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Care Management Services

Allison Hirschorn

Associate Director, Coverage and Reimbursement

American Society of Clinical Oncology

GASCO Administration and Business of Oncology Meeting

June 10th, 2022

Topics

- Definition and purpose
- Medicare utilization
- Care delivery
- Practice administration
- Coding and reporting
- Reimbursement

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Definition and Purpose of Care Management Services

Care Management Services

Managing and supporting patients with a single high-risk condition or multiple chronic conditions.

Goals of Care Management

Improve care coordination and collaboration.

Reduce hospital admissions or services.

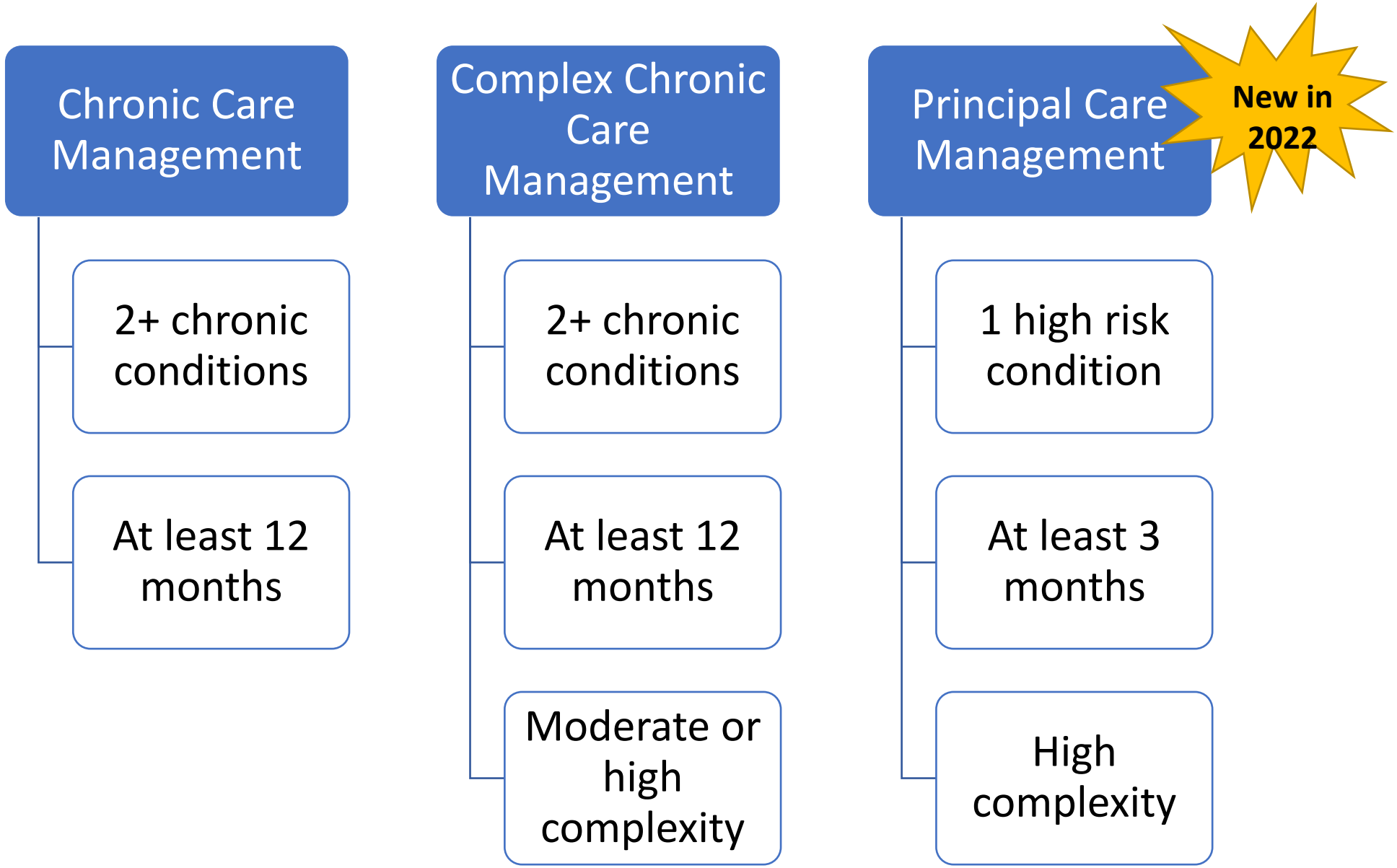
Engage patients and caregivers in the care plan.

