AAHCM December Webinar Questions and Answers
Webinar originally presented Monday, December 12, 2016

Question: If a clinician comes to our practice in 2017 but has been a provider at another practice will the exemption apply?

Answer: This question will be further researched. However, the clinician is not newly enrolled with the Medicare program during the performance year then in effect, and thus, according to the MACRA language would not be exempt.

Question: Can a psych care management be billed on the same day as a medical care management?

Answer. Yes. And as provided further below, each monthly code can be submitted during the same monthly services period provided the time spent on the behavioral care management is distinct from the time spent on the medical chronic care management.

Question: How do we document all the time? On the behavioral and chronic care management together?

Answer: The time spent on the behavioral care management and the chronic care management must be distinct and so documented. In summary "CCM and BHI services can only be billed the same month for the same beneficiary if all the requirements to bill each service are separately met."

> More detail from the Final Rule
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> "Response: While any care planning should take into account the whole patient, our intent is that the care planning included in the CCM coding (and G0506, the CCM initiating visit add-on code) will be the most comprehensive in nature, addressing all health issues with particular focus on the multiple chronic conditions being managed by the treating practitioner. In contrast, the BHI care planning will focus on behavioral health or psychiatric issues, in particular, just as the cognitive impairment care planning will focus on cognitive impairment issues, in particular (see section II.E.5. of this final rule).
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> And again, from the Final Rule
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> "We believe the format of the care plan(s) is less important than having a process

whereby feedback and expertise from all relevant practitioners and providers, whether
internal or external to the billing practice, are integrated into the beneficiary's treatment
plan and goals; that this plan be regularly assessed and revisited by the practitioner who is assuming an overall care management role for the beneficiary in a given month; that the patient is engaged in the care planning process; and that the care planning be
documented in the medical record (as with any required element of any PFS service). We have framed the care planning service element for G0507 accordingly, "Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes."

Note: The same time spent managing care transitions cannot be counted more than once (if counted toward CCM or TCM), and from the Final Rule

"Also, time and effort that is spent managing care transitions for CCM or TCM patients
and that is counted towards reporting TCM or CCM services, cannot also be counted
towards reporting any transitional care management activities reported under a BHI
service code(s). We welcome additional input from stakeholders regarding appropriate
(or inappropriate) settings of service for G0507."

The CCM and BHI service codes differ substantially in potential diagnosis and comorbidity, the expected duration of the condition(s) being treated, the kind of care planning performed (comprehensive care planning versus care planning focused on behavioral/mental health issues), service elements and who performs them, and the interventions the beneficiary needs and receives apart from the CCM and BHI services themselves. *The BHI codes include a more focused process than CCM for the clinical integration of primary care and behavioral health/psychiatric care, and for continual reassessment and treatment progression to a target or goal outcome that is specific to mental and behavioral health or substance abuse issues. However there is no explicit BHI service element for managing care transitions or systematic assessment of receipt of preventive services; there is no requirement to perform comprehensive care planning for all health issues (not just behavioral health issues); and there are different emphases on medication management or medication reconciliation, if applicable.*

In deciding which code(s) to report for services furnished to a beneficiary who is eligible for both CCM and BHI services, practitioners should consider which service elements were furnished during the service period, who provided them,

how much time was spent, and should select the code(s) that most accurately and specifically identifies the services furnished without duplicative time counting. Practitioners should generally select the more specific code(s) when an alternative code(s) potentially includes the services provided. We are not precluding use of the CCM codes to report, or count, behavioral health care management if it is provided as part of a broader CCM service by a practitioner who is comprehensively overseeing all of the beneficiary's health issues, even if there are no imminent non-behavioral health needs. However, such behavioral care management activities could not also be counted towards reporting a BHI code(s).

If a BHI service code more specifically describes the service furnished (service time and other relevant aspects of the service being equal), or if there is no focus on the health of the beneficiary outside of a narrower set of behavioral health issues, then it is more appropriate to report the BHI code(s) than the CCM code(s). Similarly, it may be more appropriate for certain specialists to bill BHI services than CCM services, since specialists are more likely to be managing the beneficiary's behavioral health needs in relation to a narrow subset of medical condition(s). CCM and BHI services can only be billed the same month for the same beneficiary if all the requirements to bill each service are separately met. We will monitor the claims data, and we welcome further stakeholder input to inform appropriate reporting rules.

