require FDA medical device; both appear to require 16 days of data
- RTM permits patient-reported data (vs. automatic transmission for RPM)
- RTM limited to 3 conditions: respiratory, musculoskeletal, and cognitive behavioral therapy
- Unclear whether established patient requirement applies to RTM
- Because RTM codes are not E/M codes -
  - May be billed by any professional who can bill under MPFS
  - No 'incident to' billing – must be personally performed by billing professional
    - CMS proposing for 2024 to permit PTs/OTs to bill for RTM services furnished by PTAs/OTAs under general supervision
- Provider cannot bill RPM and RTM codes for same patient during same time period

RTM Reimbursement

CPT Code	Service Description	2023 MPFS Payment (Non-Facility)	2023 MPFS Payment (Facility)	2023 OPPS Payment
98975	Service Initiation	$19.32	$0	APC 5012 = $120.86
98976	Data Transmission– Respiratory System	$50.15	$0	APC 5741 = $35.00*
98977	Data Transmission Musculoskeletal System	$50.15	$0	APC 5741 = $35.00*
989X6	Data Transmission – Cognitive Behavioral Therapy	Contractor priced	Contractor priced	N/A
98980	Treatment Mgmt (20 min)	$49.48	$30.84	N/A
98981	Treatment Mgmt (+20 min)	$39.65	$30.16	N/A

* Assigned Status Indicator Q1

For More Information

https://www.pyapc.com/wp-content/uploads/2023/02/Providing-and-Billing-Medicare-for-RPM-PYA-022223.pdf

Our Next Health Care Regulatory Round-Up:

No Surprises Act – New Proposed Rules

Wednesday October 25, 2023

A national healthcare advisory services firm providing consulting, audit, and tax services