Maintaining Clinical Revenues in GIM requires Resilience, Grit and a little help from CMS

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John D Goodson, MD
Learning Objectives

• Recognize the substantial efforts the Center for Medicare and Medicaid Services (CMS) have made to increase Primary Care compensation

• Identify new reimbursement opportunities in PFS Final Rule for 2017

• Understand how to optimizing service code billing

• Strategize about the infrastructure and electronic support needed to deliver all billable primary care services

• Embrace the value of understanding how physician compensation is developed

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Agenda

• 5 minutes: agenda and introductions
• 5 minutes: MD payment 101 and what CMS has done in the last decade to improve PC payment
• 30 minutes: 2017 PFS rule: new codes and reimbursement opportunities
• 15 minutes: organizational and clinic structures that can work and the $$ at stake: ROI
• 5 minutes: wrap up and evaluations

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MD Payment: The Game of Codes

- Since 1992, Medicare has paid for discrete MD services, each with a unique numerical or alphanumerical “code”
- Service definitions are largely derived from the AMA’s CPT Manual
- However, CMS has the authority independently define services
- Medicare payments for each code are established January 1st each year in the Physician Fee Schedule (PFS)
- Payment = Service value in “relative value units” (RVUs) multiplied by an annual Conversion Factor (2017 = $35.89)
- Payments are adjusted for the site of service, facility vs. non facility, geographic location
- MACRA is based on the PFS

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The codes for primary care:
What we are neglecting?

• **IPPE**: initial preventive physical exam, “Welcome to Medicare”
  – G0402

• **AWVs**: annual wellness visits
  – G0438 and G0439

• **TCM**: transitional care management codes
  – 99495 and 99496
AWV: The benefit nobody knows


*Medicare’s records suggest that uptake is only 6.5 percent
### Table. Characteristics of Medicare Annual Wellness Visit Users and Nonusers in 2011-2012 and 2013-2014, Among All Seniors* With Traditional Medicare

<table>
<thead>
<tr>
<th>Patient Characteristic</th>
<th>2011-2012</th>
<th>2013-2014</th>
<th>P Value</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All (n = 30 477)</td>
<td>Yes (n = 963)</td>
<td>No (n = 29 514)</td>
<td>77.0</td>
</tr>
<tr>
<td>Mean age, y</td>
<td>37</td>
<td>37</td>
<td>37</td>
<td>57</td>
</tr>
<tr>
<td>Men, %</td>
<td>55</td>
<td>70</td>
<td>54</td>
<td>57</td>
</tr>
<tr>
<td>Race, %</td>
<td>Black</td>
<td>40</td>
<td>10</td>
<td>41</td>
</tr>
<tr>
<td>White</td>
<td>56</td>
<td>66</td>
<td>55</td>
<td>62</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total chronic conditions, n</td>
<td>2.5</td>
<td>1.8</td>
<td>2.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Median income, $</td>
<td>50 869</td>
<td>68 505</td>
<td>50 295</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>High school graduate, %†</td>
<td>86</td>
<td>92</td>
<td>86</td>
<td>87</td>
</tr>
<tr>
<td>Other preventive services use, %</td>
<td>Colorectal cancer screening</td>
<td>12</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Prostate cancer screening</td>
<td>59</td>
<td>77</td>
<td>58</td>
<td>47</td>
</tr>
<tr>
<td>Influenza virus vaccine and administration</td>
<td>46</td>
<td>51</td>
<td>46</td>
<td>39</td>
</tr>
<tr>
<td>Mammography</td>
<td>53</td>
<td>64</td>
<td>53</td>
<td>45</td>
</tr>
<tr>
<td>Papanicolou test</td>
<td>17</td>
<td>28</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>Pelvic examination</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Other wellness examinations</td>
<td>30</td>
<td>61</td>
<td>29</td>
<td>24</td>
</tr>
<tr>
<td>Primary physician visits, n</td>
<td>4.9</td>
<td>4.3</td>
<td>4.9</td>
<td>3.8</td>
</tr>
<tr>
<td>Any physician visits, n</td>
<td>9.9</td>
<td>8.7</td>
<td>10.0</td>
<td>8.6</td>
</tr>
</tbody>
</table>

* Aged ≥66 y.
† Zip code level.

