COMMENTARY

Expanding incentives for coordinated, patient-centered care

Implications for neurologists

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Abstract

Historically, payment for cognitive, nonprocedural care has required provision of face-to-face evaluation and management as part of general ambulatory or inpatient care. Although non-face-to-face patient care (e.g., care via electronic means or telephone) is commonly performed and is integral to patient-centered care, appropriate reimbursement for this type of care is lacking. Beginning in 2017, Centers for Medicare and Medicaid (CMS) has taken a large step forward in reimbursing an increased number of cognitive care and non-face-to-face codes. CMS has also included language indicating that nonphysician providers (i.e., nurse practitioners and physician assistants) can perform many of these services independently. The 2017 and now the 2018 fee schedules thus create new payments for non-face-to-face, patient-centered services, and may allow neurologists to reach out to more patients through nonphysician providers. As health care in the United States moves toward value-based incentives, these newly supported non-face-to-face services will provide neurologists with new tools to deliver sustainable, high-value care.

The ongoing national conversation surrounding health care reform has emphasized access to insurance coverage (a major focus of the 2010 Affordable Care Act [ACA]) and payment reform (a major focus of the Medicare Access and CHIP Reauthorization Act of 2015 [MACRA]). Embedded within the evolving structures of health delivery system reform are a number of policies and program expectations, which in some cases date back several decades. Among these policies is the requirement that most ambulatory nonprocedural services require face-to-face interactions between the provider and the patient. This requirement likely arose from concerns regarding program integrity, with the intent of ensuring that services were actually being delivered to the patient. Clearly, many high-value services delivered to patients are provided outside of the in-person visit, such as medication refills, follow-up telephone calls, and coordination with other providers.

The Centers for Medicare & Medicaid Services (CMS) policy acknowledges the value of these non-face-to-face services. Recent CMS regulatory rulemaking has created more appropriate reimbursement for providers to offer these services to patients. This article outlines the details of some of these financial incentives, the characteristics of the overall trend, and the specific relevance to neurologists.

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Cognitive care restricted to face-to-face evaluation and management visits

Approximately 60% of Medicare payments to neurologists are for evaluation and management (E&M) services, and 20% of neurologists provide only E&M services for their Medicare patients.[1] E&M services constitute the primary cognitive care services in the United States.[2] Examples of E&M services include established and new patient visits in the ambulatory setting, and consults, admissions, or established visits in the hospitalized setting. Although historically CMS policies have stipulated that E&M services require a face-to-face visit,[2] within the last decade private and federal payors have slowly started to increase reimbursement for telemedicine services. Adoption of telemedicine has been hindered by perceptions of poor reimbursement and major regulatory requirements, and despite progress in telemedicine development, the vast majority of E&M services are delivered in the face-to-face setting.[3-5] With reimbursement lagging behind advances in technology and care delivery, efforts for providers to financially sustain innovative non-face-to-face services have been hampered.[6-8] For example, although there have been Current Procedural Terminology (CPT) codes for telephone services for decades,[9] CMS and many private payers have denied payment for these services.[6,7] One justification for these denials has been that the E&M visit inherently includes this non-face-to-face time a provider spends before and after the patient visit. However, the determination of this pre- and post-service time was determined decades ago and does not reflect the current time needs for many patients.[10,11] In addition, changes in available technology and patient preference have created an environment where many high-value cognitive services could now be more efficiently delivered without face-to-face interaction.[12,13]

Innovations in non-face-to-face cognitive care

With an aging, mobility-constrained population and anticipated physician and neurologist shortages,[14] non-face-to-face services will likely be required to promote patient-centered care. Some of these non-face-to-face services have already become part of standard practice; with the widespread incorporation of electronic health records, providers frequently spend considerable sums of time outside the face-to-face visit reviewing extensive patient health records, placing orders, and communicating with patients electronically.[15] Subspecialists who are geographically restricted to large tertiary centers can offer valuable expertise through virtual consultation, by remotely reviewing medical charts for distant patients.[16]

Although part of the CMS physician fee schedules since 2002,[17] telehealth has not met its full potential, and represents a potential growth area for improving patient access and timeliness of care; providers increasingly spend time communicating and coordinating care over the telephone and by electronic means.[8,18] Live audio and video conferencing, including not only live streaming, but also asynchronous store and forward care (where videos, photographs, or radiologic imaging can be sent to the provider, who can review and reply to the patient at a later time), are promising solutions to shortfalls in health care delivery. These innovations in care delivery have not reached their full potential, again in part because of perceived inadequate payment and burdensome regulatory requirements.[6,7]

