NORIDIAN IMPAC
(Informal Medicare Professional Advisory Council)

Pacific Club
Honolulu, Hawaii
February 21, 2020
Call to Order and Introduction of Attendees

Centers for Medicare and Medicaid Services (CMS)

Noridian Education Provider Relations – Tammy Ewers

Comprehensive Error Rate Testing – Patricia Holton, RN

Medical Director’s Report – Dr. Arthur Lurvey

Open Discussion

Upcoming Noridian Meetings

– Ask the Contractor Part B Teleconference; Dates and Links for Registration:
  – March 18, 2020 - General
  – July 15, 2020 - Diagnostic Lab and X-rays
  – November 11, 2020 - General

Adjourn
CMS REPORT

See Handout From Ashby Wolfe, MD, MPP, MPH;

• Regional Chief Medical Officer
  CMS Denver, San Francisco and Seattle Offices
AGENDA

• Medicare 2020 Updates
• Chronic Care Management (CCM)
• Telehealth

*Future IMPAC dates by state:
  – https://med.noridianmedicare.com/web/jeb/policies/lcd/impac
  – https://med.noridianmedicare.com/web/jfb/policies/lcd/impac
Medicare 2020 Updates
Noridian Home Page – Latest Updates

• Be in the know with 2020 information!
  – https://med.noridianmedicare.com/web/jeb
  – https://med.noridianmedicare.com/web/jfb
Appropriate Use Criteria (AUC) Program

• If ordering certain advanced imaging ONLY
  – Certain CT, MRA, MRI, PET, Nuclear, SPECT
• Professional ordering imaging required to
  – Consult first with qualified Clinical Decision Support Mechanism (CDSM) list for appropriate treatment decision
  – Through interactive electronic portal tool
• AUC Education/Operations 2020 testing period
  – Full implementation January 1, 2021
• Revised CR 11268 effective January 1, 2020
  – CMS Medicare Learning Network (MLN) Matters (MM)11268
New DMEPOS Order Requirements

• Streamlined to “Standard Written Order (SWO)”
  – Effective January 1, 2020, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) has one type of provider order

• To help reduce provider burden; no longer need
  – Preliminary/Dispensing Order, Detailed Written Order (DWO), Five Element Order (5EO)/Written Order Prior to Delivery (WOPD), Seven Element Order (7EO) or Detailed Product Description (DPD)
  – Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)

• Interested in B/DME webinar PDF; then let us know
ICD-10 Revisions to NCDs

- If you perform any of these services, refer to https://www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR11392.zip
- CR 11392 Effective January 1, 2020
  - 20.7 Percutaneous Transluminal Angioplasty
  - 110.18 Aprepitant
  - 110.23 Stem Cell Transplantation
  - 150.3 Bone Mineral Density Studies
  - 220.4 Mammography
  - 220.13 Percutaneous Image-Guided Breast Biopsy
  - 270.3 Blood Derived-Products for Chronic, Non-Healing Wounds
Opioid Misuse Reduction

- CMS Roadmap fighting Opioid crisis
  - Prevention, Treatment & Data
- Videos & learn more
Opioid Treatment Program (OTP) - Weekly Billing

• Interested in this special enrollment? Visit your jurisdiction link:

• CMS Billing/Payment page:
  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Opioid-Treatment-Program/Billing-Payment.html

• Education on Demand 3-part OTP series recordings
  https://med.noridianmedicare.com/web/jfb/education/tutorials
Quality Payment Program (QPP)

• 2019-2021 Incentive Program CMS update

Quality Payment Program Participation Status Lookup Tool
– Contact QPP@cms.hhs.gov or 1-800-288-8292

• QPP Participation Status Tool to re-check/confirm your final 2019 MIPS eligibility

• QPP Participation Status Tool Now Includes Third Snapshot of 2019 Qualifying APM Participant and MIPS APMs Data

• Now Available: 2020 CMS-Approved Qualified Registries and Qualified Clinical Data Registries (QCDRs)
Chronic Care Management (CCM)
CCM Non F2F Overview

• Chronic Care Management (CCM) where physician & clinical staff time count
  – Directed by physician/qualified health provider
  – Time aggregated/documented/collected from different clinicians
  – Minimum of 20 minutes to bill
• Only one practitioner (primary care) bills
• Allowed every 30 days/monthly
• Acute care billed separately (other procedures, services, E/Ms, etc.)
CCM Non F2F Overview

• Non F2F monthly services furnished to eligible beneficiaries with at least 2/more chronic conditions
  – Significant risk of death
  – Acute exacerbation
  – Decompensation
  – Functional decline

• New patient or patient not seen within 1 year prior
  – Requires initiating visit; either AWV, IPPE or comprehensive E/M (99202-99205)
  – Must explain CCM benefit

• Need patient permission first - verbal and/or written
  – Unmet Deductible and Coinsurance apply

• Comprehensive Care Plan required-no formal form
Billing Practitioners Eligible

- Physician (MD/DO)
- Certified Nurse Midwife (CNM)
- Clinical Nurse Specialist (CNS)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Specialists (Neurology, Oncology, Cardiology, etc.)