Care Management Services

MANAGEMENT AND SUPPORT

QUALITY CARE

IMPROVED PATIENT OUTCOMES



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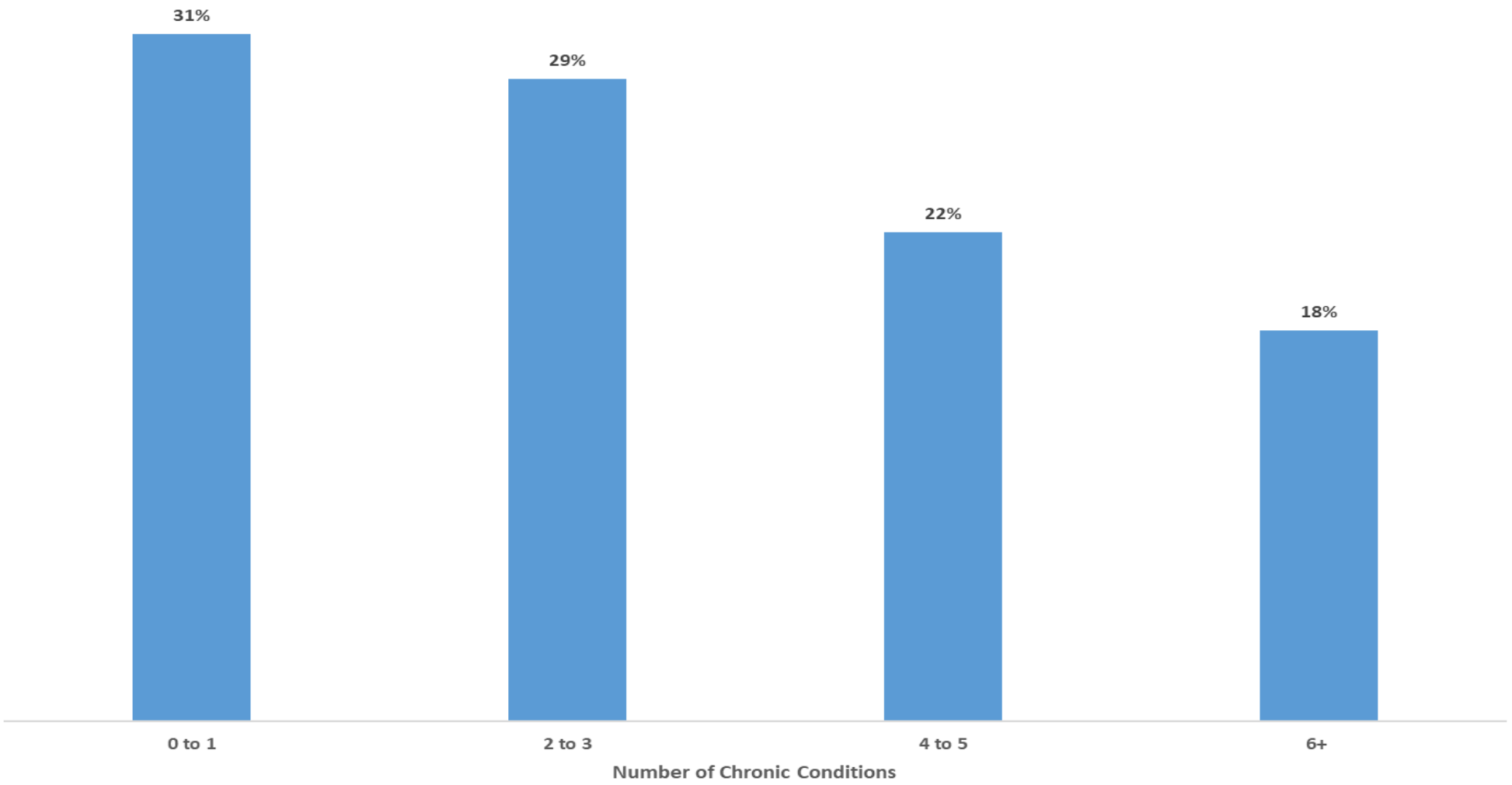
Medicare Utilization of Care Management Services

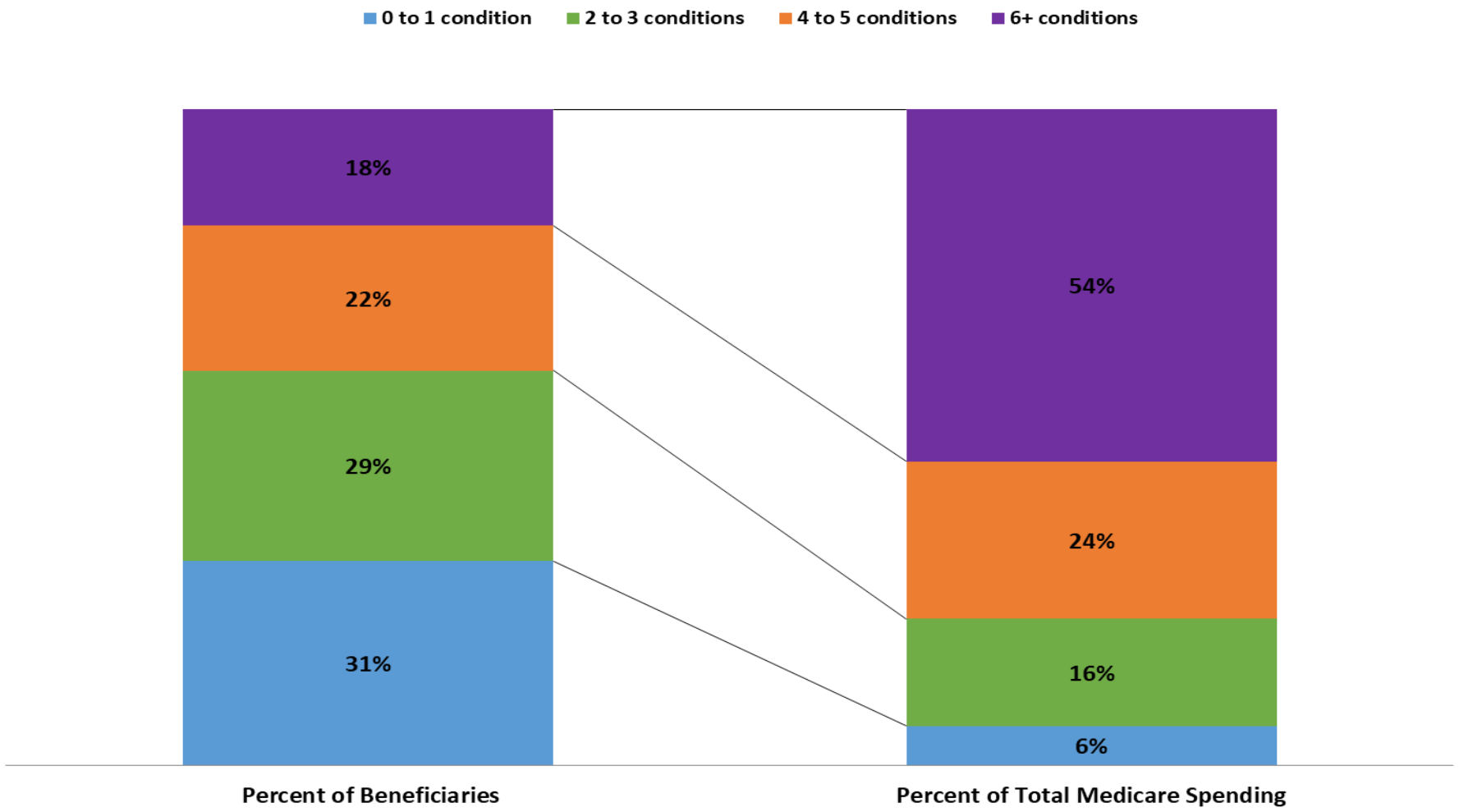
[National Center for Chronic Disease Prevention and Promotion About Chronic Diseases]

Figure 5: Prevalence of Multiple Chronic Conditions among Fee-for-Service Beneficiaries: 2018



