The Alphabet Soup of Medicare Provisions and Promises

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Learning Objectives

1. Describe how preventive care options for seniors have evolved under the ACA
2. Describe how depression and dementia evaluations are changing
3. Define TCM and CCM as they relate to the care of older adults
4. Describe the provisions for advanced care planning (ACP) for older adults

No Disclosures

ACA and the Relevance of Preventive Care

#1 Mrs. GE is an 86 yo woman with treated HTN, OA and stress incontinence. She comes in for her q 6 month visits and wants everything updated. Her BMI is 28, labs and exam are unremarkable.

What preventive care should she receive?

#2 Mrs EG is an 85 yo woman with poorly controlled HTN, CKD4 (GFR<30, Cr 2.6), HLD, CAD, PVD. Exam BMI is 19, otherwise unremarkable x stigmata of PVD, Labs notable for anemia, CKD

What preventive care should she receive?

The ACA and Medicare Coverage for Wellness

In effect since January 2011

"Welcome to Medicare" preventive visit:

A one-time free and easy benefit during the first 12 months you have Medicare.

There's no copayment or deductible for the visit.

If you have Medicare for >12mo, you can get a yearly "Annual Wellness" visit (AWV) for free.

The provisions highlight the complexity of designing patient-specific preventive care in older patients.

Welcome to Medicare Visit

G0438 – first annual wellness visit, within 12mo of Part B
- Comparable to a level 4 new patient visit
- Est. face-to-face time is 45 minutes
- $172 (before geographic adjustment)

Review of medical and social history

Review of potential (risk factors) for depression

Review of functional ability and level of safety

Measurement of height, weight, body mass index, blood pressure, visual acuity screen, and other factors deemed appropriate

Discussion of end-of-life planning, *upon agreement of the individual*

The Yearly Wellness Visit (AWV)

G0439 – subsequent annual wellness visit for those on Medicare > 12 months
- Comparable to a level 4 established patient visit
- Emphasis on team approach under provider supervision
- Est. face-to-face time is 25 minutes (provider)
- $111 (before of geographic adjustment)

Health risk assessment

Medical/family history

List of current providers/suppliers

Blood pressure, height, weight, and other routine measurements

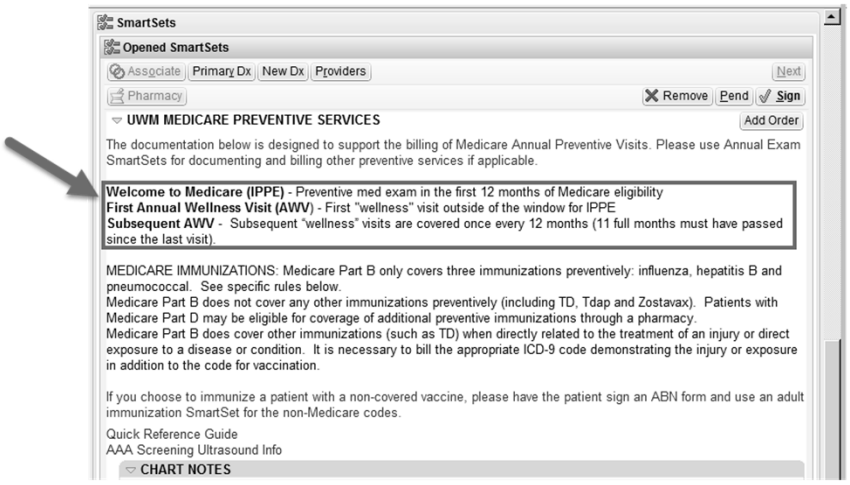
The Typical AWV

Check-in via Medical Assistant, ideally with the assistance of an already completed questionnaire

A “progress note” from the Providers

Focus is on education, counseling and referrals based on results of review and evaluation during the visit, including a brief written plan such as a checklist, and if appropriate, education, counseling and referral for obtaining additional tests, such as an electrocardiogram or DEXA