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# Medicare FFS Utilization 2014

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Total services (2014 data)</th>
<th>Denominator (2014 MC data*)</th>
<th>Penetration</th>
<th>Facility payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPPE</td>
<td>360,065</td>
<td>2,843,060 (new benes)</td>
<td>12.7%</td>
<td>$120.55</td>
</tr>
<tr>
<td>AWV initial</td>
<td>1,162,210</td>
<td>33,806,695 (Part B FFS MC)</td>
<td>13.9% (initial + sub)</td>
<td>$165.44</td>
</tr>
<tr>
<td>AWV sub</td>
<td>3,528,096</td>
<td></td>
<td></td>
<td>$111.00</td>
</tr>
<tr>
<td>TCM mod</td>
<td>301,622</td>
<td>33,806,695 (Part B FFS MC)</td>
<td>1.7% received TCM (assumes 1 service per beneficiary)</td>
<td>$107.17</td>
</tr>
<tr>
<td>TCM high</td>
<td>259,447</td>
<td>33,806,695 (Part B FFS MC)</td>
<td></td>
<td>$155.73</td>
</tr>
<tr>
<td>CCM</td>
<td>954,396**</td>
<td>33,806,695 (Part B FFS MC)</td>
<td>2.8% (assumes 1 per bene)</td>
<td>approx $44</td>
</tr>
<tr>
<td>99214</td>
<td>91,503,066</td>
<td>33,806,695</td>
<td>2.7/beneficiary</td>
<td>$77.46</td>
</tr>
<tr>
<td>99204</td>
<td>9,128,695</td>
<td></td>
<td></td>
<td>$130.31</td>
</tr>
</tbody>
</table>


**2015 data from RUC database

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Bottom Line

• CMS is trying
  – More codes augmenting PC payment AND PC services
• Services are not being used in volumes expected
• Patients may be missing out on needed preventive services
• Physicians and practices are missing out on revenues
• If we do not use the services, they may be defunded
• Primary care has a fiduciary responsibility to optimize revenue regardless of payment models

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The New Codes for 2017

A whirlwind review
Critical codes for primary care: 2017 updates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0507</td>
<td>Care management services for BH condition, at least 20 minutes (1 month)</td>
</tr>
<tr>
<td>G0505</td>
<td>Cognitive &amp; functional assessment using standard instrument and care plan</td>
</tr>
<tr>
<td>99358</td>
<td>Prolonged non-face-to-face; 31-60 min</td>
</tr>
<tr>
<td>99359</td>
<td>Prolonged non-FTF; &gt; 76 min</td>
</tr>
<tr>
<td>G0506</td>
<td>CCM care planning (add on code)</td>
</tr>
<tr>
<td>99487</td>
<td>Complex CCM at least 31-60 minutes (per month)</td>
</tr>
<tr>
<td>99489</td>
<td>Complex CCM each additional 30 minutes</td>
</tr>
</tbody>
</table>
Psychiatric Collaborative Care Model

- Behavioral Health Integration (BHI)
- 3 new CPT codes for 2018
- G codes are bridge for 2017
- Billed by PCP, care provided (time) by clinical staff
- Psych consultant is “practice expense”
- G0507 does NOT require this model

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Bottom Line: the BHI codes

• If your clinic has fully developed CoCM for BHI: SUPER
• More likely: be aware that G0507 is out there
  – 20 minutes of care management services for behavioral health conditions per month
  – Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
  – Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
  – Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation;
  – Continuity of care with a designated member of the care team.

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Cognitive and Functional Assessment

• G0505: Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office or other outpatient setting or home or domiciliary or rest home
G0505: required elements

• Cognition-focused evaluation including a pertinent history and examination.
• Medical decision making of moderate or high complexity (defined by the E/M guidelines).
• Functional assessment (for example, Basic and Instrumental Activities of Daily Living), including decision-making capacity.
• Use of standardized instruments to stage dementia.
• Medication reconciliation and review for high-risk medications, if applicable.
• Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized instrument(s).