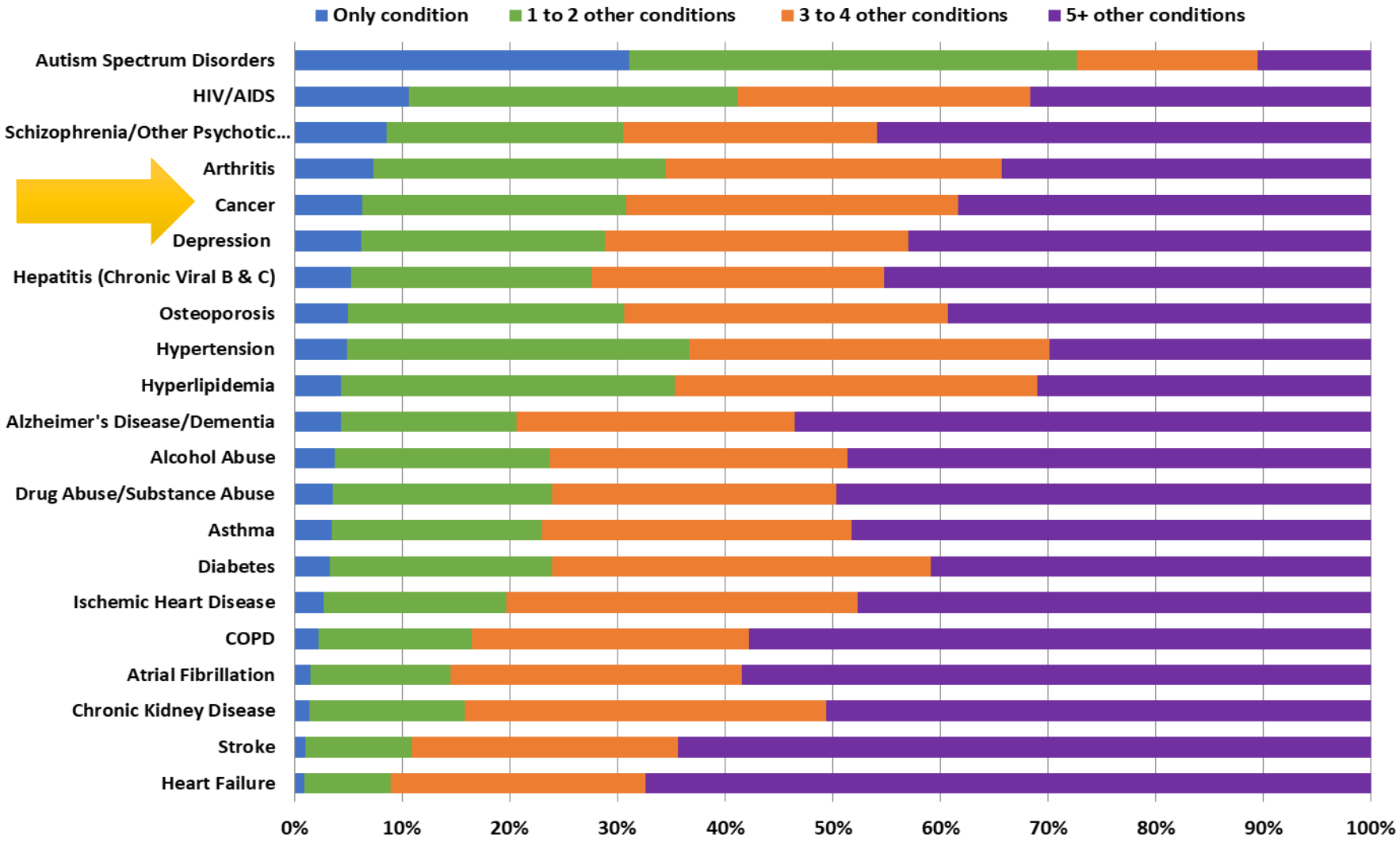
Centers for Medicare and Medicaid Services
Chartbook and Charts- Chronic Conditions Charts: 2018

Figure 13: Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2018



Centers for Medicare and Medicaid Services
Chartbook and Charts- Chronic Conditions Charts: 2018

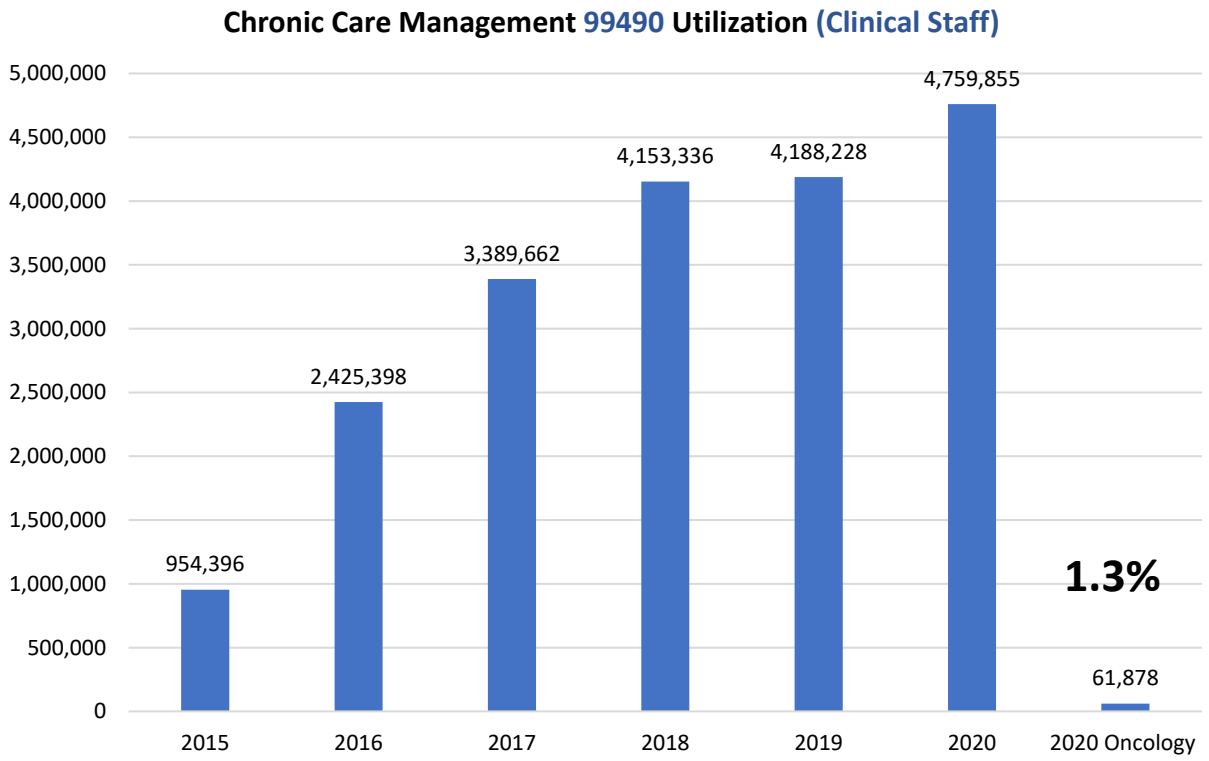
Figure 15: Co-morbidity among Chronic Conditions for Medicare Fee-for-Service Beneficiaries : 2018