Question: Can you bill 99489 and G0506 in addition to an E&M code?

Answer: No. Both 99489 and G0506 are add-on codes to an evaluation service.

And the G0506 can only be used one time when the E and M during which the chronic care management is established. Therefore, either the 99489 or G0506 if satisfied can be used as the add-on code to the underlying E and M service. Here is the Final Rule language:

"Regarding intersection of CPT codes 99358 and 99359 with G0506, we note that G0506 is already an add-on code to another E/M service (the CCM initiating visit, which can be the AWV/IPPE or a qualifying face-to-face E/M visit). We are providing in section II.E.4.a that at this time (beginning in CY 2017), G0506 will be a code that is only billable one time, at the outset of CCM services. We agree with commenters that it would be unusual for physicians to spend enough time with a given beneficiary on a given day to warrant reporting all three codes (the initiating visit code, G0506, and a prolonged service code). We also believe that a simpler approach is preferable at this time (two related codes for CCM initiation, instead of possibly three). Therefore our final policy for CY 2017 is that prolonged services (whether face-to-face or non-face-to-face) cannot be reported in addition to G0506 in association with a companion E/M code that also qualifies as the CCM initiating visit. In association with the CCM initiating visit, a billing

practitioner may choose to report either prolonged services or G0506 (if requirements to bill both prolonged services and G0506 are met), but cannot report both a prolonged service code and G0506."

Question: Will chronic care management and complex management be recognized as APM services?

Answer: The chronic care management services are specific CPT codes. APMs are alternative payment models (APMs). Certain of the care management services may be subsumed over time in the services and payment for alternative payment models as the APMs are developed and implemented. As an example, the care management fee (CMF) in the Comprehensive Primary Care Plus initiative takes the place of CPT 99490 and CMS will not pay for CPT 99490 for the same month for the same beneficiary your practice is paid the CMF. The relationship of newly developed APMs and the care management services will be announced as the he models are developed.

However, The Final Rule notes the reverse in that "we note that activities undertaken as part of participation in MIPS or an APM under the Quality Payment Program may support the ability of a practitioner to meet our final requirements for the continuity of care document(s) and the electronic care plan."

This is provided in the Final Rule as relates to chronic care management services.

Questions: Are the Prolonged Services Codes specific to inpatient or outpatient? Or are those the same for all POS?

Answer: Prolonged services codes are not limited in terms of Place of Service (POS). The now covered and paid codes are for non-direct (non-face-to-face time) and per AMA-CPT guidelines applicable regardless of place of service for the base evaluation and management service.

Question: Can G0506 be added onto a subsequent annual wellness visit?

Answer: Yes. G0506 is a code that can be added on if the requirements for the G0506 are satisfied), to the underlying evaluation and management services during which the chronic care management is established. Since CCM can be established with an annual wellness visit the G05060 can be used.

> "Regarding intersection of CPT codes 99358 and 99359 with G0506, we note that G0506 is already an add-on code to another E/M service (the CCM initiating visit, which can be the AWV/IPPE or a qualifying face-to-face E/M visit). We are providing in section II.E.4.a that at this time (beginning in CY 2017), G0506 will be a code that is only billable one time, at the outset of CCM services. We agree with commenters that it would be unusual for physicians to spend enough time with a given beneficiary on a given day to warrant reporting all three codes (the initiating visit code, G0506, and a prolonged service code). We also believe that

a simpler approach is preferable at this time (two related codes for CCM initiation, instead of possibly three). Therefore our final policy for CY 2017 is that prolonged services (whether face-to-face or non-face-to-face) cannot be reported in addition to G0506 in association with a companion E/M code that also qualifies as the CCM initiating visit. In association with the CCM initiating visit, a billing practitioner may choose to report either prolonged services or G0506 (if requirements to bill both prolonged services and G0506 are met), but cannot report both a prolonged service code and G0506.

Question: Can G0507 be billed with prolonged service codes?

Answer: Subject to further guidance from CMS, the answer from the Final Rule the answer is yes, "provided time is not counted twice towards the same code."