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G0505: required elements

- **Evaluation of safety** (for example, home), including motor vehicle operation, if applicable.
- Identification of **caregiver(s)**, caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks.
- **Advance care planning** and addressing palliative care needs, if applicable and consistent with beneficiary preference.
- **Creation of a care plan**, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed (for example, adult day programs, support groups); care plan shared with the patient and/or caregiver with initial education and support.
Cognitive and Functional Assessment: Caveats

- Non-facility: 6.64 RVU/ $238
- Facility: 4.96 RVU/ $178
- Can be “base-code” for 99358/59 (non-FTF prolonged service codes)
- Must be furnished by physician or billing provider
- Can not be billed on same DOS with 99201-15 among others
- CAN be billed during service period CCM/TCM

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Prolonged Service Codes

• CMS has recognized the additional work required by some patients and will provide payment for prolonged services performed either before or after the face-to-face visit.

• Services can be provided on another day as appropriate.

• Services can be combined among professional staff

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Prolonged Service Codes

• **Prolonged service code 99358 (facility 3.16, non-facility 3.16):** Prolonged E/M services before or after direct patient care, first 60 minutes.
  – Cannot be reported with CCM initiation, Complex CCM (see later) or TCMs
  – Current times for a 99214: 5 min pre visit, 25 minutes face-to-face, 10 minutes post visit = 40 minutes

• **Prolonged service code 99359 (facility 1.52, non-facility 1.52):** Prolonged E/M services before or after direct patient care, each additional 30 minutes

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Prolonged Service Codes: Caveats

• The clock starts after 40 minutes total time (if base code is 99214)
• Medicare allows cumulative time over 31 minutes to equal 60 minutes
• MD and “other practitioner” professional time can be combined
• 99359 requires 60 minutes plus at least 16 minutes (over half of the 30 minutes) = ≥76 minutes
• Cumulative time must be documented. Likely best if activities specified
• Must be related to an E/M encounter but service delivery can be on a separate day.
• The beneficiary is liable for 20% of allowable charges

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Chronic care management:
Service code choices

• **CCM service code +G0506 (facility 1.29, non-facility 1.78):** This new service code designed to cover the time required to develop a CCM plan

• **CCM service code 99490 (facility 0.91, non-facility 1.19):** This is the existing service code that requires 20 minutes of asynchronous, non-face-to-face clinical staff time per month.

• **CCM service code 99487 (facility 1.47, non-facility 2.61):** This is a new service code covers the first 60 minutes of extended CCM care provided per month. This can only be billed once per month.

• **CCM service code +99489 (facility 0.74, non-facility 1.31):** This new service code covers each additional 30 minutes beyond the first 60 minutes of CCM care. This can only be billed once per month, after 99487 has been billed.

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Chronic care management: Who?

Any Medicare patient, “expected to live 12 months or until death,” with two or more chronic conditions will be eligible for CCM services. This code “may be billed for periods in which the medical needs of the patient require establishing, implementing, revising, or monitoring the care plan.”

CCM services can be outsourced after the initiation visit.

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Chronic care management: Key stipulations

• CCM planning (G0506, facility 1.29, non facility 1.78)
  – Combined with: AWV, IPPE, or E/M visit (Level 4 or 5 visit not required).

• Beneficiary Consent
  – Inform the beneficiary of the availability of CCM services
  – Document that the required information was explained and CCM services were accepted
Chronic care management: What must be provided?

- **Structured Recording of Patient Information Using Certified EHR Technology**
  - Demographics, problems, medications and medication allergies
  - Certified EHR technology.
- **Comprehensive Care Management**
  - Medical, functional, and psychosocial needs; preventive care; medication reconciliation; and oversight of beneficiary self-management of medications.
- **Comprehensive Care Plan**
  - Electronic comprehensive care plan for all health issues.
  - Share care plan information electronically (can include fax)
  - A copy to the patient and/or caregiver.
- **Management of Care Transitions**
  - Management of care transitions between and among health care providers and settings
  - Create and exchange/transmit continuity of care document(s)
- **Home- and Community-Based Care Coordination**
  - Coordination with home and community based clinical service providers.
  - Communication to and from home- and community-based providers
- **Enhanced Communication Opportunities**
  - Telephone access, secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

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Clinic care management: Caveats