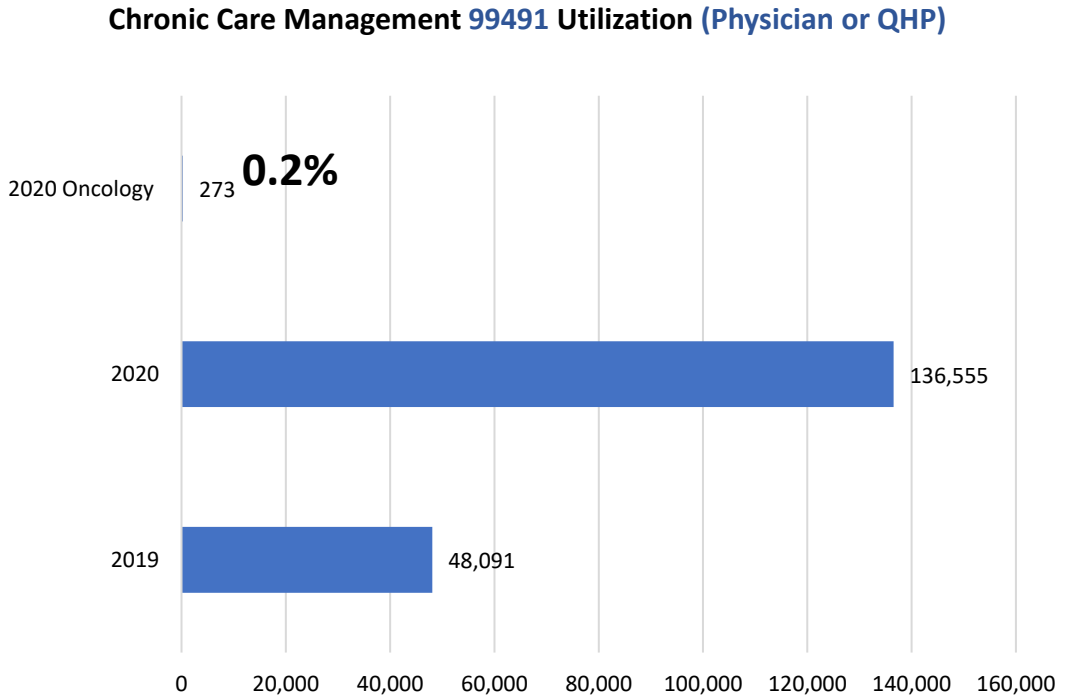


Most beneficiaries diagnosed with cancer have **multiple chronic conditions**.

Centers for Medicare and Medicaid Services
Chartbook and Charts- Chronic Conditions Charts: 2018

Medicare Utilization
Chronic Care Management Services





Code Descriptions

99490-Chronic care clinical staff, 1st 20 minutes

99491-Chronic care, physican/QHP, 1st 20 minutes

Add on codes for 99490 and 99491 (additional time) were implemented in 2022, therefore no claims data is available yet.

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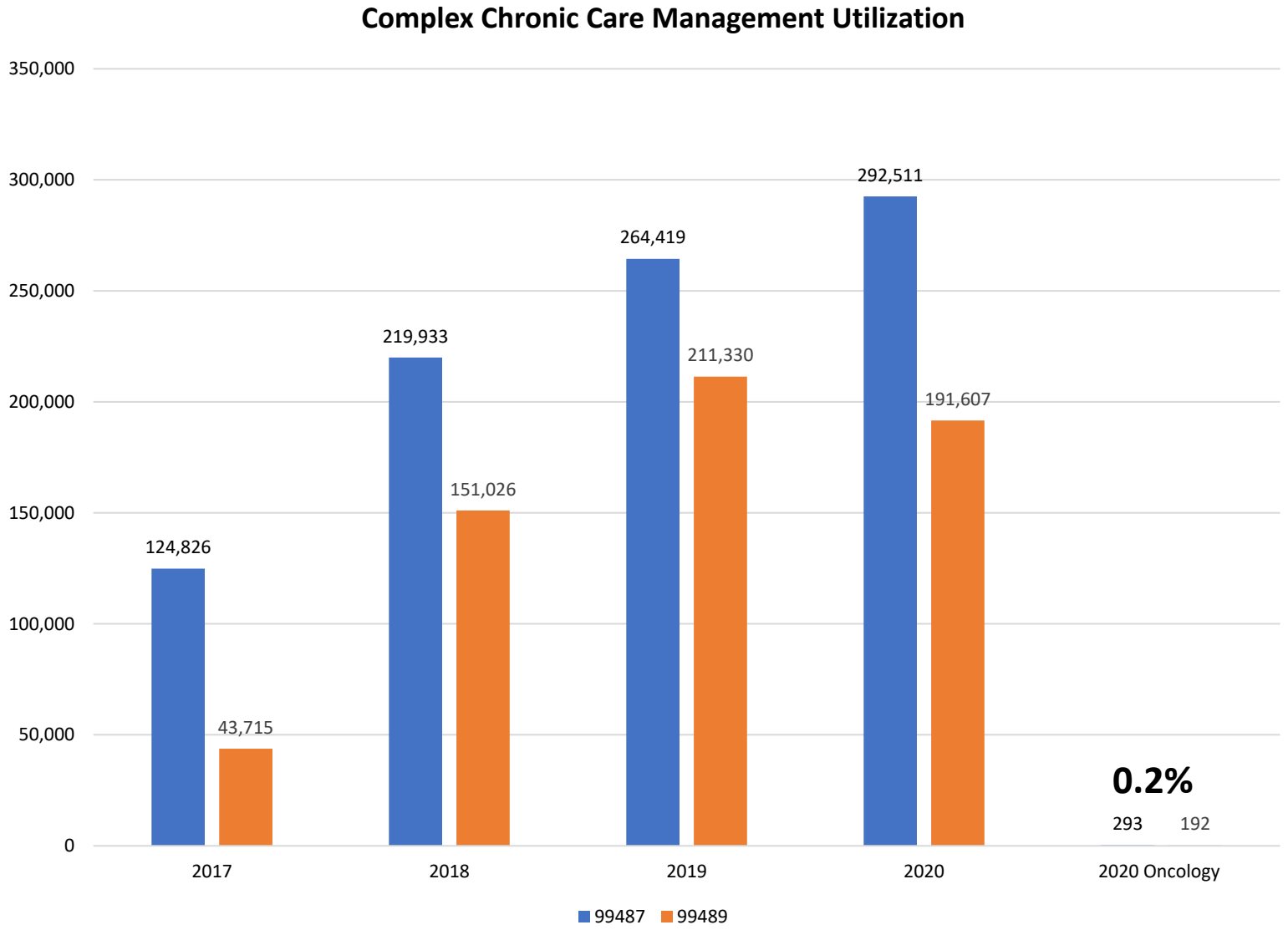
Medicare Utilization: Complex Chronic Care Management Services