**Note:** Use of telecommunications system may substitute for in-person encounter in emergency department or inpatient initial and follow-up consultations with all other requirements met.
Clinical Staff Eligible

- Eligible to contribute time to monthly CCM, if “incident to” & state scope of licensure met
  - Licensed Clinical Social Worker (LCSW)
  - Certified Medical Assistant (CMA/MA)
  - Advanced Practice Registered Nurse (APRN)
  - Licensed Practical Nurse (LPN)
  - Pharmacist/RPH
  - Registered Nurse (RN)
  - Technician
  - Therapist (PT, OT)

- Non-clinical staff time does not count
  - Billers, coders, financial staff
  - Other administrative (secretary, receptionist)
Clinical Staff Eligible

- Employed by physician may count (e.g., medication management)
  - Cannot bill direct for services
  - Must be contracted/employed by physician
- Accountable Care Organization (ACO)
  - Not Medicare eligible to bill; however, employed physicians/NPPs may count time
- Community Health Workers
  - Physician employees may count time
- In-person visits, including group visits, do not count toward CCM codes
CCM Monthly Billing

• Noridian’s Browse by Specialty-under E/M_CCM
  – Eligibility (patient/provider), billing & documentation
  – 3-part recording tutorials available
CCM 2020 Updates

- Add on codes for physician, qualified health care professional (QHP) and clinical staff
- Revised comprehensive care plan language
  - Replaced phrase ordered “social & community services” with “interaction and coordination with outside resources”
- CR 11560 effective January 1, 2020
- Stay tuned for upcoming 2020 CCM webinars!
- CMS Connected Care website for toolkit
Telehealth
What is Telehealth?

• Permits real-time communication between physician/practitioner and beneficiaries
• Use of (HIPAA-compliant) telecommunications system substitutes for in-person encounter
  – Must be an interactive system
  – Patient must be present and participating
• Asynchronous “store and forward” technology permitted only in Federal telemedicine demonstration programs
  – Conducted in Alaska or Hawaii
Eligibility

• Medicare beneficiary
• Medicare enrolled physician or practitioner
  – Medicare Services within practitioner’s scope of practice under State law
  – Practitioner provides and bills services in state of licensure
Location of Originating Sites

- Medicare beneficiary location-service performed
  - Rural health professional shortage area (HPSA)
  - Determined by Health Resources & Services Administration (HRSA)
  - County outside Metropolitan Statistical Area (MSA)
  - Determined by United States Census Bureau

- Next slide contains patient eligibility analyzer at

  [https://data.hrsa.gov/tools/medicare/telehealth](https://data.hrsa.gov/tools/medicare/telehealth)
Telehealth Eligibility Search Analyzer

Medicare Telehealth Payment Eligibility Analyzer

Check if an address is eligible for Medicare telehealth originating site payment.

Search Criteria
Please provide a street address, city, and state or a street address and ZIP Code.

Street Address:
Address

City:
City

State/Territory:

ZIP Code:
ZIP Code

Search
Reset

Eligible

Medicare Telehealth Payment Eligibility Analyzer
Check if an address is eligible for Medicare telehealth originating site payment.

Input address: 915 anderson drive, seattle, wa, 98520
Geocoded address: 915 Anderson Dr, Aberdeen, Washington, 98520

Yes
Yes, the geocoded address is eligible for Medicare telehealth payment.

Not Eligible

Medicare Telehealth Payment Eligibility Analyzer
Check if an address is eligible for Medicare telehealth originating site payment.

Input address: 550 17 Ave SW, Seattle, WA, 98112
Geocoded address: 550 17th Ave E, Seattle, Washington, 98112

No
No, the geocoded address is not eligible for Medicare telehealth payment.
Authorized Originating Sites

- Physician or practitioner office
- Outpatient Hospital
- Critical Access Hospital (CAH)
- Rural Health Clinic (RHC)
- Federally Qualified Health Center (FQHC)
- Hospital-Based or CAH-Based Dialysis Center
- Skilled Nursing Facility (SNF)
- Community Mental Health Center (CMHC)*
- Mobile Unit
- Walk-in Retail Health Clinic
- Urgent Care Facility

*not a partial hospitalization service
Sites Not Authorized

• Beneficiary’s home
  – Exception for CJR Model
• Independent renal dialysis facility
• Sites within MSA or not within HPSA
  – Exception for CJR Model
Distant Site

• Physician/practitioner location providing interactive services
  – Within scope of practice under State law
  – Do not provide telehealth without state license
• System must be interactive audio and video; real–time telecommunication
• Beneficiary must be physically present and participating at originating site
• Payment equal to current fee schedule amount
# Distant Site Eligible Practitioners

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Nurse Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Assistants</td>
<td>Certified Nurse Midwives</td>
</tr>
<tr>
<td>Clinical Psychologists (billing independent)*</td>
<td>Certified Registered Nurse Anesthetists</td>
</tr>
<tr>
<td>Clinical Social Workers*</td>
<td>Clinical Nurse Specialists</td>
</tr>
<tr>
<td>Registered Dietitians</td>
<td>Nutritional Professionals</td>
</tr>
</tbody>
</table>

*CP and CSW can **not** bill/receive payment for psychiatric diagnostic interview exams with E/Ms or **medical services** (90792, 90833, 90836, 90838)
CPT/HCPCS Approved List

• [https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes)

• Updated annually
In Conclusion

Are these subjects you would be interested?