Prolonged services relate to the work of the physician that is not in direct contact with the patient and is based on the underlying evaluation and management service on a day of the E and M encounter. Also, BHI is not specifically excluded from being used in the same month as prolonged services codes as the *complex comprehensive care management codes* as discussed in question below.

Whereas, from the Final Rule:

"The code G0507 is valued to include minimal work by the treating practitioner; the bulk of the valuation is based on clinical staff time (see section II.L on valuation). However, we want to emphasize that the treating practitioner must direct the service, continue to
oversee the beneficiary's care, and perform ongoing management, collaboration and
reassessment. If the service (or part thereof) is provided incident to the treating practitioner's services, whether on site or remotely, the clinical staff providing services
must have a collaborative, integrated relationship with the treating practitioner. They
must also have a continuous relationship with the beneficiary.

Evaluation and management services, such as face-to-face E/M visits, may be separately billed during the service period or on the same day as G0507, provided time is not counted twice towards the same code."

Question: Many of us received letters from CMS stating that a 2% reduction rate will be imposed due to no reporting for 2015? Will this reduction be re-considered?

Answer: No. The 2017 payment adjustments relate to reporting for 2015 and those adjustments are for not reporting under PQRS in 2015. Similarly the 2018 adjustments

will be for reporting (performance) in 2016. The payment adjustments can be found: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html

> "Individual eligible professionals (EPs) and group practices who do not satisfactorily report data on quality measures for covered professional services will be subject to a negative payment adjustment under the Physician Quality Reporting System (PQRS) beginning in 2015. Note that program participation during a calendar year will affect payments after two years (i.e. 2016 program participation will affect 2018 payments).
> The PQRS negative payment adjustment applies to all of the individual EP's or PQRS group practice's Part B covered professional services under the Medicare Physician Fee Schedule (MPFS).Accordingly, individual EPs and group practices receiving a negative payment adjustment in 2016 (based on participation in 2014) will be paid 2.0% less than the MPFS amount for that service. For 2017 and 2018 (based on participation in 2015 and 2016 program years), the negative payment adjustment is also 2.0%."

Question: What are the differences in criteria/ documentation for 99358-99359 compared to 99495-99496?

The specifics will be provided and added to these Questions and Answers.

However, while CMS "Based on our analysis of comments, we do not believe there is significant overlap between CPT codes 99358 and 99359 and the CCM codes (CPT 99487, 99489, 99490) or our finalized BHI service codes (G0502, G0503, G0504, G0507 discussed below)…."For CY 2017, for administrative simplicity, we are adopting the CPT provision (and finalizing as proposed) that complex CCM cannot be reported during the same month as non-face-to-face prolonged services, CPT codes 99358 and 99359 (by a single practitioner). Similarly, we are adopting the CPT provision that non-face-to-face prolonged services, CPT codes 99358 and 99359 may not be reported when performed during the service time of TCM (CPT codes 99495 and 99496) (by a single practitioner). We interpret the CPT provision to mean that CPT codes 99358 and 99359 cannot be reported during the TCM 30-day service period, by the same practitioner who is reporting the TCM"

Question: G0506 and G0505 are not a timed codes, correct?

Answer: Correct. G0505 and G0506 are not time based codes.

Question: What registries do you recommend to report through for MIPS or APM?

Answer: CMS has approved registries that were in place for PQRS. However, CMS has not yet approved registries for use under the Quality Payment Program. CMS has noted that the process to be approved will be similar for Qualified Clinical Date Registries.

https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/qualified-clinical-data-registry-reporting.html

We will provide more information as CMS announces the approve registries. Academy members are recommended to review the registry approved under PQRS that is relevant for your housecall services. This is The National Home Based Primary Care and Palliative Care Registry https://www.medconcert.com/NHBCPCR.

Question: How are other practices handling the patients who 'decline' CCM billing? Do they still get the same level of service from the practice or does something change in how the practice delivers care?

Answer: Practices on a non-surveyed basis report that they ae not changing the way they deliver care when a patient declines consent to CCM service.

Again, note that written consent will no longer be required effective 2017. However, discussion and consent to receive CCM service must be documented in the medical record.

> From the Final Rule
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> Beneficiary Consent
> ..
> Inform the beneficiary 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 beneficiary's medical record that the required information was explained and whether the beneficiary accepted or declined the services.