Code Descriptions

99487- Complex chronic care, clinical staff, 1st 20 minutes

99489- Complex chronic care, clinical staff, each additional 20 minutes

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Care Management Services

Challenges

Identification	Patients in need of care management.
Workflow	Staff providing the service.
Administration	Practice processes.
Reporting	Awareness and understanding of guidelines.

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Care Delivery

What's included in a comprehensive care plan?

- Problem list
- Outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions
- Medication management
- Community/social
- Coordination of care
- Review schedule

Care Management Services Activities

Includes both face-to-face *and* non-face-to-face activities:

- Transition management.
- Communication with patient and/or caregiver.
- Assessment and support for treatment regimen.
- Communication with other healthcare professionals.
- Development and updating of the care plan.
- Patient and/or caregiver education.
- Ongoing review of patient status.

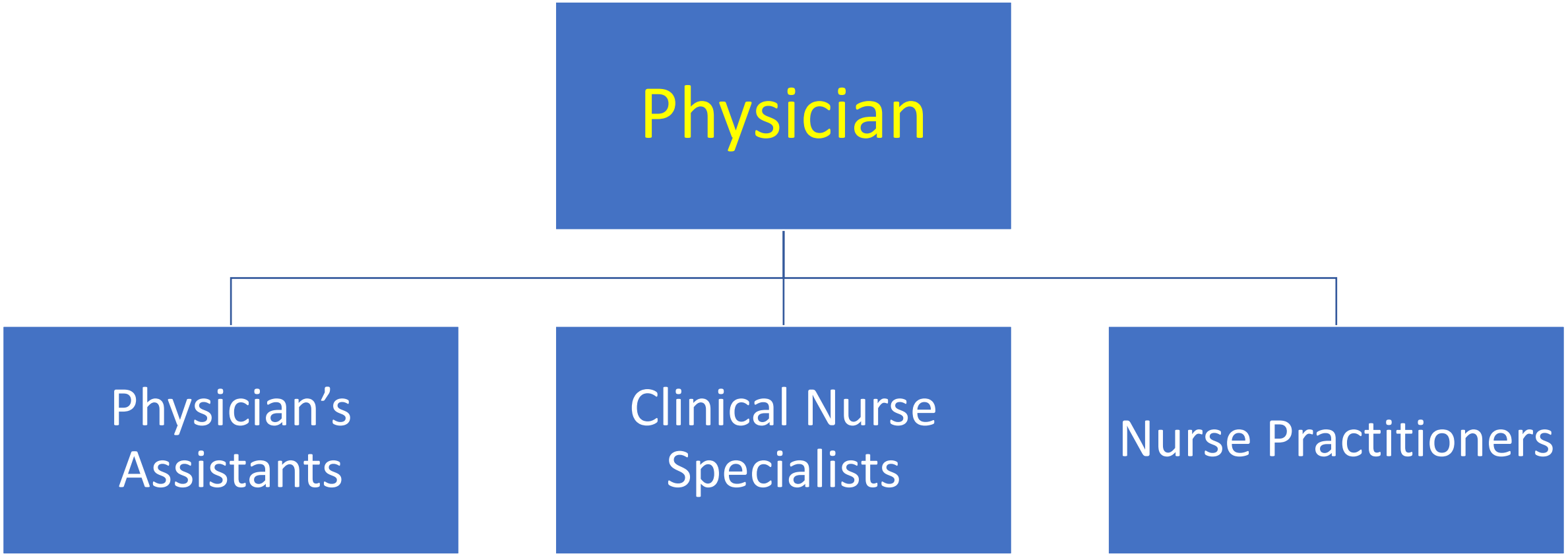
Care Management Activities
Addressing SDOH

Tool for reducing geographic and racial/ethnic disparities in health.

- Addressing a patient's SDOH may be part of the care plan required as part of a care management service in addition to work performed by the physician/QHP or clinical staff.

- Includes communication and coordination with home- and community-based clinical service providers. Also accounts for non face to face communication with the patient/family/caregiver.

Care Team



Role of the Physician vs. Clinical Staff

Physician

- Develop a comprehensive care plan and assessment.
  - Address all health issues (medical and psychosocial)
  - Focus on patient's chronic condition(s)
- Provide guidance and direction to clinical staff

Clinical staff

- Educate patient and/or caregiver.
- Respond to patient inquiries.
- Reconcile medications list (including those prescribed by other providers).
- Manage care transitions.
- Share information with other health care providers.

Clinical staff provides services under the direction of a physician or qualified healthcare provider. Requires general supervision to report as "incident-to."

Care Management Services
Patient Example: Complex Chronic Care

An 80-year-old man with prostate cancer needs a hip replacement immediately. In addition to prostate cancer, he is also a type 2 diabetic.

The patient's oncology care team collaborated on the plan of care with the orthopedic team. The hip surgery was performed at Memorial Sloan Kettering where the patient was obtaining treatment for the prostate cancer.

The oncology team kept in regular communication with the orthopedic team regarding the patient's status and care plan.

The patient's care team conducted a review and revision of the care plan to treat the prostate cancer post hip surgery.

Care Management Activities

Establishment and implementation of care plan

- Prostate cancer treatment plan and regimen.
- Status of diabetes and osteoarthritis of the hip.
- Medication reconciliation.
- Next steps regarding prostate cancer in conjunction with hip surgery.
- Treatment goals.