Now an easy navigation tab in most EMRs



The AWV-Patient Expectations

It is important to set patient expectations on what this visit entails

Use Modifier 25 for E/M service necessitated by things found in the Wellness Visit that will be dealt with on that visit (if there is time…)

Alternative is to create a second encounter

Note additional services are subject to co-pay and deductibles

Setting expectations

Dear Patient,

- We want you to receive wellness care – health care that may lower your risk of illness or injury. Medicare pays for some wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medicare benefits and how we can help you get the most from them.
- *The term "physical" is often used to describe wellness care. But Medicare does not pay for a traditional, head-to-toe physical.* Medicare does pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:
- Screenings to detect depression, risk for falling and other problems,
- A limited physical exam to check your blood pressure, weight, vision and other things depending on your age, gender and level of activity,
- Recommendations for other wellness services

Setting expectations

- Before your appointment, our staff will ask you some questions and may ask you to fill out a form.
- *A wellness visit does not deal with new or existing health problems.* That would be a separate service and requires a longer appointment. Please let our scheduling staff know if you need the doctor's help with a health problem, a med refill or something else. We may need to schedule a separate appointment. A separate charge applies to these services, whether provided on the same date or a different date than the wellness visit.
- We hope to help you get the most from your Medicare wellness benefits. Please contact us with any questions.

Physiology, not Chronology

The AWV: Key Features for Geriatrics

Detection of any cognitive impairment

Review potential (risk factors) for depression, functional ability, and level of safety

Establishment of:

- Written screening schedule (such as a checklist) for the next 5-10 years
- List of risk factors and conditions where interventions recommended
- Personalized health advice and referrals for health education and preventive counseling

The Initial (MA portion)

FIRST ANNUAL WELLNESS VISIT QUESTIONNAIRE (Ideally do at home rather than on check in)

HEALTH RISK ASSESSMENT:
Current providers and suppliers regularly involved in providing medical care:
{NONE ADDITIONAL:105532::"none"}

SELF ASSESSMENT OF HEALTH:
How do you rate your overall health in the past 4 weeks? {HEALTH
Can you manage your health problems? {YES NO (HH):104741::"YES"}
Due to any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing or getting around the house? {YES-VARIABLE:102603}

PSYCHOSOCIAL HEALTH:

DEPRESSION SCREEN:
{Note: If answer to either of the first two questions is "Yes", then a more complete depression screening is indicated. Please use PHQ-9 form within SmartSet}
Bothered by these problems over the past two weeks:
Feeling down, depressed, or hopeless: {PHQ9:107504::"not at all"}
Little interest or pleasure in doing things: {PHQ9:107504::"not at all"}

HEALTH AND HABITS:
How much alcohol do you drink weekly? {ALCOHOL # OF DRINKS:102512}
Dietary issues discussed: {DIETARY ISSUES DISCUSSED:103939}
Current exercise habits:
Type of exercise: {EXERCISE TYPES:100113}
Frequency of exercise: {EXERCISE FREQUENCY:103940}
Do you always use your seat belt in the car? {YES - DEFAULT:107767::"YES"}
How would you describe the condition of your mouth and teeth - including false teeth or dentures? {HEALTH STATUS:104494}
Are you sexually active? {YES - DEFAULT:107767::"YES"}
Do you find yourself having trouble hearing people speak? Do you wear a hearing aid/devise? {NO/YES:107423::"No"}
Do you have a fire extinguisher in your home? {YES/NO (YES Do you have a smoke detector? {YES/NO (YES DEFAULTED):104750::"YES"}

The Initial (MA portion)

