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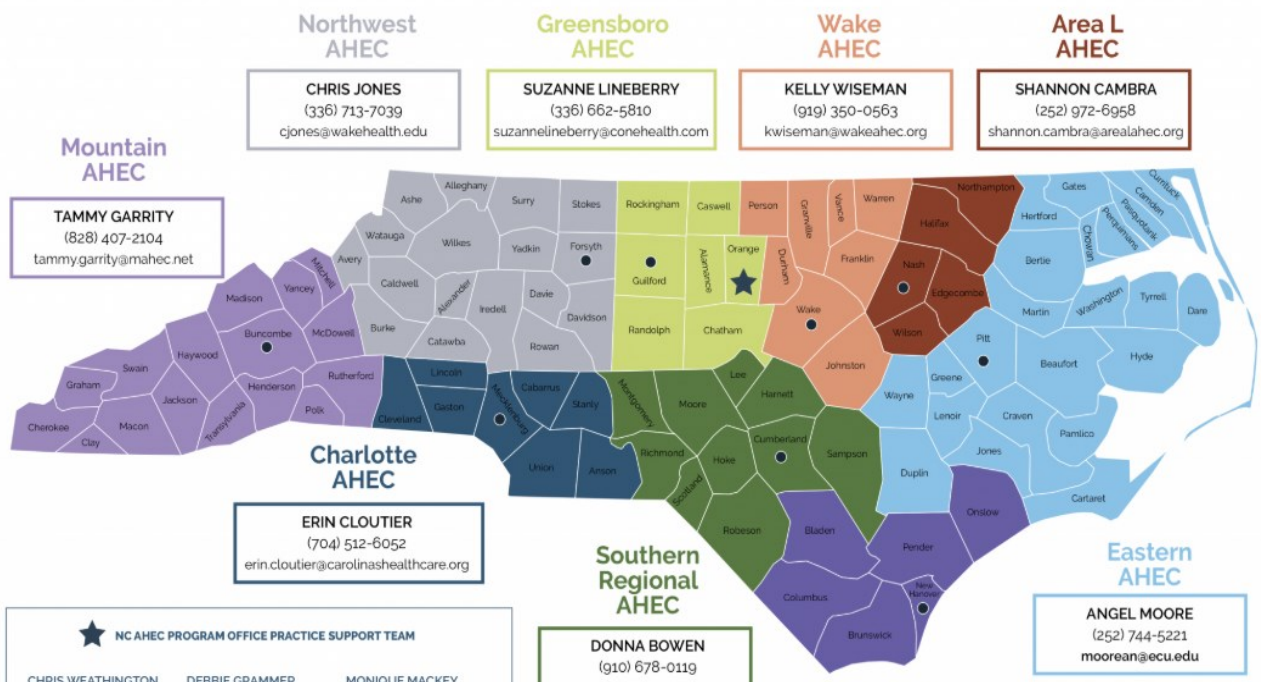
Chronic Care and Wellness Services Telehealth Visit Toolkit

This toolkit includes tip sheets that takes a look at the traditional delivery methods of common primary care visits and how they may look when converted to a telehealth platform. Tips sheets in the packet include the following: Annual Wellness Visit, Chronic Care Management Services, and Transitional Care Management Services.

If you have questions or would like support on this topic please reach out to your local AHEC practice support team.
We can help!

NORTH CAROLINA AHEC REGIONAL PRACTICE SUPPORT CONTACTS



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Annual Wellness Visit (Medicare Service)

- ***Why do them?***

  Medicare's Annual Wellness Visit (AWV) is a way for your practice to keep patients as healthy as possible. As health care moves from volume- to value-based models, the AWV addresses gaps in care and enhances the quality of care you deliver. A personalized prevention plan created for the Medicare beneficiary is a way to improve patient engagement and promote preventive health care.

- ***What are they?***

Medicare Coverage of Physical Exams-Know the Differences		
Initial Preventive Physical Examination (IPPE)	Annual Wellness Visits (AWV)	Routine Physical Examination
Review of medical and social health history, and preventative services education. ✓ Covered only once, within 12 months of Part B enrollment ✓ Patient pays nothing (if provider accepts assignment)	Visit to develop or update a personalized prevention plan, and perform a health risk assessment. ✓ Covered once every 12 months ✓ Patient pays nothing (if provider accepts assignment)	Exam performed without relationship to treatment or diagnosis for a specific illness, symptom, compliant, or injury. Ø Not Covered by Medicare: prohibited by statute Ø Patient pays 100% out-of-pocket

⇒ ***NOTE: This is not a physical exam***

Medicare Part B covers an AWV if performed by a:

- Physician (a doctor of medicine or osteopathy)
- Qualified non-physician practioner (PA, NP, or certified clinical nurse specialist)
- Medical Professional (including a registered nurse, health educator, registered dietitian, nutrition professional, or other licensed practioner), or a team of medical professionals directly supervised by a physician (doctor of medicine or osteopathy)

⇒ ***NOTE:*** **Medicare does pay for focused problem based exams and many providers use a 25 modifier to "add" an exam to the AWV.**

The provider may determine that a problem focused exam is necessary at the time of the AWV.