Care coordination

- Collaboration with orthopedics team.
- Reviewing of care plan, patient status, surgery plan, and post-op care.

Revision of care plan post-surgery and rehab

- Focus on prostate cancer treatment.
- Patient status post-op.
- Plan for post-op care.

Communication with the family

- Advising of next steps and review of care plan.
- Addressing questions and concerns regarding treatment.

Care Management Services
Patient Example: Chronic Care

A 75-year-old patient with lung cancer and hypertension is also experiencing cognitive issues. They consistently forget to take their medications at home.

Clinical staff discusses the care plan and treatment with the patient and their family, emphasizing the importance of adhering to the medication regimen.

Clinical staff and the family have regular communications regarding the patient's medications in addition to discussing possible adjustments due to side effects.

Care Management Activities

Establishment and implementation of care plan

- Lung cancer treatment plan.
- Status of hypertension.
- Medication reconciliation.
- Expected outcomes and goals.
- Management and intervention regarding medication adherence.

Provider communication

- Collaboration with the patient's PCP on hypertension and cognitive issues.
- Referrals to neurologist to address cognitive issues.

Communication with the family

- Review and discussion of care plan.
- Patient adherence to taking medication.
- Monthly follow ups.

Revision and updates to care plan

- Patient may become more complex depending on progression of cognitive issues.

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Practice Administration

Care Management Services
Practice Administration Requirements

24/7 access to physicians or other qualified health care professionals or clinical staff.

A designated member of the care team to provide continuous care.

Timely access and management for follow-ups.

Timely access to clinical information through an EHR.

Coordination and integration of care among all service professionals.

A physician or other qualified health care professional overseeing the activities of the care team.

Required Actions for Care Management Services

Obtain patient consent.	Cost sharing.
	Termination of services.
	One practitioner per month (*Applies to chronic care management services.)
Assign a designated care team lead.	Ensures continuity of care.
	Serve as a point of contact.
Establish, implement, revise, or monitor care plan.	Share with patient and/or caregiver.
	Share with other healthcare providers.
Record data in electronic health record.	Demographics.
	Medications.
	Medical problems.

Steps for Practice Implementation

Verify	Verify which practice administration requirements are currently in place.
Assign and train	Assign and train staff to perform care management services.
Establish	Establish practice-wide standards and workflow.
Document	Document the time and work of the care management service provided.
Utilize	Utilize the CPT codes to report care management services.

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Coding and Reporting

Care Management Services Comparison

Chronic Care Management	Complex Chronic Care Management	Principal Care Management
Two or more chronic conditions expected to last **at least 12 months** (or until the death of the patient).		**One** complex chronic condition expected to last **at least 3 months**.
Significant risk of death, acute exacerbation/decompensation or functional decline.		
A care plan is established, implemented, revised, or monitored.		
	Moderate or high complexity medical decision making.	Management of the condition is **complex** due to comorbidities.

Care Management CPT® Codes

Provider	Chronic Care Management	Complex Chronic Care Management	Principal Care Management
Clinical staff	99490: First 20 minutes 99439: Each additional 20 minutes (Limited to 2x per month)	99487: First 60 minutes 99489: Each additional 30 minutes	99426: First 30 minutes 99427: Each additional 30 minutes (Limited to 2x per month)
Physician/QHP	99491: First 30 minutes 99437: Each additional 30 minutes	Not applicable	99424: First 30 minutes 99425: Each additional 30 minutes

Reporting Guidelines

- All time is total time **per calendar month** (not date of service).
- Must perform **at least** the number of minutes indicated in the code description (mid-point rule does not apply)
- The PCM CPT ® codes have replaced the CMS HCPCS codes (G2064 and G2065) as of January 1, 2022.

See full CPT ® code descriptions and guidelines in the AMA CPT Professional Edition 2022

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Initiating Visit Requirement
Chronic Care Management Services

Applies to a **new patient** *or* **patient not seen within 1 year** prior to the start of the chronic care management service. One of the following services must be performed:

- Annual Wellness Visit (AWV).
- Initial Preventive Physical Exam (IPPE).
- E/M visit.

Reporting Guidelines

Can clinical staff *and* the physician/QHP both report a care management service in the same calendar month? (Ex. 99490 and 99491)

NO. The service can only be reported by either clinical staff OR the physician.

However…if the physician personally performs any of the care management services and those activities are *not* used to meet the criteria for a separately reported code (99424, 99491), then their time may be counted toward the clinical staff time of the applicable service.

Reporting Guidelines

What is the date of service?

The appropriate date of service (DOS) for CCM, CCCM, and PCM services is the **date the time requirement was reached**.

Example

- January 18th- Clinical staff performs a Complex CCM service of **20 minutes**.
- January 25th- Clinical staff performs a Complex CCM service of **40 minutes**.

Total time of **60 minutes** for **99487** was reached (**first** 60 minutes).

The date of service for CPT® code 99487 in the **calendar month** would be **January 25th.**

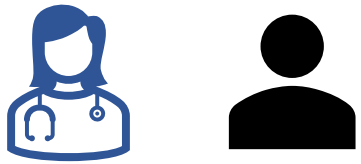
Reporting Guidelines

The time of these services **do not** count towards the time of care management service.

- Telephone E/M services
- Medication therapy management-Pharmacist
- Online digital E/M services
- Prolonged E/M Services (different day than E/M)
- Patient/caregiver training INR monitoring
- ESRD services

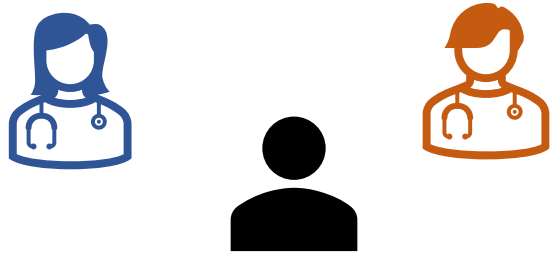
Reporting Guidelines

Chronic and Complex Care Management Services



Only **one** clinician per beneficiary per calendar month.