ACTIVITIES OF DAILY LIVING:
In your present state of health how much difficulty do you have with the following activities?
Preparing food and eating: {FUNCTIONAL ABILITY
Bathing yourself: {FUNCTIONAL ABILITY ASSESSMENT:103948::"0 No
Getting dressed: {FUNCTIONAL ABILITY ASSESSMENT:103948::"0 No
Using the toilet: {FUNCTIONAL ABILITY ASSESSMENT:103948::"0 No
Moving around from place to place: {FUNCTIONAL ABILITY
In the past year have you fallen or had a near fall? {YES-
Do you feel safe in your home environment? {YES/NO-

INSTRUMENTAL ACTIVITIES OF DAILY LIVING:
In your present state of health how much difficulty do you have with the following activities?
Shopping: {FUNCTIONAL ABILITY ASSESSMENT:103948::"0 No
Using the telephone: {FUNCTIONAL ABILITY ASSESSMENT:103948::"0
Housekeeping: {FUNCTIONAL ABILITY ASSESSMENT:103948::"0 No
Laundry: {FUNCTIONAL ABILITY ASSESSMENT:103948::"0 No
Driving or using transportation (bus, taxi): {FUNCTIONAL ABILITY
Managing your own finances: {FUNCTIONAL ABILITY
Taking your own medication: {FUNCTIONAL ABILITY

SIGNS OF COGNITIVE IMPAIRMENT:
Direct observation? {YES-VARIABLE:102603}
Patient report? {YES-VARIABLE:102603}
Concerns raised by family members, friends, caretakers or others? {YES-

CARDIAC RISK FACTORS:
Smoker: {NO/YES:107423::"No"}
Obesity: {NO/YES:107423::"No"}
Diabetic: {NO/YES:107423::"No"}
Known heart disease: {NO/YES:107423::"No"}
Family history of heart disease: {NO/YES:107423::"No"}
Sedentary lifestyle: {NO/YES:107423::"No"}
Hyperlipidemia: {NO/YES:107423::"No"}

The Initial (Provider Summary)

FIRST ANNUAL WELLNESS VISIT PROGRESS NOTE BY THE PROVIDER

I have reviewed and confirmed with the {PATIENT VS PARENT:102635} the information entered in the questionnaire above: {YES/NO/NA.:106712}. There are the following changes or comments regarding the above information: ***.

{Reminder to enter and review Histories and Meds as required by Medicare}
I have reviewed the patient's recorded medical history including the {history review:109953} and confirmed it with the patient.

During the course of the visit the patient was educated and counseled about appropriate screening and preventive services including:
Pneumococcal vaccine: {NO/YES:107423::"No"}
Influenza vaccine: {NO/YES:107423::"No"}
Hepatitis B vaccine: {NO/YES:107423::"No"}
Screening mammography: {NO/YES:107423::"No"}
Screening pap smear and pelvic exam: {NO/YES:107423::"No"}
Colorectal cancer screening: {NO/YES:107423::"No"}
Screening for diabetes: {NO/YES:107423::"No"}
Diabetes self management training: {NO/YES:107423::"No"}
Bone densitometry screening: {NO/YES:107423::"No"}
Screening for glaucoma: {NO/YES:107423::"No"}
Nutrition counseling: {NO/YES:107423::"No"}
Cardiovascular screening blood tests: {NO/YES:107423::"No"}
End-of-life planning: {NO/YES:107423::"No"}

OBJECTIVE:
Vitals: {VITAL SIGNS COMMENTS:101228}
Body mass index is 19.38 kg/(m^2). {this is mandatory}
GENERAL: {GEN APPEARANCE:100947::"no acute distress"}
GAIT: {gait:101372::"normal"}

ASSESSMENT AND PLAN:***
F/U: ***
Patient Ed: Discussed in detail all aspects of the patient's care described above.
Patient Instructions (the written plan) was given to the patient/patient's caregiver.