- If so, the patient should be informed of the need for this visit (this may be done virtually under the waver).
- The patient may have responsibility for coinsurance and part B deductible for this part of the visit while the AWV portion is covered completely
- A separate after visit summary for the Acute care should be provided as well as the "written plan of care" for the AWV.

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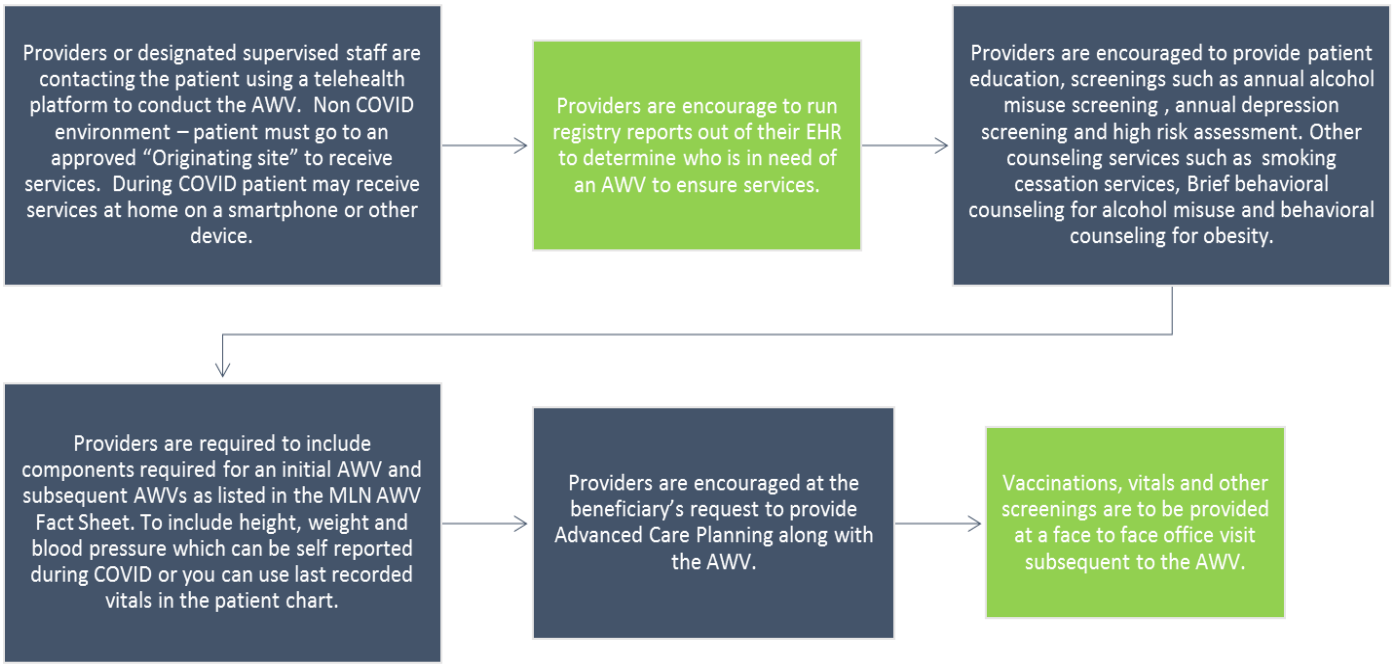
Annual Wellness Visit

- ***Telehealth Delivery of Annual Wellness Visit***



- ***Telehealth Billing***
  - Billing during COVID has expanded to include their home as a place of approved service. Please see the link to CMS 1135 Waiver below. **Annual Wellness Visits completed via Telehealth are paid at parity as an office visit.**

- ***Telehealth Special Considerations***
  - May 1, 2020 CMS approved AWV to be provided during COVID using Audio only. Please see link below.
  - Benefits to Telehealth AWVs have discussed such visual of home and environment (falls risk and family dynamics), SDOH food insecurity and discussing what is in the fridge? Also, discussion with combining an AWV at the same time as a Home Health visit for a more robust visit.

