Section 4.6 Implement

Documentation for CCC Reimbursement

This tool describes the importance of documentation and potential workflow changes to take advantage of any opportunity for reimbursement of services associated with transitional care management (TCM), chronic care management (CCM), and community-based care coordination (CCC).

Time needed: 2 hours

Suggested other tools: Matrix of CCC-Related Activities and Staff Roles; CCC Patient Plan; Patient Action Plan; Patient Tracking and Follow up Tools; Technology Tools and Optimization for CCC; Workflow and Process Analysis/ Redesign/ Optimization for CCC tool suite; Documentation for CCC Reimbursement Template

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How to Use

1. **Review** reimbursement opportunities for various forms of value-based purchasing and recognize that they are rapidly changing. Continually monitor the reimbursement and payment landscape and plan to address reimbursement for TCM, CCM, or CCC as payer contracts are renegotiated.
2. **Review** the principles of documentation that may support reimbursement for TCM, CCM, or CCC for care coordination services. Plan to adopt these principles as a means to prepare for the eventuality of increased value-based purchasing.
3. **Keep abreast** of what reimbursement opportunities are available for TCM, CCM, or CCC from Medicare, commercial payers, and Blue Cross Blue Shield (BCBS) plans.

Payment in Value-Based Purchasing

Reimbursement opportunities are continuing to be evaluated and adopted by Medicare, some commercial payers, and some BCBS plans. Medicare regulations change annually and commercial/BCBS payers may adopt changes as frequently as every six months. Reimbursement opportunities may vary by the state in which a health care practice or CCC program operates (although, to date, Medicaid has not yet adopted a value-based reimbursement structure). In addition to reimbursement opportunities, there may also be lump sum payment opportunities for adopting new models of care, such as the patient-centered medical home.

Transitional Care Management (TCM)

In 2013, Medicare acknowledged the additional work involved in managing a patient following a hospital discharge and created a new payment for TCM. Payment under these codes may be roughly equal to the highest payment for a new patient office visit. The service must be conducted by a physician.

- **99495:** Physician holds and documents a medical discussion about care transitions with a patient or caregiver within two days of discharge from a facility; and a face-to-face visit occurs *within two weeks*.
- **99496:** Physician holds and documents a medical discussion about care transitions with a patient or caregiver within two days of discharge from a facility; and a face-to-face visit occurs *within one week*.

Chronic Care Management (CCM)

CPT codes also exist for reporting complex chronic care coordination services conducted by a physician or advanced practice professional (e.g., NP, PA, CNS, CNM, NPP).

- **99487:** First hour of clinical staff time spent coordinating care over a 30-day period in cases where there is no face-to-face visit.
- **99488:** First hour of care coordination time over a 30-day period and a face-to-face visit.
- **99489:** 30 minute increments of clinical staff time directed by a physician or other qualified health care professional over the initial hour of care coordination.

Note that hospitalists generally are not eligible to use such codes, as the hospitalist will bill for discharge day services under CPT codes 99238 or 99239 and refer patients for follow up to a primary care provider or other community provider. If the patient does not have such a provider, the hospitalist should suggest a provider to the patient and document such in the discharge summary. The hospitalist should introduce the patient to TCM, CCM, or CCC if the care coordinator has not already done so, or remind the patient to expect contact by a care coordinator and provider.

The 2015 Proposed Medicare Physician Fee Schedule is also proposing to reimburse providers for furnishing specified non-face-to-face services to qualified beneficiaries over a 30-day period for chronic care management.

Emerging Value-Based Payments

Accountable care organizations (ACO) of various types – both governmental and non-governmental – are also emerging with new value-based payment structures such as shared savings plans, shared risk plans, etc. In fact, the value-based purchasing scene is changing so rapidly that any tool that would attempt to provide definitive answers would be out-of-date before it could be published. As such, CCC programs continually should monitor reimbursement and other value-based purchasing opportunities to determine what may apply to the specific nature of the CCC program and whether a change in some aspect of the program may be productive.

Documentation and Workflow Changes for Reimbursement

While each payment schema will have specific documentation and timeline requirements (including which type of health care professional should document for reimbursement), it is important to initiate good documentation practices for TCM, CCM, or CCC in general. In addition to provider documentation, workflow changes may also result from new roles that front office staff and nurses can undertake to prepare for TCM, CCM, or CCC visits.

Specific documentation requirements should always be reviewed, understood, and adopted. The following *general* documentation principles should be followed. Review which documentation components the CCC program will include in the patient's health record, who (role) may best provide the documentation and what changes may be needed. (See *Documentation for CCC Reimbursement Template* for a fillable form.)