• State Beneficiary Data
• Invite guest speakers
  – Medicaid
  – Quality Improvement Organization (QIO)
    • Newer contractor Livanta just posted QIO
• Trending Rural Health
Questions?

Thank You!!
February 2020 IMPAC: CERT Information

By: A/B CERT Team
Hawaii Error: Top Provider Types

- Infectious Disease
- Physical Therapist in Private Practice
- Internal Medicine
- Family Practice
- Podiatry
- Clinical Laboratory (Billing Independently)
Top Provider Types Errors

• Infectious Disease
  – Billed Evaluation and Management (E/M) does not meet all required key elements for billed E/M but may meet for a lower level E/M service or submitted documentation may support an upcoding

• Physical Therapist in Private Practice
  – Missing/insufficient supportive documentation (plan of care, treatment notes, etc.)
Top Provider Types Errors

• Internal Medicine
  – Billed E/M does not meet all required key elements for billed E/M but may meet for a lower level E/M service or submitted documentation may support an upcoding
  – Documentation does not support billed code but does supports a different code

• Family Practice
  – Billed E/M does not meet all required key elements for billed E/M but may meet for a lower level E/M service or submitted documentation may support an upcoding
Top Provider Types Errors

• Podiatry
  – Billed E/M does not meet all required key elements for billed E/M but may meet for a lower level E/M service or submitted documentation may support an upcoding

• Clinical Laboratory (Billing Independently)
  – Missing supportive documentation (visit notes, clinical documentation, etc.)
Top Errors: Categories

• Incorrect Coding
  – The required criteria was not met for the code that was billed
  – Documentation supports a different level of code, resulting in code being either downcoded or upcoded

• Insufficient Documentation
  – Missing supportive documentation
  – Missing physician order/intent
  – Missing or illegible signature; missing attestation or signature log
Conditions of Participation

• Respond to all CERT requests timely
• Common inappropriate responses
  – No record of this patient in our system
  – No records for date of service requested
  – Patient was seen at facility “A”, not our office
  – Check with “Said” facility as we have no record of this patient
• Billing provider responsible to support claim
Natural Disasters

CERT Provider Website: https://certprovider.admedcorp.com/
Preventative Actions

• Document orders and intent
• Legibly sign records
• Code and bill for only the level of service/procedure specified in medical records
• Collaborate with the ordering/referring physician to ensure your practice has all the necessary records to support the claim billed (as necessary)
• Supply attestations or signature logs for illegible signatures
• Authenticate certifications/recertification’s, plan of care, etc.
Contact Us

• Email Us
  – CERTQuestion@noridian.com

• Phone Number
  – (701) 277-7826

Or send us a secure message on the Noridian Medicare Portal!
WE WILL DISCUSS

- **Introduction to Medicare**
  - When it Started
  - All Services Reasonable and Necessary...

- **Initial Preventive Physical Examination (IPPE)**
  - Components of IPPE
  - Documenting, Billing and Coding

- **Annual Wellness Visit (AWV)**
  - Initial Visit Requirements
  - Subsequent Visit Requirements

- **Transitional Care Management**
  - Requirements and Elements
  - Coding and Billing

- **Communication Technology Services**

- **Chronic Care Management**
  - Basic Management and Elements
  - Complex Chronic Care Management and Elements
  - Billing, Coding and Patient Consent
  - Comprehensive Care Plan and Other Services
President Johnson signing the Medicare Bill
DOCUMENTING REASONABLE & NECESSARY: NOT CHANGING

• Only the actual physician who is treating the patient knows what is reasonable and necessary for that patient being evaluated and treated.

• The only way a Noridian reviewer can determine if something is (was) reasonable and necessary on a claim is to review the complete documentation submitted.
# UNDERSTANDING IPPE AND AWV

Medicare Coverage of Physical Exams—Know the Differences

<table>
<thead>
<tr>
<th>Initial Preventive Physical Examination (IPPE)</th>
<th>Annual Wellness Visit (AWV)</th>
<th>Routine Physical Examination (See Section 90)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of medical and social health history, and preventive services education</td>
<td>Visit to develop or update a personalized prevention plan, and perform a health risk assessment</td>
<td>Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury</td>
</tr>
<tr>
<td>✔ Covered only once, within 12 months of Part B enrollment</td>
<td>✔ Covered once every 12 months</td>
<td>☑ Not covered by Medicare; prohibited by statute</td>
</tr>
<tr>
<td>✔ Patient pays nothing (if provider accepts assignment)</td>
<td>✔ Patient pays nothing (if provider accepts assignment)</td>
<td>☑ Patient pays 100% out-of-pocket</td>
</tr>
</tbody>
</table>

Once a lifetime  Once a year  Not covered by Medicare

INTRODUCTION PREVENTIVE PHYSICAL EXAM (IPPE)