New incentives for cognitive services

Within the last several years, CMS has demonstrated a willingness to support more flexible care delivery services, such as chronic care management (CCM) and transitional care management (TCM) services.[19] Both CCM and TCM offer incentives to providers, in the form of payment, for non-face-to-face services provided to coordinate complex medical care between visits in the ambulatory setting (CCM) or following dismissal from the inpatient setting (TCM). While this change has been welcomed in the provider community, there are extensive and complex documentation elements necessary to complete these services.[20] In the case of CCM services, the requirements can be burdensome to both patients and providers: patients may be required to make copayments, while the extensive documentation requirements create a barrier for provider adoption. Perhaps for these reasons the effect of this service utilization on patient experience and patient outcomes has even been questioned by CMS.[20]

Encouragingly, with the support of neurology advocates and other provider organizations, in January 2017 CMS introduced an expanded number of cognitive, patient-centered neurologic care codes, and has taken important steps forward in reducing the administrative burden associated with performing and reporting these services. For instance, CMS has started to reimburse prolonged reviews of a patient's medical record, assessments for cognitive impairment and developing a care plan, extensive time spent developing a care plan during the initial chronic care management visit, and telehealth services for critical care and advanced care planning (table).

Incorporation into practice and implications for neurologists

Although this expanded repertoire of codes and corresponding services represents great progress in aligning provider financial incentives with innovative patient-centered care, implementation in practice will require neurologists to consider the effect on their practices and on their patients.

Table New and expanded services covered by Medicare

Code	Brief description	2018 Payment	Required elements	CPT and billing guidelines
		Chronic care management		
99490	Chronic care management services, at least 20 minutes of time directed by a billable provider or supervised clinical staff,[a] per calendar month.	$42.84	Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk or death, acute exacerbation/ decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.	CCM services of less than 20 minutes duration, in a calendar month, are not reported separately. Non-face-to-face time included.
99487	Complex chronic care management services, at least 60 minutes of time directed by a billable provider or supervised clinical staff,[a] per calendar month.	$93.68	See 99490, except time spent must be at least 60 minutes; medical decision-making must be at least of moderate to high complexity.	Complex CCM services of less than 60 minutes' duration, in a calendar month, are not reported separately. Non-face-to-face time included.
+99489	Each additional 30 minutes of time directed by a billable provider or supervised clinical staff, per calendar month.	$47.16	See 99487	Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month. Non-face-to-face time included.
+G0506	Assessment and planning outside of the usual effort described by the initiating CCM code. Billable providers and clinical staff[a] eligible.	$64.44	The care plan that the practitioner must create in order to bill G0506 would be subject to the same requirements as the care plan included in the monthly CCM services (99490 or 99487).	G0506 is billed as part of the initiating chronic care face-to-face initiating visit, but separately from monthly care management services.
Code	**Brief description**	**2017 Payment**	**Required elements**	**CPT guidelines**
		Prolonged evaluation and management service before and after direct patient care		
99358	Prolonged evaluation and management service before or after direct patient care; first hour. Billing provider, not clinical staff[a] time.	$113.76	Used to report non-face-to-face prolonged service time beyond the usual physician service time.	May be reported on a different date than the primary service to which it is related. Must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.
+99359	Each additional 30 minutes	$54.72	See 99358	See 99358
Code	**Brief description**	**2017 Payment**	**Required elements**	**CPT guidelines**
		Assessing and creating a care plan for beneficiaries with cognitive impairment		
99483	Cognition and functional assessment, creation of care plan. Billing provider, not clinical staff[a] time.	$241.92	Evaluation and creation of care plan relating to functional status, dementia stage, medical reconciliation, neuropsychiatric symptoms, caregiver identification and participation, palliative care needs, creation of care plan.	Only face-to-face time included.
Code	**Brief description**	**2017 Payment**	**Required elements**	**CPT guidelines**
		Telehealth (includes critical care, transitional care, and advanced care planning)		
G0508	Telehealth consultation, critical care, physicians typically spend 60 minutes communicating with the patient and providers via telehealth (initial). Nonphysician providers or clinical staff[a] not eligible.	$153.36	Subject to CMS requirements for telemedicine including distant site practitioners, modality reimbursement limitations, geographic limitations, and originating site requirements.	CPT defines a critical illness or injury as an illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition.
G0509	Telehealth consultation, critical care, physicians typically spend 50 minutes communicating with the patient and providers via telehealth (subsequent). Nonphysician providers or clinical staff[a] not eligible.	$146.50	Subject to CMS requirements for telemedicine including distant site practitioners, modality reimbursement limitations, geographic limitations, and originating site requirements.	CPT defines a critical illness or injury as an illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition.