Principal Care Management Services



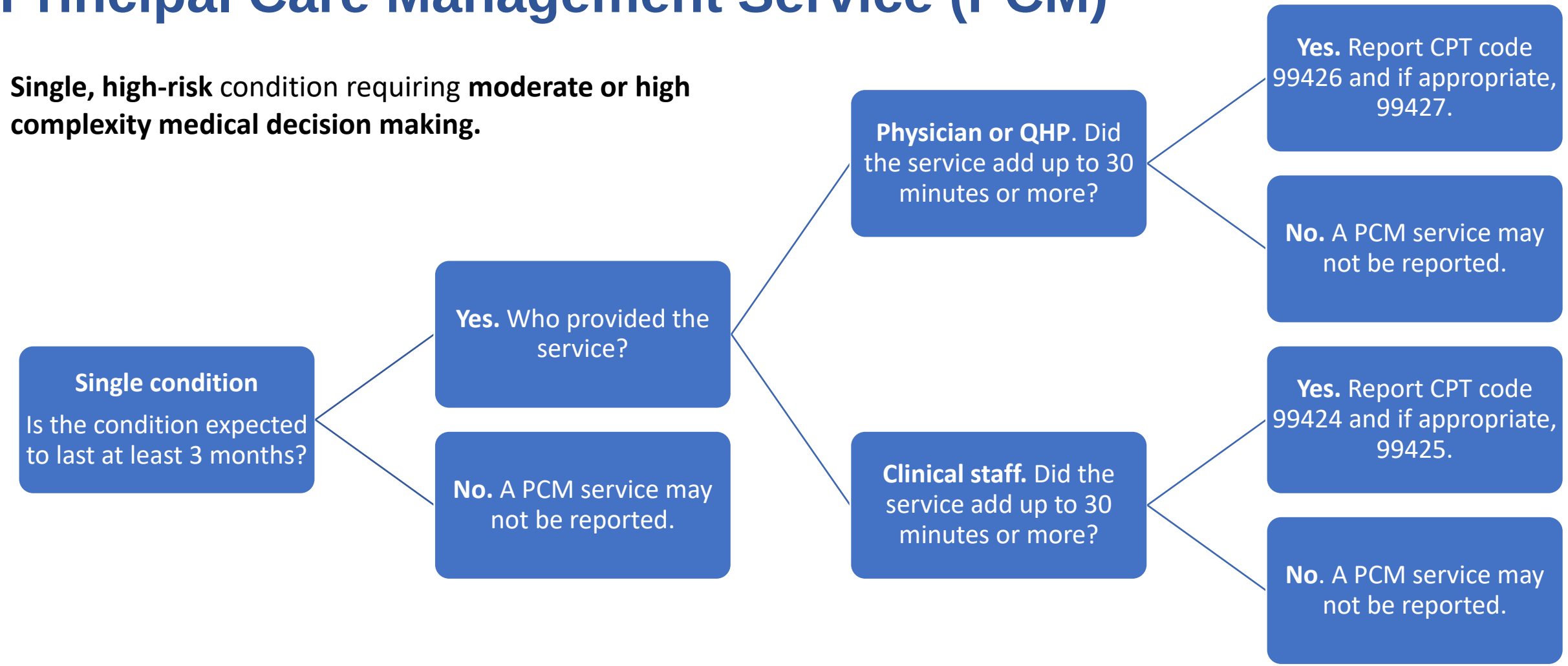
More than one clinician per beneficiary *if* the patient experiences an exacerbation of more than one complex chronic condition simultaneously.

Care Management Services
Code Selection

How many conditions are being managed? → **How long** is the condition expected to last? → **Who** provided the service? → Were the **time requirements** for the code(s) met?

Care Management Services
Principal Care Management Service (PCM)

Single, high-risk condition requiring **moderate or high complexity medical decision making.**



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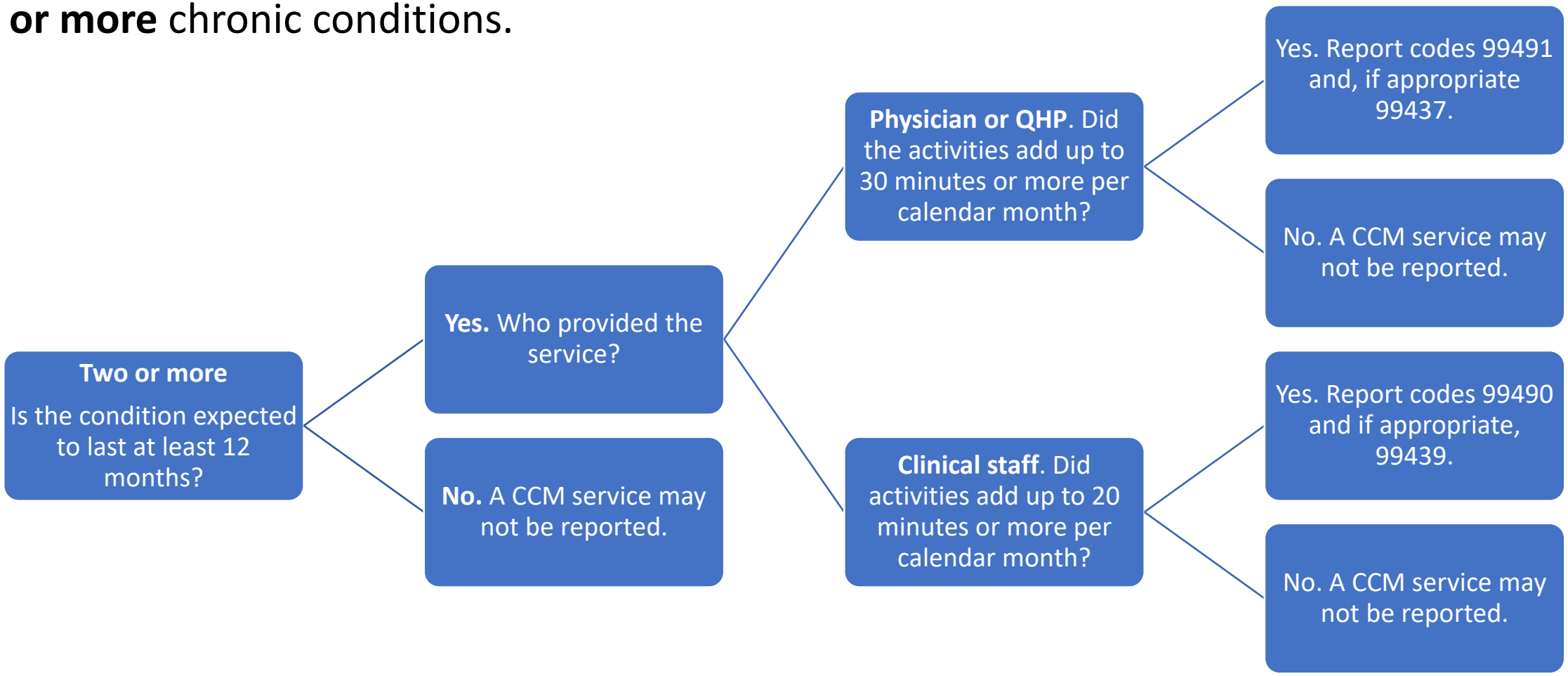
Care Management Services
Chronic Care Management Services (CCM)

Two or more chronic conditions.