Written Plan for the patient as part of the Annual Wellness Visit (Medicare PE Patient Instructions) added to AVS as required by Medicare: {YES -

In addition, the following recommendation was pasted into patient instructions so it prints on the AVS : {YES - DEFAULT:107767::"YES"}
I recommend you consider: {MEDICARE PHYSICAL COUNSELING - FEMALE:103976}

The AWV (Provider Portion)

SUBSEQUENT AWV (AGAIN QUESTIONNAIRE AND THEN PROVIDER PORTION)

Update of the HRA (Health Risk Assessment) and the following key elements furnished to an eligible beneficiary by a health professional:

Review (and administration, if needed) of an updated HRA;

An update of the beneficiary's medical/family history;

An update to the list of the beneficiary's current medical providers and suppliers

An assessment, including measurements of the beneficiary's:

- -Weight (or waist circumference, if appropriate),
- -Blood pressure, and Other routine measurements as deemed appropriate, based on the beneficiary's medical and family history;
- -Detection of any cognitive impairment that the beneficiary may have (includes the assessment of a beneficiary's cognitive function by direct observation, by way of patient reports or concerns raised by family members, friends, caretakers, or others)
- -An update of the beneficiary's written screening schedule, as that schedule was developed at the first AWV providing PPPS or most recent AWV
- -An update of the list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway for the beneficiary, as that list was developed at the first AWV providing PPPS or most recent AWV
- -Furnishing of personalized health advice to the beneficiary and a referral, as appropriate, to health education or preventive counseling services or programs

AWV: Practical Considerations

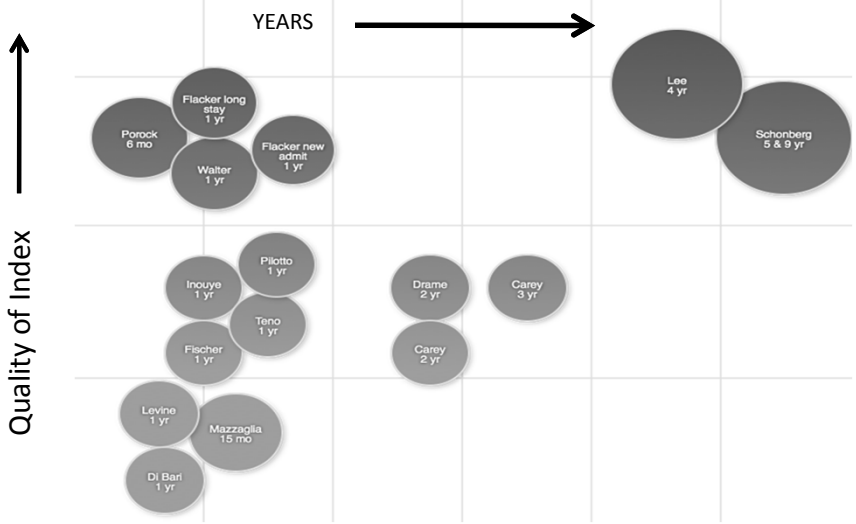
- When implementing the workflow, need to ensure correct scheduling
- Ensure comfort of Medical Assistants with EpicCare/EMR Medicare documentation requirements
- Allow adequate time for MA & provider to complete Medicare required documentation
- Correct billing or we have to pay; patients know the visit is supposed to be completely free
- Only return patients should be scheduled into AWV appointments…if you don't know the patient how can you do an AWV?

AWV: Practical Considerations

- Managed Medicare Plans are marketing this directly
  - Patients receive a letter advising them to schedule an annual wellness visit.
- 30 minutes for MA portion of visit, and 45-60 minutes for provider portion is realistic.
- Synonyms for AWV make scheduling challenging: "physical", "annual"
- Analysis of a large system in Detroit indicates approaching 20% utilization in more affluent white population. About ½ that in black beneficiaries, but latter had more chronic conditions thereby making the AWV potentially less of a priority in appts.

Hu et al., Letters Annals of Internal Medicine, 6 Oct 2015.