- ***Resources***
  - CMS Telehealth Services Fact Sheet
  - CMS MLN AWV Fact Sheet
  - 1135 Waiver Billing Information
  - CMS Telehealth Webpage and April 30, 2020 update to Telehealth and Audio only CPT codes
  - Mid Atlantic Telehealth Resource Center

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Chronic Care Management (Medicare Service)

- ***What and Why do them?***
  - Chronic care management includes any care provided by medical professionals to patients who have chronic diseases and conditions. A disease or condition is chronic when it lasts a year or more, requires ongoing medical attention or limits the activities of daily life. It includes physical conditions like diabetes or mental conditions, like depression. ***The goal of chronic care management is to help patients achieve a better quality of life through continuous care and management of their conditions.***

- ***Tradition Delivery for Chronic Care Management Services***
  - Chronic care management involves a comprehensive care plan that includes:
    - ⇒ a record of the patient's chronic conditions and problem list,
    - ⇒ symptoms,
    - ⇒ goals,
    - ⇒ health care providers (including specialists and home health services),
    - ⇒ medications,
    - ⇒ any other services needed to manage their condition

Medicare	Non-Medicare
Medicare allows billing separately for CCM and has guidelines to follow: ◦ Chronic care management consists of reviewing the patient's medical record for twenty minutes or more per month: reviewing the care plan, contacting the patient via telephone if possible, medication reconciliation, discussing any visits during the month to the ER, hospital, or specialist, checking appointment status, and any pending referrals. ◦ Documentation in the patient's chart is required. ◦ Most EHRs maintain a list, or report, of Medicare CCM patients that can be continuously worked. ◦ Face-to-face visits are usually scheduled every three months, and lab testing may be performed.	◦ For Non-Medicare chronically ill patients, face-to-face visits are usually scheduled every 3 months with a provider. ◦ Lab testing may be done. ◦ ***Payers other than Medicare do not have separate codes for Chronic Care Management.*** ◦ Patients call the office as needed between appointments or send questions/concerns through the patient portal. ◦ Patients with chronic conditions may be considered "high-risk", and may be contacted more frequently during a pandemic or flu season. ◦ A list or report can be run based on diagnoses, and an employee assigned to contact them.

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Chronic Care Management

- ***Telehealth Delivery for Chronic Care Management Services***
  - During the current pandemic, visits can be conducted virtually through an audio-visual platform, or telephonic if the patient does not have audio capability. Lab testing may be ordered and the patient may "drive through" if offered at the practice, or come into the office briefly for lab testing only. ***Medicare CCM is not affected during the pandemic as patient contact is via telephone (between regularly scheduled appointments).***

Telehealth Billing	
99490	Twenty minutes or more of clinical staff time per calendar month; 2 or more chronic conditions, comprehensive care plan established, implemented, revised, or monitored
99491	Thirty minutes or more of clinical staff time per calendar month; 2 or more chronic conditions, comprehensive care plan established, implemented, revised, or monitored
99487	Complex; 60 minutes or more of clinical staff time per calendar month; 2 or more chronic conditions, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making
99489	Each additional 30 minutes (add-on code to 99487)
*G05011 should be added to RHC and FQHC claims (either alone or with other services) for Medicare CCM	
Billing for Non-Medicare Telehealth There are no specific codes. Office visit codes 99201-99215 should be used.	

- ***Telehealth Special Considerations***
  - During a Pandemic or flu season, patient access via telehealth can help with compliance.

- ***Resources***
  - CMS MLN Chronic Care Management Information
  - CMA Medicare Fee for Service Payment, FAQs for FQHC and RHC