• **Medicare covers an IPPE for all patients who are newly enrolled in Medicare Part B.**
• **The patient must receive this service within first 12 months after effective date of Medicare Part B coverage.**
• **The IPPE is a one-time benefit & consists of following:**
  
  – Review patient’s medical and social history (Medicare would like to emphasize that review of opioid use is a routine component of this element, including OUD. If a patient is using opioids, assess benefit from other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.) Review potential risk factors for depression and other mood disorders
  
  – Review functional ability and level of safety
  
  – Measurement of height, weight, body mass index (BMI), and visual acuity screening
  
  – End-of-life planning (upon agreement of the individual)
  
  – Education, counseling and referral based on the review of

<table>
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<tr>
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</table>
| Review the beneficiary’s medical and social history | At a minimum, collect information about:  
  - Past medical and surgical history (experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments)  
  - Current medications and supplements (including calcium and vitamins)  
  - Family history (review of medical events in the beneficiary’s family, including conditions that may be hereditary or place the beneficiary at risk)  
  - History of alcohol, tobacco, and illicit drug use  
  - Diet  
  - Physical activities  
  - We encourage providers to pay close attention to opioid use during this part of the IPPE, which includes opioid use disorders (OUD). If a patient is using opioids, assess the benefit for other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.  
Refer to the CMS Roadmap to Address the Opioid Epidemic fact sheet for more information on combating opioid misuse.  
For more information about Medicare Coverage of Substance Abuse Services and mental health services, refer to the MLN’s Screening, Brief Intervention, and Referral to Treatment (SBIRT) booklet. |
## MORE COMPONENTS OF IPPE

<table>
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<tr>
<td>2. Review the beneficiary’s potential risk factors for depression and other mood disorders</td>
<td>Use any appropriate screening instrument. You may select from various available standardized screening tests designed for this purpose. For more information, refer to the <a href="#">Depression section</a> on the Substance Abuse and Mental Health Services Administration–Health Resources and Services Administration’s Screening Tools website.</td>
</tr>
</tbody>
</table>
| 3. Review the beneficiary’s functional ability and level of safety | Use appropriate screening questions or standardized questionnaires recognized by national professional medical organizations to review, at a minimum, the following areas:  
  - Activities of daily living  
  - Fall risk  
  - Hearing impairment  
  - Home safety |
| 4. Exam | Obtain the following:  
  - Height, weight, body mass index, and blood pressure  
  - Visual acuity screen  
  - Other factors deemed appropriate based on the beneficiary’s medical and social history and current clinical standards |
### MORE COMPONENTS OF IPPE

| 5. End-of-life planning, on beneficiary agreement | End-of-life planning is verbal or written information provided to the beneficiary about:
- The beneficiary’s ability to prepare an advance directive in case an injury or illness causes them to be unable to make healthcare decisions
- If you are willing to follow the beneficiary’s wishes expressed in an advance directive |
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<tbody>
<tr>
<td>6. Educate, counsel, and refer based on the previous five components</td>
<td>Based on the results of the review and evaluation services in the previous components, provide appropriate education, counseling, and referral.</td>
</tr>
</tbody>
</table>
| 7. Educate, counsel, and refer for other preventive services | Includes a brief written plan, such as a checklist, for the beneficiary to obtain:
- A once-in-a-lifetime screening electrocardiogram (EKG/ECG), as appropriate
- The appropriate screenings and other preventive services Medicare covers including the Annual Wellness Visit |
BILLING CODING AND REIMBURSEMENT FOR IPPE

- **G0402** - Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment  **$174-183**
- **G0403** - Electrocardiogram, routine ekg with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report  **$18-19**
- **G0404** - Electrocardiogram, routine ekg with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical exam  **$9-10**
- **G0405** - Electrocardiogram, routine ekg with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination  **$8-9**
- **G0468** - Federally qualified health center (fqhc) visit, ippe or awv; a fqhc visit that includes an initial preventive physical examination (ippe) or annual wellness visit (awv) and includes a typical bundle of medicare-covered services that would be furnished per diem to a patient receiving an ippe or awv  **(no price)**
- For billing: Choose any diagnosis code consistent with the beneficiary’s exam.

2/20/2020

2019 fee schedule numbers
QUESTIONS

• **Is the IPPE the same as a beneficiary’s yearly physical?**
  - No. The IPPE is not a routine physical that some older adults may get periodically from their physician or other qualified non-physician practitioner. The IPPE is an introduction to Medicare and covered benefits and focuses on health promotion and disease prevention and detection to help beneficiaries stay well. CMS encourages providers to inform beneficiaries about the Annual Wellness Visit and perform such visits. The Social Security Act (SSA) explicitly prohibits Medicare coverage for routine physical examinations.

• **Are clinical laboratory tests part of the IPPE?**
  - No. The IPPE does not include clinical laboratory tests, but you may make appropriate referrals for such tests as part of an IPPE.