Life Expectancy Calculators



http://www.eprognosis.org/…. Sei Lee, MD (sei.lee@ucsf.edu), Alex Smith, MD (aksmith@ucsf.edu), Eric Widera, MD (eric.widera@ucsf.edu)

Summary of USPSTF guidelines

Annals of Internal Medicine
ESTABLISHED IN 1927 BY THE AMERICAN COLLEGE OF PHYSICIANS

From: Personalized Estimates of Benefit From Preventive Care Guidelines: A Proof of Concept

Ann Intern Med. 2013;159(3):161-168.

Table. USPSTF Recommendations for Nonpregnant Adults*

Preventive Care Topic	USPSTF Recommendation	Grade	Date
AAA screening for men	One time, by ultrasonography, in men aged 65–75 y who have ever smoked	B	February 2005
Alcohol misuse counseling	Screening and behavioral counseling interventions	B	April 2004
Aspirin to prevent CVD			
Men	Men aged 45–79 y, when the potential benefit due to a reduction in MIs outweighs the potential harm due to an increase in gastrointestinal hemorrhage	A	March 2009
Women	Women aged 55–79 y, when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage	A	March 2009
Blood pressure screening in adults	Adults aged ≥18 y	A	December 2007
Counseling about BRCA screening	Referral of women whose family history is associated with an increased risk for deleterious mutations in *BRCA1/BRCA2* genes for genetic counseling and evaluation	B	September 2005
Breast cancer preventive medication	Discuss chemoprevention with women at high risk for breast cancer and low risk for adverse effects of chemoprevention	B	July 2002
Breast cancer screening	Biennial screening mammography for women aged 50–74 y	B	December 2009
Cervical cancer screening	Women aged 21–65 y with cytology every 3 y or, for women aged 30–65 y, screening with cytology plus HPV testing every 5 y	A	March 2012
Chlamydial infection screening for nonpregnant women	Sexually active, nonpregnant young women aged ≤24 y or older; nonpregnant women at increased risk	A	June 2007
Cholesterol abnormalities screening			
Men aged ≥35 y	Men aged ≥35 y	A	June 2008
Men aged <35 y	Men aged 20–35 y if at increased risk for CHD	B	June 2008
Women aged ≥45 y	Women aged ≥45 y if at increased risk for CHD	A	June 2008
Women aged <45 y	Women aged 20–45 y if at increased risk for CHD	B	June 2008
Colorectal cancer screening	Everyone aged 50–75 y, by FOBT, sigmoidoscopy, or colonoscopy	A	October 2008
Depression screening for adults	Screening when staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment, and follow-up	B	December 2009
Diabetes screening	Screening for type 2 diabetes mellitus in asymptomatic adults with sustained blood pressure (treated or untreated) >135/80 mm Hg	B	June 2008
Gonorrhea screening for women	All sexually active women if at increased risk for infection	B	May 2005
Healthy diet counseling	Adults with hyperlipidemia and other known risk factors for CVD and diet-related chronic disease	B	January 2003
HIV screening	Everyone at increased risk for HIV infection	A	July 2005
Obesity screening and management for adults	Everyone and patients with a BMI ≥30 kg/m² should be provided with or referred to intensive, multicomponent behavioral interventions	B	June 2012
Osteoporosis screening for women	Women aged ≥65 y and younger women if at increased risk for osteoporotic fractures	B	January 2011
Counseling about sexually transmitted infections	High-intensity behavioral counseling for everyone at increased risk	B	October 2008
Tobacco use counseling and interventions	Ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products	A	April 2009
Syphilis screening	Everyone at increased risk for syphilis infection	A	July 2004

AAA = abdominal aortic aneurysm; BMI = body mass index; CHD = coronary heart disease; CVD = cardiovascular disease; FOBT = fecal occult blood test; HPV = human papillomavirus; MI = myocardial infarction; USPSTF = U.S. Preventive Services Task Force.
* Excludes folic acid supplementation because benefits accrue to an unborn child rather than the patient.