• The CCM planning code, G0506, can only be submitted once for a new patient.
• For an established patient, the CCM planning code, G0506, will be paid if the patient does not have a CCM plan and has not been seen within the year.
• Cannot be billed with TCM services
• Patient is liable for 20% of allowable charges
What’s at Stake?
$\textbf{Dollars at stake}$

- For a hypothetical physician with 620 Medicare patients (panel 2000, 31% MC):
  - Revenue from 99914 (3 visits per patient per year) = 1860 x $77.46 (facility payment UT) = $144,075
  - Added revenue for subsequent AWVs = 500 x $111 = $55,500
  - Added revenue for TCMs* (60 moderate and 30 high MDM discharges) 60 x 107.17 = $6430.20 and 30 x $155.73 = $4671.90 = $11,102

*hospitalization rate 20%
$\$\$\$ Dollars at stake $\$\$\$

• For a hypothetical physician with 620 Medicare patients:
  – If 61% have 2+ chronic conditions, and PC practice bills CCM 9 months out of the year for half:
    – $189 \times 9 \times $44 = $74,844

• Total additional revenue: AWV, TCM, CCM (99490)
  – $55,500 + $11,102 + $74,844 = $141,446
  – These add-ons nearly double your revenue compared to 3 E&Ms per year.

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These nearly double the revenues compared to three E&Ms per year.
### Table 3. Net Revenue for Clinics Under Different CCM Delivery Strategies*

<table>
<thead>
<tr>
<th>CCM Plan Development</th>
<th>CCM Monthly Services Provider</th>
<th>Year 1</th>
<th>Subsequent Years (Annualized)</th>
<th>Year 1</th>
<th>Subsequent Years (Annualized)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual wellness visit (50% physician, 50% RN)</td>
<td>RN</td>
<td>295.17 (162.55 to 427.79)</td>
<td>331.52 (233.91 to 429.12)</td>
<td>69,665 (30,372 to 108,958)</td>
<td>79,197 (39,340 to 119,054)</td>
</tr>
<tr>
<td>Annual wellness visit (50% physician, 50% LPN)</td>
<td>LPN</td>
<td>326.37 (192.81 to 459.93)</td>
<td>372.09 (275.98 to 468.19)</td>
<td>77,295 (35,199 to 119,392)</td>
<td>89,110 (44,856 to 133,364)</td>
</tr>
<tr>
<td>25-min visit (100% physician)</td>
<td>RN</td>
<td>176.13 (82.21 to 270.04)</td>
<td>282.81 (202.36 to 363.27)</td>
<td>41,257 (15,686 to 66,827)</td>
<td>67,607 (33,743 to 101,470)</td>
</tr>
<tr>
<td>25-min visit (100% physician)</td>
<td>LPN</td>
<td>196.44 (100.11 to 292.77)</td>
<td>315.07 (234.75 to 395.38)</td>
<td>46,195 (18,819 to 73,572)</td>
<td>75,471 (38,044 to 112,899)</td>
</tr>
<tr>
<td>Unreimbursed time (100% physician)</td>
<td>RN</td>
<td>76.03 (−4.48 to 156.55)</td>
<td>184.06 (77.99 to 290.13)</td>
<td>16,573 (−999 to 34,144)</td>
<td>42,962 (15,459 to 70,465)</td>
</tr>
<tr>
<td>Unreimbursed time (100% physician)</td>
<td>LPN</td>
<td>90.18 (0.67 to 179.68)</td>
<td>215.00 (104.90 to 325.10)</td>
<td>19,919 (38 to 39,798)</td>
<td>50,488 (20,280 to 80,696)</td>
</tr>
<tr>
<td>Annual wellness visit (100% physician)</td>
<td>Physician</td>
<td>150.38 (−37.70 to 338.45)</td>
<td>142.07 (−47.46 to 331.60)</td>
<td>17,369 (−12,197 to 46,935)</td>
<td>28,940 (−9017 to 66,897)</td>
</tr>
</tbody>
</table>

CCM = chronic care management; LPN = licensed practical nurse; RN = registered nurse.
* Revenue per full-time equivalent physician is shown at 50% enrollment. We reran the model 10,000 times while repeatedly sampling from the probability distributions of all input parameters to generate nationally representative estimates and 95% CIs (18).
CCM Payment and Financial Returns

• Bottom line from simulation data:
  – Expenses of 1.0 FTE RN or LPN would be recouped if one half of eligible Medicare patients were enrolled in CCM
  – RN: 131 (CI 115-140) patients
  – LPN: 76 (CI 66-81) patients
  – Net revenue loss if all CCM services delivered by Physicians

– Lots of “what-if” scenarios:
  • ↓ clinic visits = less revenue, but could fill that time with new patients

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Let's add in some new codes!