• **Do deductible or coinsurance/copayment apply for the IPPE?**
  - No. Medicare waives both the coinsurance/copayment and the Medicare Part B deductible for the IPPE (HCPCS code G0402). Neither is waived for the screening ECG (HCPCS codes G0403, G0404, or G0405).
ANNUAL WELLNESS VISITS

- Medicare covers an AWV providing Personalized Prevention Plan Services (PPPS) for beneficiaries who:
  - Are no longer within 12 months after the beneficiary’s eligibility date for Medicare Part B benefits
  - Have not received an IPPE or AWV within the past 12 months
  - You must provide all elements of the AWV prior to submitting a claim for the AWV—including starting and continuing a health risk assessment (HRA).
- Initial AWV has 11 elements, subsequent AWV has less
## INITIAL AWV COMPONENTS: APPLIES THE FIRST TIME A BENEFICIARY RECEIVES AN AWV

<table>
<thead>
<tr>
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</table>
| 1. Perform an HRA (Health Risk assessment) | • Get self-reported information from the beneficiary  
  ○ You or the beneficiary can complete the HRA before or during the AWV encounter; it should take no more than 20 minutes  
  • Consider the best way to communicate with underserved populations, persons with limited English proficiency, persons with health literacy needs, and persons with disabilities  
  • At a minimum, get information on the following topics:  
  ○ Demographic data  
  ○ Self-assessment of health status  
  ○ Psychosocial risks  
  ○ Behavioral risks  
  ○ Activities of Daily Living (ADLs), including but not limited to: dressing, bathing, and walking  
  ○ Instrumental ADLs (IADLs), including but not limited to: shopping, housekeeping, managing own medications, and handling finances |
MORE INITIAL AWV COMPONENTS

2. Establish the beneficiary’s medical and family history

At a minimum, document the following:

- Medical events of the beneficiary’s parents, siblings, and children, including conditions that may be hereditary or place the beneficiary at increased risk
- Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments
- Use of, or exposure to, medications and supplements, including calcium and vitamins
- We encourage providers to pay close attention to opioid use during this part of the AWV, which includes opioid use disorders (OUD). If a patient is using opioids, assess the benefit for other, non-opioid pain therapies instead, even if the patient does not have OUD but is possibly at risk.

Refer to the CMS Roadmap to Address the Opioid Epidemic fact sheet for more information on combating opioid misuse.

For more information about Medicare Coverage of Substance Abuse Services and mental health services, refer to the MLN’s Screening, Brief Intervention, and Referral to Treatment (SBIRT) booklet.
## MORE INITIAL AWV COMPONENTS

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<tbody>
<tr>
<td>3. Establish a list of current providers and suppliers</td>
<td>Include current beneficiary providers and suppliers that regularly provide medical care</td>
</tr>
<tr>
<td>4. Measure</td>
<td>Obtain the following:</td>
</tr>
<tr>
<td></td>
<td>• Height, weight, body mass index (BMI; or waist circumference, if appropriate), and blood pressure</td>
</tr>
<tr>
<td></td>
<td>• Other routine measurements deemed appropriate based on medical and family history</td>
</tr>
<tr>
<td>5. Detect any cognitive impairment the beneficiary may have</td>
<td>Assess the beneficiary’s cognitive function by direct observation, while considering information from beneficiary reports and concerns raised by family members, friends, caregivers, and others. If appropriate, use a brief validated structured cognitive assessment tool. For more information, refer to the National Institute on Aging’s Alzheimer’s and Dementia Resources for Professionals website.</td>
</tr>
<tr>
<td><strong>MORE INITIAL AWV COMPONENTS</strong></td>
<td></td>
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<td>--------------------------------</td>
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<tr>
<td><strong>6. Review the beneficiary’s potential risk factors for depression, including current or past experiences with depression or other mood disorders</strong></td>
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<tr>
<td>Use any appropriate screening instrument. You may select from various available standardized screening tests designed for this purpose. For more information, refer to the Depression section on the Substance Abuse and Mental Health Services Administration–Health Resources and Services Administration’s Screening Tools website.</td>
<td></td>
</tr>
<tr>
<td><strong>7. Review the beneficiary’s functional ability and level of safety</strong></td>
<td></td>
</tr>
<tr>
<td>Use direct observation of the beneficiary or select appropriate questions from various available screening questionnaires, or use standardized questionnaires recognized by national professional medical organizations to assess, at a minimum, the following topics:</td>
<td></td>
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<tr>
<td>- Ability to successfully perform ADLs</td>
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<tr>
<td>- Fall risk</td>
<td></td>
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<tr>
<td>- Hearing impairment</td>
<td></td>
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<tr>
<td>- Home safety</td>
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<tr>
<td><strong>8. Establish an appropriate written screening schedule for the beneficiary, such as a checklist for the next 5 to 10 years</strong></td>
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<tr>
<td>Base written screening schedule on:</td>
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<tr>
<td>- Recommendations from the United States Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunization Practices (ACIP)</td>
<td></td>
</tr>
<tr>
<td>- The beneficiary’s HRA, health status and screening history, and age-appropriate preventive services Medicare covers</td>
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### MORE INITIAL AWV COMPONENTS