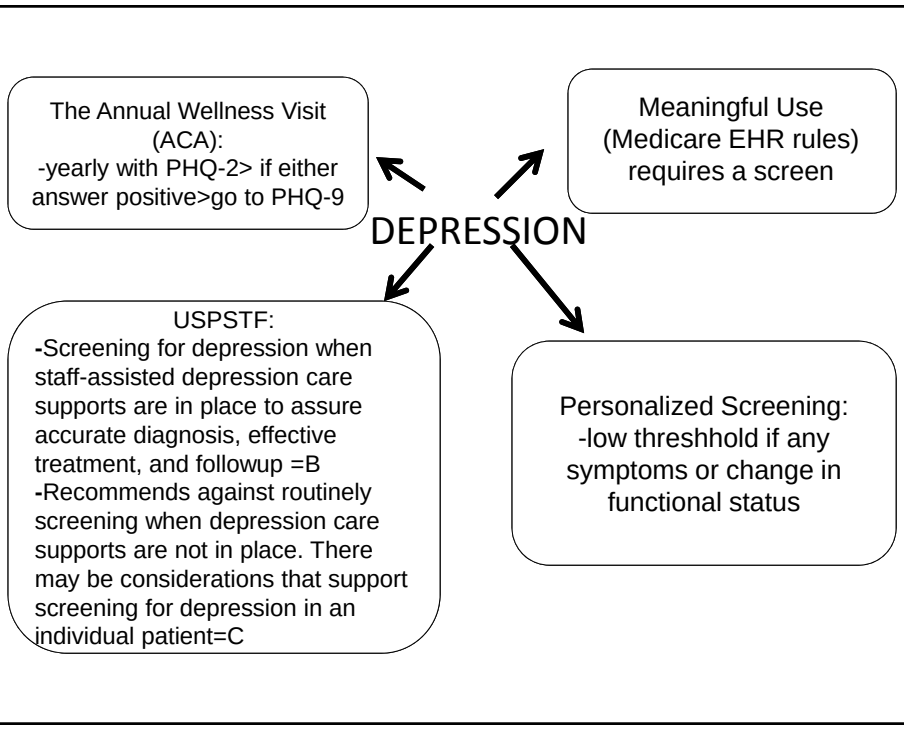
Meaningful Use

Meaningful use is using certified EHR technology to:
•Improve quality, safety, efficiency, and reduce health disparities
•Engage patients and families in their health care
•Improve care coordination
•Improve *population and public health*
•All the while maintaining privacy and security
Will be replaced when MACRA rolls in

Meaningful Use

•MU is mandated by law for providers to receive incentives from CMS for EHR use
•MU documentation for preventive health care is sometimes at odds with:
-what is appropriate for the patient
-the EHR documentation for AWV
-documentation in patients already on treatment for a specific condition!

Physiology, not Chronology



Depression: after the screening

20% of the Medicare-approved amount for visits to a health care provider to diagnose your condition or to monitor or change your prescriptions. The Part B deductible applies.

New since ACA: 20% of Medicare-approved amount for outpatient treatment of your condition (like individual or group psychotherapy or counseling) in a health provider's office or hospital outpt department. Broader coverage of providers and conditions including alcohol and drug use. Note: If you get services in a hospital outpt clinic or hospital outpt department, you may have to pay an additional copayment or coinsurance amount (facility fee). This amount will vary, but will be between 20-40% of the Medicare-approved amount.

Depression screening since the ACA

One large study reports no increase in screening for depression since the AWV. Psychiatr Serv. 2015 Jul 15:appips201400524.

Impact of Medicare Annual Wellness Visits on Uptake of Depression Screening. Pfoh E[1], Mojtabai R[1], Bailey J[1], Weiner JP[1], Dy SM[1].