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>wRVU</th>
<th>Non-fac PE</th>
<th>Facility PE</th>
<th>Mal-practice</th>
<th>Total non-fac RVU</th>
<th>Total Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0505</td>
<td>Assess cognitive impairment standard instrument &amp; care plan</td>
<td>3.44</td>
<td>3.00</td>
<td>1.32</td>
<td>0.20</td>
<td>6.64</td>
<td>4.96</td>
</tr>
<tr>
<td>+G0506</td>
<td>CCM care plan (add on)</td>
<td>0.87</td>
<td>0.85</td>
<td>0.36</td>
<td>0.06</td>
<td>1.78</td>
<td>1.29</td>
</tr>
<tr>
<td>G0507</td>
<td>Behavioral health; 20 min</td>
<td>0.61</td>
<td>0.68</td>
<td>0.25</td>
<td>0.04</td>
<td>1.33</td>
<td>0.90</td>
</tr>
<tr>
<td>99358</td>
<td>Prolonged non-FTF First hour</td>
<td>2.10</td>
<td>0.91</td>
<td>0.91</td>
<td>0.15</td>
<td>3.16</td>
<td>3.16</td>
</tr>
<tr>
<td>+99359</td>
<td>Prolonged non-FTF additional 30 min</td>
<td>1.00</td>
<td>0.45</td>
<td>0.45</td>
<td>0.07</td>
<td>1.52</td>
<td>1.52</td>
</tr>
<tr>
<td>99487</td>
<td>Complex CCM at least 60 minutes (per month)</td>
<td>1.00</td>
<td>1.55</td>
<td>0.41</td>
<td>0.06</td>
<td>2.61</td>
<td>1.47</td>
</tr>
<tr>
<td>+99489</td>
<td>Complex CCM + 30 minutes</td>
<td>0.50</td>
<td>0.78</td>
<td>0.21</td>
<td>0.03</td>
<td>1.31</td>
<td>0.74</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>wRVU</td>
<td>Total non-fac RVU</td>
<td>Total Facility</td>
<td>Non-fac payment</td>
<td>Facility payment</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------------------------------------</td>
<td>------</td>
<td>-------------------</td>
<td>----------------</td>
<td>----------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>G0505</td>
<td>Assessment of cognitive impairment; standard instrument &amp; care plan</td>
<td>3.44</td>
<td>6.64</td>
<td>4.96</td>
<td>$238.31</td>
<td>$178.01</td>
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</tr>
<tr>
<td>+G0506</td>
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<td>0.87</td>
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<td>0.90</td>
<td>$47.73</td>
<td>$32.30</td>
<td></td>
</tr>
<tr>
<td>99358</td>
<td>Prolonged non-FTF; First hour</td>
<td>2.10</td>
<td>3.16</td>
<td>3.16</td>
<td>$113.41</td>
<td>$113.41</td>
<td></td>
</tr>
<tr>
<td>+99359</td>
<td>Prolonged non-FTF + 30 min</td>
<td>1.00</td>
<td>1.52</td>
<td>1.52</td>
<td>$54.55</td>
<td>$54.55</td>
<td></td>
</tr>
<tr>
<td>99487</td>
<td>Complex CCM at least 60 minutes (per month)</td>
<td>1.00</td>
<td>2.61</td>
<td>1.47</td>
<td>$93.67</td>
<td>$52.76</td>
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<tr>
<td>+99489</td>
<td>Complex CCM +30 minutes</td>
<td>0.50</td>
<td>1.31</td>
<td>0.74</td>
<td>$47.02</td>
<td>$26.56</td>
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</tbody>
</table>