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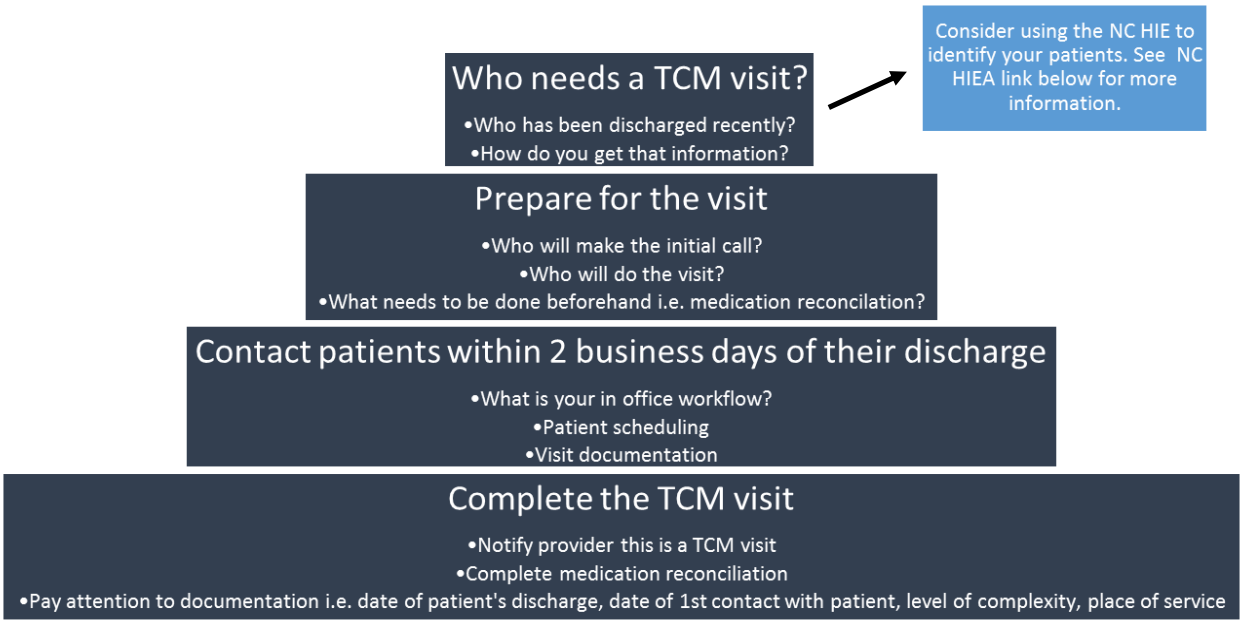
Transitions of Care (Medicare Service)

- ***What and Why do them?***
  - These are visits with a primary care provider that take place within 30 days of a patient being discharged from an acute-care facility. Transitions of Care (TCM) visits ensure that patients/ caregivers have the resources needed to smoothly transition between healthcare settings. The goal of TCM is to reduce preventable readmissions by coordinating services for all medical conditions, identifying and addressing psychosocial needs, and arranging for assistance with activities of daily living.

Benefits to the Practice	Benefits to Your Patients
✓Improved awareness of discharges. ✓Opportunity to utilize discharge reports to inform post-hospitalization care. ✓Enhanced care coordination via institutional care managers and/or technology such as telehealth apps or health information exchanges. ✓More opportunities to improve patient outcomes via interaction with care team and better documentation of transitions. ✓Boosts practice revenue.	✓Reduced risk of preventable readmissions. ✓ Better experience of care during care facility transitions. [HealthInsight. (n.d.). *Transitional Care Management Implementation Guide*. Retrieved from https://healthinsight.org/tools-and-resources/send/412-strengthening-primary-care/1574-tcm-implementation-guide. Accessed 05/20/2020].

- ***Traditional Delivery of Transitions of Care Services***



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Transitions of Care

- ***Telehealth Delivery of Transitions of Care Services***
  - During the pandemic, the provider portion (qualified clinician) can be done virtually under the waiver. Provider responsibilities include; Review the discharge, Evaluate need for follow-up, testing or additional treatment, Interact with consulting providers, Educate, Referrals, Assist in scheduling. The clinical staff can complete the communication responsibilities via telehealth. Under the direction of a physician, clinical staff can provide coordination, medication reconciliation, education, resources, and facilitation of access needs.

In-office and Telehealth Billing		
99495	Used for both face-to-face and telehealth	Two-way communication with patient within two business days of discharge and TCM services with **moderate** medical decision complexity. (face-to-face visit within 14 days of discharge).
99496	Used for both face-to-face and telehealth	Two-way communication with patient within two business days of discharges and TCM services with **high** medical decision complexity (face-to-face visit within 7 days of discharge).

The following codes may not be billed during the 30-day period covered by the TCM code: Based on Medicare 2020 Physician Fee Schedule Final Rule

Care plan oversight (G0181 and G0182)
Prolonged services without direct patient contact (99358, 99359)
Home and outpatient INR monitoring (93792-93793)
End stage renal disease services (90960, 90961, 90962, 90966, 90970)
Analysis of data (99091)
Complex chronic care coordination services (99487, 99489)
Medication therapy management services (99605-99607)
Chronic Care Management (CCM) services and TCM service periods cannot overlap
Effective 01/01/2020: G0511 may be billed with Transitional Care Management (99495, 99496)

- ***Telehealth Special Considerations***
  - ***None***

- ***Resources***
  - American Academy of Family Practice: FAQ on Transitional Care Management
  - American College of Physicians: What Practices Need to Know about Transition Care Management Codes
  - Rural Health Information health: Transitional Care Management
  - HealthInsight Quality Innovation Network: Transitional Care Management Implementation Guide
  - HealthInsight Quality Innovation Network: TCM Checklist
  - NC HIEA Information: Get Connected