This might reflect other drivers of depression screening such as MU and USPSTF/Society guidelines

Cognitive Impairment Screening (ACA)

- Screen via AWV
- Any concern (by any observer) allows for initiation of evaluation (separate E&M or modifier 25)
- Usual cognitive impairment evaluation with history, physical, labs.
- No specific testing is mandated
- Neuropsych testing is covered with reimbursement differing little whether PhD or a technician administers the test

Cognitive Assessment: Imaging

- CT or MRI is covered. However, some carriers are noting that providers order MRIs when CTs are negative, so are requesting MRI.
- FDG-PET scans are approved by Medicare for atypical presentation or course of dementia in which frontotemporal dementia diagnosis is suspected, or to evaluate the cause of memory disorders that cannot be determined from any other diagnostic test. ***

Cognitive Assessment: Imaging

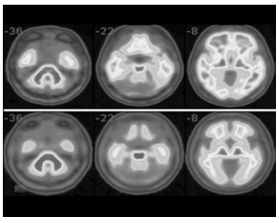
***PET SCANS: Positron emission tomography (PET) is a noninvasive diagnostic imaging procedure that assesses the level of metabolic activity and perfusion in various organ systems of the [human] body. A positron camera (tomograph) is used to produce cross-sectional tomographic images, which are obtained from positron emitting radioactive tracer substances (radiopharmaceuticals) such as 2-[F-18] Fluoro-D-Glucose (FDG), that are administered intravenously to the patient.

Covered also under CED: Coverage with Evidence Development

https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=263

Amyloid Scans

- The use of PET with imaging agents, such as florbetapir F 18 injection (Amyvid) or Flutemetamol (renamed Vizamyl), to exclude a diagnosis of Alzheimer's disease also requires coverage with evidence development (CED).
- This is a second layer of $$ due to the cost of the tracer. CMS will cover one PET scan to exclude Alzheimer's disease, but only for patients participating in specific clinical studies under a CED, which grants conditional reimbursement upon collection of specific data



Cognitive Impairment: Amyloid PET

Clinical trials that meet the requirements for coverage under CED:

•Cognitive Training and Practice Effects in MCI
Sponsor: University of Utah

•Molecular Cerebral Imaging in Incipient Dementia
Sponsor: University of California, Los Angeles

•Imaging Dementia—Evidence for Amyloid Scanning (IDEAS) Study
Sponsor: American College of Radiology Imaging Network

•Effect of Aerobic Exercise on Pathophysiology in Preclinical Alzheimer's Disease

https://www.cms.gov/Medicare/Coverage/Coverage-with-Evidence-Development/Amyloid-PET.html

Dementia: What the patient pays

20% of the Medicare-approved amount for visits to a doctor or other provider to diagnose your condition or to monitor or change your prescriptions. Part B deductible applies.

Since ACA: 20% of Medicare-approved amount for outpatient treatment (like individual or group psychotherapy or counseling) in a doctor or other health provider's office or hospital outpatient department. Broader coverage of providers and conditions including alcohol and drug use.

Note: Facility fees: if services are in a hospital outpatient clinic or hospital outpatient department, you may have to pay an additional copayment or coinsurance amount to the hospital. Amount will vary depending on the service provided, but will be between 20-40% of the Medicare-approved amount.

Association Recommendations

Alzheimer's Association:

-Full Hx and PE including meds and neuro exam, evaluate mood

-Labs including: CBC, Chem7, UA, drug and alcohol tests, CSF analysis, TFTs

-mini-cog/MMSE

-CT or MRI

-would like CMS decision to more broadly cover Amyloid Scans

NINDS/NIA:

-clinical criteria for AD

-no consensus on use of biomarkers or imaging

http://www.alz.org/research/science/earlier_alzheimers_diagnosis.asp#Brain

Case #3

Mr. AA is a marginally housed 75 year old man with severe PVD and HF with preserved EF. He uses Etoh and crack 3x/wk. He has finally had a left transmetatarsal amputation and has been in a SNF for 7 weeks.

He is now d/c to home with "close f/u from the PCP".

His most recent apt is SHAG housing and the phone is in the lobby.

He has no LNOK, Emerg contact is "Jesse the security guard at the front desk".