2017 conversion factor: $35.89
For a hypothetical physician with 620 Medicare patients (panel 2000, 31% MC):

- Revenue from 99914 (3 visits per patient per year) = 1860
  $77.46 (facility payment UT) = $144,075
- Added revenue for subsequent AWVs = 500 x $111 = $55,500
- Added revenue for TCMs* (60 moderate and 30 high MDM discharges, 60 x 107.17 = $6430.20 and 30 x $155.73 = $4671.90) = $11,102
- 61% of these patients have 2+ chronic conditions

*hospitalization rate 20%
$\$ Dollars at stake $\$ 

• For a hypothetical physician with 620 Medicare patients:
  – If 61% have 2+ chronic conditions, half enroll in CCM:
  – PC practice bills CCM 9 months out of the year: 189 x 9 x $44 = $74,844
  – CCM add-on code for initiation of care plan: 150 x $46.30 = $6945

• Total CCM revenues
  – $74,844 + $6945 = $81,789

*Please note that information provided is believed to be correct at the time of writing, is for educational purpose and a compilation of several sources. As information may change frequently, please be sure to review the most current information available.*
• 620 Medicare patients
  – 1/6 have depression: 103; bill G0507 6 times on half of these patients: 52 x 6 = 312 x $32.3 = $10,078
  – Prolonged non-FTF: 35 minutes of time billed weekly on one patient: 50 x $113 (99358) = $5650
  – Extensive Prolonged non-FTF service billed occasionally during the year: 80-90 min: 20 x $55 (99359) = $1100
  – 1/9 have Alzheimer’s disease: 69; bill G0505 once on half of these patients: 35 x $178 = $6230

*Please note that information provided is believed to be correct at the time of writing, is for educational purpose and a compilation of several sources. As information may change frequently, please be sure to review the most current information available*
<table>
<thead>
<tr>
<th>Code</th>
<th>N</th>
<th>Total revenues</th>
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</thead>
<tbody>
<tr>
<td>99214</td>
<td>1860</td>
<td>$144,075</td>
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<tr>
<td>G0438 (subsequent AWV)</td>
<td>500</td>
<td>$55,500</td>
</tr>
<tr>
<td>TCM</td>
<td>60/30</td>
<td>$11,102</td>
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<tr>
<td>CCM monthly</td>
<td>189x9</td>
<td>$74,844</td>
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<tr>
<td>CCM care plan</td>
<td>150</td>
<td>$9,260</td>
</tr>
<tr>
<td>G0507 (20 min Behav health)</td>
<td>312</td>
<td>$10,078</td>
</tr>
<tr>
<td>Non-FTF</td>
<td>50/20</td>
<td>$6,750</td>
</tr>
<tr>
<td>G0505 (Cog assessment)</td>
<td>35</td>
<td>$6230</td>
</tr>
<tr>
<td>Total additional revenues</td>
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<td>$173,764</td>
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<tr>
<td>Total yearly revenues after 2017 PFS rule</td>
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<td>$317,839</td>
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<tr>
<td>Additional revenues prior to 2017 PFS rule</td>
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<td>$141,446</td>
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<tr>
<td>Total yearly revenues prior to 2017 PFS rule</td>
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<td>$285,521</td>
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</table>

620 Medicare patients, conservative estimate of services billed during one year

*Please note that information provided is believed to be correct at the time of writing, is for educational purpose and a compilation of several sources. As information may change frequently, please be sure to review the most current information available.*
What’s a doc to do?

• Be the revenue (cheer) LEADER for your group
• Read and understand what is available for billing in January 2017
• Communicate with your Professional Billing group to be sure they are aware, and know when/how/if to bill these services
• Work with your EHR/HIT group to produce documentation templates which help you and staff document these services

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-F.html
What’s a doc to do?

• Do your own calculations, to show potential revenues to your practice managers/leadership
  – Particularly if you need additional staff to assist with CCM or behavioral health management

• Start thinking like a lawyer: when you are reviewing records, making phone calls, sending emails: track your time per patient, and if it goes past 31 minutes on one day, this may qualify to bill for prolonged non-FTF
THANK YOU!

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