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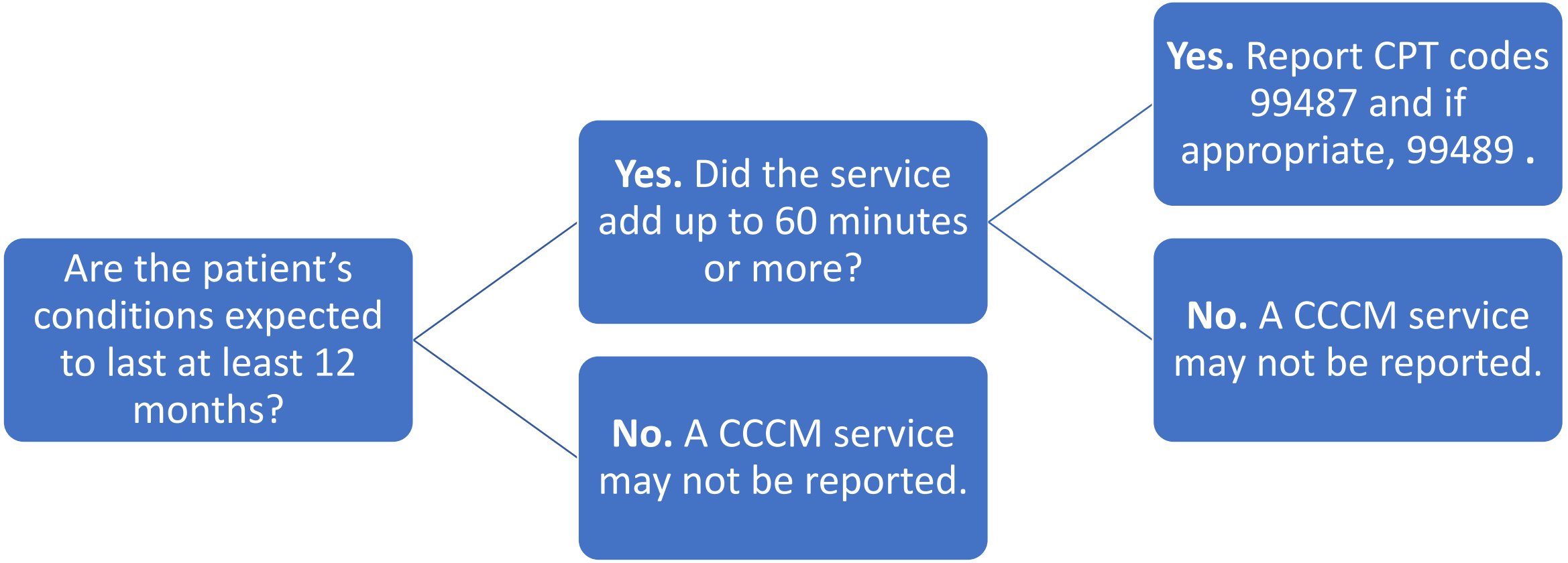
Care Management Services
Complex Chronic Care Management Services (CCCM)

Two or more chronic conditions requiring **moderate or high-level MDM**.



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Common Reasons for Claim Denials

- Multiple claims for the same beneficiary:
  - Two or more providers submitting claims for either a complex or non-complex CCM service.
  - One provider submitting multiple initial care management services for the same patient.
  - Service reported by both clinical staff and the physician/QHP.
- Not meeting the service's time requirements.
- Reporting complex chronic care services, chronic care services or principal care management services during the same time period (calendar month).
- Reporting care management services with other overlapping services.

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Reimbursement for Care Management Services

Reimbursement Information

CPT Code	2022 Work RVU	National Payment Amount Non-Facility*
99490: First 20 minutes, clinical staff	1.00	$63.78
99439: Each additional 20 minutes, clinical staff	0.70	$48.45
99491: First 30 minutes, Phys/QHP	1.50	$86.17
99437: Each additional 30 minutes, Phys/QHP	1.00	$61.25
99487: First 60 minutes	1.81	$134.27
99489: Each additional 30 minutes	1.00	$70.60
99426: First 30 minutes, clinical staff	1.00	$63.33
99427: Each additional 30 minutes, clinical staff	0.71	$48.45
99424: First 30 minutes, Phys/QHP	1.45	$83.40
99425: Each additional 30 minutes, Phys/QHP	1.00	$60.22

Established Patient Office/Outpatient E/M		
CPT Code	**2022 Work RVU**	**National Payment Amount Non-Facility**
99213	1.30	$92.05
99214	1.92	$129.77
99215	2.80	$183.07

****Actual payment amount varies by MAC and/or locality.***

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Resources

Resources and References

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Cancer survivors with multiple chronic conditions: A rising challenge—Trend analysis from National Health Interview Survey.

Changchuan Jiang, Haowei Wang, Qian Wang, Binbin Zheng, and Charles L. Shapiro

Journal of Clinical Oncology 2020 38:15_suppl, e24089-e24089

Chronic conditions among advanced cancer patients and their spouse caregivers.

Dana Ketcher, Amy Otto, and Maija Reblin

Journal of Clinical Oncology 2019 37:31_suppl, 20-20

Living with Chronic Cancer

Cancer.Net

Resources and References

Centers for Medicare and Medicaid Services

Connected Care Toolkit

MLN Booklet: Chronic Care Management Services

Chronic Conditions Prevalence, State/County 2018

American Medical Association

“Get paid for the care management your physician practice delivers”

“Physician-led team-based care”

Resources and References

Other Information

Chronic Care Management (CCM) Toolkit: Your implementation guide for patients with chronic conditions

Provider Experiences with Chronic Care Management (CCM) Services and Fees: A Qualitative Research Study

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Q&A

Questions about care management services or any other coding question may be sent to practice@asco.org.