The front desk says they are not responsible for his medical care, but they will let him know about upcoming appointments via a "stick em" on his door.

TCM

Transitional Care Management Services: since January 1, 2013, CPT codes (99495 and 99496 dep on complexity) used to report provider care management services for a patient following a discharge from a hospital, SNF, or CMHC stay, outpatient observation, or partial hospitalization.

- $170/99; $230/145 (NF/F)

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

TCM: the fine print

- Service begins with a qualified D/C from a facility (ED visit does not qualify)=Day 1
- The date of service on the claim is the final day of the period of TCM services (the 30-day period for the TCM service begins on the day of qualified Medicare discharge and continues for the next 29 calendar days. The reported date of service should be the 30th day).

TCM: the fine print

- Must try to contact patient within 2 business days (documentation required, success is not)
- Must document: review of information, interaction with other providers, interaction with caregivers, education, referrals
- Must see patient F2F within 14 calendar days (7 if high complexity bill). For eligible telehealth services, the use of a telecommunications system qualifies.
- Can be used even if pt is readmitted
- 1 provider, only once per patient every 30 days, but can bill for other E/M services during that time
- Can not bill if patient dies during 30 day period

Case #4

Mrs. AL is a moderately demented female with HTN, severe glaucoma with only large print vision, osteoporosis and falls. She comes to SCC every 3 months for IV bisphosphonate. Mrs. AL calls SCC about once a week asking for med refills. Specifically she is concerned about vitamin D. Each time she is reassured that she has refills (charity care). She is reminded that her glaucoma meds are not getting refilled per the RAC and this is very important.

Mrs. AL lives with a nephew who works fulltime and goes to school. She comes to clinic alone thanks to Hopelink. MMSE is 18/30 with very poor ST memory.

CCM

Chonic Care Management Services:

- Beginning January 1, 2015, Medicare pays separately under the Medicare Physician Fee Schedule (PFS) under American Medical Association CPT code 99490, for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions (2 or more)
- $42/32 (NF/F) per month per eligible pt

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

CCM

CPT 99490: Chronic care management services during which at least 20 minutes of clinical staff (assumes 15 min by provider) time is directed by a provider, per calendar month, for patients with 2 or more (=2/3 of Medicare Beneficiaries)

- 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
- Expected to last at least 12 months, or until the death of the patient

Complex CCM: the next level

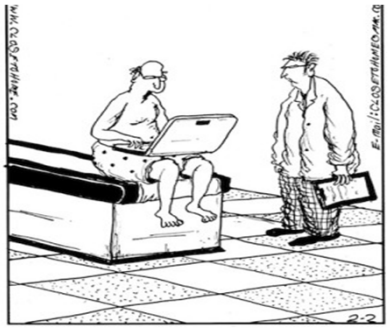
CPT 99487 ($93/$53 NF/F): Complex chronic care management services, with the following required elements:

- As with basic CCM, but Moderate/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: Each additional 30 minutes

CCM: the fine print

- The patient is actively engaged in the process
- Consent process has been loosened, but still requires an F2F if pt not seen in 12 mo.
- Consent includes:
  - 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)



Advanced Care Planning (ACP)

- Effective January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) pays for voluntary Advance Care Planning (ACP) under the Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (OPPS)

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

Advanced Care Planning (ACP)

- CPT Codes 99497: Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
- Code 99498: each additional 30 minutes (list separately in addition to code for primary procedure)
- Can be billed more than once a year

Summary Points

The ACA has resulted in many options to improve the care of seniors.

The value of the AWV remains to be seen, many older folks do not see the point of reviewing the check list required to fulfill the rules.

The TCM code is helpful, but burdensome with respect to the F:F component (which can be done via a home visit or telehealth).

Summary Points

The CCM code is burdensome in terms of rollout, but has great potential to reimburse the care team for work they are already doing. This is especially true with new provisions for complex CCM.

Reimbursement for advanced care planning is a welcome provision for providers