General Documentation Practices for TCM, CCM, and CCC		
Documentation Component	**Potentially Performed By**	**Potential Changes Needed**
Date of hospital discharge	Front office staff	
Receives discharge documents	Front office staff	
Date and time nurse initiates call with patient to conduct medication reconciliation	Nurse calls patient prior to visit to check medications being taken, prescriptions filled, and health record updated	
Review of pending lab results (report)	Nurse ensures lab results are present in health record	
Documentation of patient concerns/questions during call	Nurse responds to any patient concerns/questions and documents in health record	
Order for new labs	Nurse determines if new labs need to be ordered (nurse or provider documents order)	
Date and time nurse completes call with patient	Nurse documents in health record	
Date and time provider communication with patient initiated	Provider documents in health record	
Place of service (facility/non-facility)	Provider documents direct contact, telephone or email contact in health record	
Medical decision making	Provider documents medical decision making in health record	
Date and time provider communication with patient ends	Provider signs off on documentation in health record	
Arrangement for face-to-face visit	Front office staff	

General Documentation Practices for TCM, CCM, and CCC		
Documentation Component	**Potentially Performed By**	**Potential Changes Needed**
Office receives lab results and other documents	Front office staff ensures information is placed in patient's health record	
Pre-visit planning conducted (e.g., new lab results, medication issues as advised by pharmacist, prescription fill issues as notified by pharmacy)	Nurse conducts and documents in health record including date, time, and findings	
Date and time face-to-face visit with physician initiated	Physician documents in health record	
Medication reconciliation at time of face-to-face visit	Physician conducts and documents in health record	
Medical decision making	Physician documents level of complexity in health record	
Date and time physician communication with patient ends	Physician documents in health record	
Other medically necessary billable services provided (including during 30 day period after discharge)	Provider documents in health record	
Regularly updated comprehensive patient-centered plan of care	Care coordinator, nurse, provider documents in health record (with copy to patient)	
Continuity of care through access to established care team for successive routine appointments	Primary care provider documents in health record	
24x7 patient access to care team to address acute chronic care needs	Care team 24x7 access to patient's full EHR	
Opportunity for patient to communicate with care team by telephone, secure messaging, and other asynchronous communication modalities	Patient communications are documented in health record	
Management of care transitions facilitated by electronic exchange of health information	Health information accessed via HIE documents in health record	
Coordination with home- and community-based providers required to support patients psychosocial needs and functional deficits	Care coordinator, nurse or provider documents in health record	

While Medicare and other payers may not yet be reimbursing for all CCC activities, getting into the habit of documenting all such activities ensures that the CCC program is ready. Such documentation can also aid in evaluation of the program.

Traditionally, health record documentation has provided information on **WHAT** the patient's condition is, what treatment was provided, the date **WHEN** this occurred, and **WHO** the provider was. Documentation to fully support value-based purchasing should also address:

- **WHEN** communication with patient took place
- **WHERE** communication with patient took place, including face-to-face, in a facility or home, via telephone, or via electronic media – including email, remote monitoring, etc.

- **WHY** decisions were made as they were (i.e., brief description of medical decision making such as use of evidence-based guidance, in shared decision making with patient, etc.)
- **WHO** else may have coordinated care, conducted pre-visit planning, conducted medication reconciliation, etc.
- **HOW** information was exchanged with other providers and patients

Ideally, the electronic health record (EHR) for each patient is easily accessible to the care coordinator. This may necessitate providing access to the care coordinator to multiple different systems and/or via a health information exchange (HIE) that can route information to and from respective EHRs. The EHRs or HIE should be able to generate reports on care coordinator activities and other types of documentation.

Resources for Keeping Current on Reimbursement and other Value-Based Purchasing Payments

Medicare is a key resource, as many commercial payers tend to follow Medicare's lead in reimbursement strategies and documentation requirements. It is recommended that the care coordinator bookmark specific www.cms.gov sites to reference regularly. In addition, Medicare circulates newsletters to providers quarterly.

Provider specialty societies are another important source of information. These societies often have their fingers on the pulse of change and can help interpret regulations in an easy-to-understand manner. Websites and other resources from the American Academy of Family Physicians (www.aafp.org) and the American College of Physicians (www.acponline.org) should be regularly reviewed.

Commercial and BCBS payers often send regular newsletters to providers with whom they contract. Updates on documentation requirements are provided frequently. Identify the major payers in the community and request to be added to their news listings.

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For support using the toolkit

Stratis Health • Health Information Technology Services

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