Table (Continued)

Code	Brief description	2017 Payment	Required elements	CPT guidelines
99495	Transitional care management. Billable provider or supervised clinical staff[a] who see (either face-to-face or via telehealth) a patient discharged from a hospital, skilled nursing facility, outpatient observation, or community mental health center within 14 days of discharge.	$167.04	Contact with patient or caregiver within 2 days postdischarge; remaining services performed within 14 days postdischarge: review discharge information; schedule appropriate follow-up appointments; educate patient or caregiver; refer to specialists as needed; identify and coordinate care with community services; evaluation and management services of at least moderate complexity. Subject to CMS requirements for telemedicine.	Only reimbursable once per 30-day postdischarge period.
99496	Complex/advanced transitional care management. Billable provider or supervised clinical staff[a] are eligible.	$236.52	See 99495, except services must be performed within 7 days postdischarge; evaluation and management services must be at least of high complexity. Subject to CMS requirements for telemedicine.	See 99495
99497	Thirty minutes of advanced care planning; may be billed via telehealth discussion. Billable provider or supervised clinical staff[a] are eligible.	$86.04	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 members, or surrogate.	NA
+99498	Each additional 30 minutes of discussion regarding advanced care planning. Billable provider or supervised clinical staff[a] are eligible.	$75.96	See 99497	NA

Abbreviations: CCM = chronic care management; CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; NA = not applicable.
[a] Billable provider definitions vary by locality, but generally include physicians, nurse practitioners, physician assistants, and clinical nurse specialists. Clinical staff definitions similarly vary by state and local regulations. To furnish a service, clinical staff require general supervision, meaning that the service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. The training of clinical staff is the responsibility of the physician. Further details can be found in Medicare's incident to rules, which outline supervision, applicable state law, licensure, and scope of practice for clinical staff.

These include the costs of meeting the regulatory burdens outlined in the code requirements and the costs to patients. CMS has recognized that regulatory burden is associated with underutilization of CCM services.[20] In response, CMS has waived the previous written consent requirement for CCM services and has considerably relaxed electronic health record requirements for interprovider and provider–patient communication. In addition, CMS permits nonphysician providers (i.e., nurse practitioners, physician assistants) to perform, document, and bill for each of the above services.[20] Physician practices could foreseeably hire nonphysician providers to help expand their practice to meet the needs of an increasing number of patients with neurologic disease.

Aside from simply receiving direct payment, there are other potential implications to implementation of these codes. The first is that CMS's decision to reimburse for these additional cognitive services will likely be mirrored by commercial payors, which in the past have used the CMS physician fee schedule as a basis for setting payment for cognitive services. Second, utilization is often measured via claims data, and CMS's support of the codes outlined in this article may increase the visibility of high-value services that neurologists deliver. As much as previous work has demonstrated higher costs but fewer adverse events when neurologists participate in patient care,[21] use of these codes could allow future health services research to explore the net benefit of neurology specialty non-face-to-face care.

Finally, these code additions will continue to be pertinent in the era of full MACRA implementation. MACRA requires most Medicare providers to choose 1 of 2 pathways for reimbursement: the Merit-Based Incentive Payment System (MIPS) or one of several Advanced Alternative Payment Models (AAPMs).[22] Especially in the early years of the program, most physicians (including neurologists) will participate in the MIPS pathway, which will continue to provide payment to physicians based on existing fee-for-service architecture. Therefore, the services and codes outlined in this article will remain a relevant consideration for most physicians participating in Medicare.

Even for neurologists who are part of a large integrated health system, these non-face-to-face services and other CPT codes will likely continue to have a place in a blended model of capitated payment alongside fee-for-service payments. For instance, although MACRA provides participation incentives for the AAPM track, many policymakers, providers, and

CMS has demonstrated a willingness to support more flexible care delivery services, such as chronic care management and transitional care management services.

academics agree that a blended model incorporating fee-for-service-based payment, along with population- and episode-based AAPMs, may be the future of Medicare.[23,24] A different reason for the continued use of CPT codes is their use as a physician work accounting tool by hospital system administrators; even for neurologists taking care of patients in a capitated payment model system, CPT codes and their associated relative value units could foreseeably be required to demonstrate one's contributions to the health system. Despite these predictions, the ultimate balance between value-based care and fee-for-service payment models is largely unknown.

CMS's physician fee schedule for 2017 takes a big step forward in expanding incentives for non-face-to-face cognitive services by improving reimbursement for a number of relatively new codes. Although the magnitude of the burden of additional documentation remains to be seen, new reimbursement for cognitive care takes a step in the right direction to promote patient-centered care and align incentives for neurologists and their patients.

Author contributions

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