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</table>
| 9. Establish a list of beneficiary risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway | Include the following:  
  - Mental health conditions including depression, substance use disorder, and cognitive impairment  
  - Risk factors or conditions identified through an IPPE  
  - Treatment options and their associated risks and benefits |
| 10. Furnish the beneficiary personalized health advice and appropriate referrals to health education or preventive counseling services or programs | Include referrals to educational and counseling services or programs aimed at:  
  - Community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including:  
    - Fall prevention  
    - Nutrition  
    - Physical activity  
    - Tobacco-use cessation  
    - Weight loss  
    - Cognition |
| 11. Furnish, **at the beneficiary’s discretion**, advance care planning services | Include discussion about:  
  - Future care decisions that may need to be made  
  - How the beneficiary can let others know about care preferences  
  - Caregiver identification  
  - Explanation of advance directives, which may involve the completion of standard forms |
### SUBSEQUENT AWV COMPONENTS: APPLIES FOR ALL SUBSEQUENT AWVs AFTER A BENEFICIARY’S FIRST AWV

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<tbody>
<tr>
<td>1. Review and update HRA</td>
<td>• Collect beneficiary self-reported information</td>
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<td></td>
<td>○ You or the beneficiary can update the HRA before or during the AWV encounter; it should take no more than 20 minutes</td>
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<tr>
<td></td>
<td>○ At a minimum, address the following topics:</td>
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<tr>
<td></td>
<td>○ Demographic data</td>
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<tr>
<td></td>
<td>○ Self-assessment of health status</td>
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<tr>
<td></td>
<td>○ Psychosocial risks</td>
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<tr>
<td></td>
<td>○ Behavioral risks</td>
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<tr>
<td></td>
<td>○ ADLs, including but not limited to: dressing, bathing, and walking</td>
</tr>
<tr>
<td></td>
<td>○ Instrumental ADLs, including but not limited to: shopping, housekeeping, managing own medications, and handling finances</td>
</tr>
</tbody>
</table>
## SUBSEQUENT AWVs

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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</table>
| 2.   | Update the beneficiary’s medical/family history  
      At a minimum, update and document the following:  
      - Medical events of the beneficiary’s parents, siblings, and children, including conditions that may be hereditary or place the beneficiary at increased risk  
      - Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments  
      - Use of, or exposure to, medications and supplements, including calcium and vitamins |
| 3.   | Update the list of current providers and suppliers  
      Include current providers and suppliers regularly involved in providing the beneficiary medical care, including any providers and suppliers added as a result of the first AWV providing PPPS. |
| 4.   | Measure  
      Obtain the following:  
      - Weight (or waist circumference, if appropriate) and blood pressure  
      - Other routine measurements as deemed appropriate based on medical and family history |
| 5.   | Detect any cognitive impairment the beneficiary may have  
      Assess the beneficiary’s cognitive function by direct observation, while considering information from beneficiary reports and concerns raised by family members, friends, caregivers, or others. If appropriate, use a brief validated structured cognitive assessment tool. |
<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
</table>
| 6.   | Update the written screening schedule for the beneficiary | Base written screening schedule on:  
- Recommendations from the USPSTF and the ACIP  
- The beneficiary’s HRA, health status and screening history, and age-appropriate preventive services Medicare covers |
| 7.   | Update the beneficiary’s list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway | Include the following:  
- Mental health conditions including depression, substance use disorder, and cognitive impairment  
- Risk factors or conditions identified  
- Treatment options and their associated risks and benefits |
| 8.   | Furnish and update, as necessary, the beneficiary’s PPPS, which includes personalized beneficiary health advice and a referral, as appropriate, to health education or preventive counseling services or programs | Include referrals to educational and counseling services or programs aimed at:  
- Community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including:  
  - Fall prevention  
  - Nutrition  
  - Physical activity  
  - Tobacco-use cessation  
  - Weight loss  
  - Cognition |
| 9.   | Furnish, at the beneficiary’s discretion, advance care planning services | Include discussion about:  
- Future care decisions that may need to be made  
- How the beneficiary can let others know about care preferences  
- Caregiver identification  
- Explanation of advance directives, which may involve the completion of standard forms |
CODES AND BILLING FOR AWV

• **G0438** - Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit $175-191

• **G0439** - Annual wellness visit, includes personalized prevention plan (PPS), subsequent visit $122-130

• **G0468** - Federally qualified health center (FQHC) visit, ippe or awv; a FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV (no price)

• Medicare Part B covers an AWV if performed by a:
  – Physician (a doctor of medicine or osteopathy)
  – Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist)
  – Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of medical professionals directly supervised by a physician (MD or DO)

• Choose any diagnosis consistent with patient’s exam.
TRANSITIONAL CARE MANAGEMENT: PATIENT GOES HOME

• When patient leaves institutional care and goes to outpatient care
• One physician in charge can bill
• Lasts for initial 30 days post institutional care
• Separate payment for TCM services
TRANSITIONAL CARE MANAGEMENT

• The requirements for TCM services include:
  – Services are required during the beneficiary’s transition to the community setting following particular kinds of institutional discharges;
  – Health care professional accepts responsibility for care of the beneficiary post-discharge without a gap;
  – Beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making.

• The 30-day TCM period begins the date of discharge from the inpatient hospital setting and continues for the next 29 days.
WHO PERFORMS TCM SERVICES

• Physicians (any specialty)
• NPP (non-physician practitioners: legally authorized and qualified to provide services in State they practice in
  – Certified nurse-midwives;
  – Clinical nurse specialists;
  – Nurse practitioners; and
  – Physician assistants.

• Cannot provide TCM Services
  – Podiatrists
  – Psychologists
  – Chiropractors
TRANSITIONAL CARE MANAGEMENT

• TCM services are furnished following patient discharge from one of the following inpatient settings:
  – Inpatient Acute Care Hospital;
  – Inpatient Psychiatric Hospital;
  – Long Term Care Hospital;
  – Skilled Nursing Facility;
  – Inpatient Rehabilitation Facility;
  – Hospital outpatient observation or partial hospitalization; and
  – Partial hospitalization at a Community Mental Health Center.

• Following discharge from one of the above settings, the beneficiary must be returned to his or her community setting, (e.g., home)
TRANSITIONAL CARE MANAGEMENT

• During the 30 days beginning on the date the beneficiary is discharged from a hospital inpatient setting, the following three TCM components must be furnished:
  – An interactive contact within 2 days;
  – Certain non-face-to-face services; and
  – A face-to-face visit within 7 or 14 days
PHYSICIAN OR NPP SERVICES

- Obtain and review discharge information (for example, discharge summary or continuity of care documents);
- Review need for or follow-up on pending diagnostic tests and treatments;
- Interact with other health care professionals who will assume or reassume care of the beneficiary’s system-specific problems;
- Provide education to the beneficiary, family, guardian, and/or caregiver;
- Establish or re-establish referrals and arrange for needed community resources;
- Assist in scheduling required follow-up with community providers and services.
ALSO REQUIRED TRANSITIONAL

• Services Furnished by Licensed Clinical Staff Under Direction of a Physician or NPP
  – Communicate with agencies and community services used by the beneficiary;
  – Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living;
  – Assess and support treatment regimen adherence and medication management;
  – Identify available community and health resources; and
  – Assist the beneficiary and/or family in accessing needed care and services.

• Face to Face Visit by Physician/NPP
  – CPT Code 99495 – Transitional care management services with moderate medical decision complexity (visit within 14 days of discharge); Reimburse $172-183
  – CPT Code 99496 – Transitional care management services with high medical decision complexity (visit within 7 days of discharge); Reimburse $244-258
COMMUNICATION TECHNOLOGY SERVICES

• Pay separately for two newly defined physicians’ services furnished using communication technology:
  – Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012) and
  – Remote evaluation of recorded video and/or images submitted by established patient (HCPCS code G2010)

• Separate payment for brief communication technology-based service when patient checks in with practitioner via telephone or other telecommunications device to decide whether office visit or other service is needed.
  – This increases efficiency for practitioners and convenience for beneficiaries.
  – Similarly, remote evaluation of recorded video and/or images sent by established patient would allow practitioners to be separately paid for reviewing patient-transmitted photo or video information conducted via pre-recorded “store and forward” video or image technology to assess whether a visit is needed.
CHRONIC CARE MANAGEMENT: DEFINITION

- Chronic care management is care coordination services done outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

- These services are typically non-face-to-face and allows eligible practitioners to bill for at least 20 minutes or more of care coordination services per month.
CPT 99490

• 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

• Assumes 15 minutes of work by the billing practitioner per month.
CPT 99491

- Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care 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 99487 COMPLEX CCM

- **Complex chronic care management services, 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
  - Establishment or substantial revision of a comprehensive care plan
  - Moderate or high complexity medical decision making

- **60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month**
CPT 99489 COMPLEX CCM

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 CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately.

- Report 99489 in conjunction with 99487.
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.

CCM (sometimes referred to as “non-complex” CCM) and complex CCM services share a common set of service elements (summarized in Table 1).

- They differ in the amount of clinical staff service time provided; the involvement and work of the billing practitioner; and the extent of care planning performed.
2019 FEE STRUCTURE FOR CHRONIC CARE MEASUREMENT

- **99490** - $43-$45
- **99491** - $83-$96
- **99487** - $93-$114
- **99489** - $47-$57

- All fees represent Southern California areas, adjusted for localized areas in 2019
PRACTITIONER ELIGIBILITY: WHO CAN BILL

• Physicians and the following non-physician practitioners:
  – Certified Nurse Midwives
  – Clinical Nurse Specialists
  – Nurse Practitioners
  – Physician Assistants

• NOTE: CCM may be billed most frequently by primary care practitioners, although in certain circumstances specialty practitioners may provide and bill for CCM.

• CCM service is not within the scope of practice of limited-license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, although practitioners may refer or consult with such physicians and practitioners to coordinate and manage care.

• CPT code 99491 includes only time that is spent personally by billing practitioner. Clinical staff time is not counted towards required time threshold for reporting code.

• CPT codes 99487, 99489, and 99490 – Time spent directly by billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month.

• CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the direction of the billing practitioner on an “incident to” The clinical staff are either employees or working under contract to the billing practitioner whom Medicare directly pays for CCM.
SUPERVISION AND BILLING

• The CCM codes describing clinical staff activities (CPT 99487, 99489, and 99490) are assigned general supervision under the Medicare PFS.

• General supervision means when the service is not personally performed by the billing practitioner, it is performed under his or her overall direction and control although his or her physical presence is not required.

• Billing practitioners cannot report both complex and regular (non-complex) CCM for a given patient for a given calendar month. In other words, a given patient receives either complex or non-complex CCM during a given service period, not both. Do not report 99491 in the same calendar month as 99487, 99489, 99490.
EXAMPLES OF CHRONIC CONDITIONS

- Alzheimer’s disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS

These are just examples of chronic diseases
INITIAL VISIT

- For new patients or patients not seen within 1 year prior to the commencement of CCM, Medicare requires initiation of CCM services during a face-to-face visit with the billing practitioner (an Annual Wellness Visit [AWV] or Initial Preventive Physical Exam [IPPE], or other face-to-face visit with the billing practitioner). This initiating visit is not part of the CCM service and is separately billed.

- Practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code G0506 (Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services [billed separately from monthly care management services] [Add-on code, list separately in addition to primary service]). G0506 is reportable once per CCM billing practitioner, in conjunction with CCM initiation.
PATIENT CONSENT REQUIRED

- A practitioner must obtain patient consent before furnishing or billing CCM. Consent may be verbal or written but must be documented in the medical record, and includes informing them about:
  - The availability of CCM services and applicable cost sharing
  - That only one practitioner can furnish and be paid for CCM services during a calendar month
  - The right to stop CCM services at any time (effective at the end of the calendar month)

- Informed patient consent need only be obtained once prior to furnishing CCM, or if the patient chooses to change the practitioner who will furnish and bill CCM.
COMPREHENSIVE CARE PLAN

- A person-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with particular focus on the chronic conditions being managed)

- Provide the patient and/or caregiver with a copy of the care plan

- Ensure the electronic care plan is available and shared timely within and outside the billing practice to individuals involved in the patient's care

- Care planning tools and resources are publicly available from a number of organizations
COMPREHENSIVE CARE PLAN

- A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:
  - Problem list
  - Expected outcome and prognosis
  - Measurable treatment goals
  - Symptom management
  - Planned interventions and identification of the individuals responsible for each intervention
  - Medication management
  - Community/social services ordered
  - A description of how services of agencies and specialists outside the practice are directed/coordinated
  - Schedule for periodic review and, when applicable, revision of the care plan
ACCESS TO CARE & CARE CONTINUITY

- Provide 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified health care professionals or clinical staff, including providing patients (and caregivers as appropriate) with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week.
- Ensure continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient’s care by telephone and also through secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods (for example, email or secure electronic patient portal).

COMPREHENSIVE CARE MANAGEMENT

- Systematic assessment of the patient’s medical, functional, and psychosocial needs.
- System-based approaches to ensure timely receipt of all recommended preventive care services.
- Medication reconciliation with review of adherence and potential interactions.
- Oversight of patient self-management of medications.
- Coordinating care with home- and community-based clinical service providers.

TRANSITIONAL CARE MANAGEMENT

- Manage transitions between and among health care providers and settings, including referrals to other clinicians, follow-up after an emergency department visit, or facility discharge.
- Timely create and exchange/transmit continuity of care document(s) with other practitioners and providers.

CONCURRENT BILLING

The billing practitioner cannot report both complex CCM and non-complex CCM for a given patient for a given calendar month. Do not report 99491 in the same calendar month as 99487, 99489, 99490.
Table 1. CCM Service Summary

**Initiating Visit** – Initiation during an AWV, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of CCM services.

**Structured Recording of Patient Information Using Certified EHR Technology** – Structured recording of demographics, problems, medications, and medication allergies using certified EHR technology. A full list of problems, medications, and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care.

**24/7 Access & Continuity of Care**
- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff, including providing patients/caregivers with means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week.
- Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.

**Comprehensive Care Management** – Care management for chronic conditions including systematic assessment of the patient’s medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.

**Comprehensive Care Plan**
- Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.
- Must at least electronically capture care plan information and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the patient’s care.
- A copy of the plan of care must be given to the patient and/or caregiver.

**Management of Care Transitions**
- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities.
- Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers.
### Table 1. CCM Service Summary (Cont.)

#### Home- and Community-Based Care Coordination

- Coordination with home- and community-based clinical service providers
- Communication to and from home- and community-based providers regarding the patient’s psychosocial needs and functional deficits must be documented in the patient’s medical record

#### Enhanced Communication Opportunities

**Enhanced Communication Opportunities** – Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient’s care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

#### Patient Consent

- Inform the patient of the availability of CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM services at any time (effective at the end of the calendar month)
- Document in the patient’s medical record that the required information was explained and whether the patient accepted or declined the services

#### Medical Decision-Making

**Medical Decision-Making** – Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner).