Chronic care management coding for neurologists

Marc R. Nuwer, MD, PhD

Abstract

Chronic care management provides a way for neurologists to code for time spent by clinical office staff who coordinate services for patients with major chronic illnesses. Medicare allows payment for one such code; some third party payers accept 2 additional codes. When using these codes, the physician develops a Care Plan that organizes the patient's medical and psychosocial needs. Clinical office staff communicates among the patient's physicians, therapists, community services, the patient, family, and caregiver. The patient chooses only one physician whose office provides these coordination services. Rules include 24/7 access for urgent phone contact and use of an electronic health record system. **Neurol Clin Pract 2015;5:430-438**

Neurologists commonly care for patients with chronic conditions that require substantial work between visits. Most Current Procedural Terminology (CPT) codes describe care provided at face-to-face visits. Recently created CPT codes¹ describe services provided for ongoing chronic care management between visits. The goal is to proactively manage the patient's health rather than just treat illnesses and disease. Neurologists may use these chronic care management CPT codes, which include rules meant to enhance patient care and access and to avoid indiscriminate code use.

These codes fit practice models for neurologists who choose to provide patients with comprehensive care² as opposed to those in a consultant-only type of practice. Whereas most time-based codes allow payment for a physician's time, these services allow payment for the office's clinical staff time between visits, e.g., the office nurse or medical aide. The service focuses on organizing care for the patient's medical and psychosocial needs while ensuring access to good continuity of care for patients with chronic illness.

This article describes these chronic care management codes, their regulations, and some typical use in neurology practices. The Centers for Medicare & Medicaid Services (CMS) estimates that two-thirds of all Medicare recipients have 2 or more chronic conditions.³ As such, a large population could qualify for these services.

Department of Neurology, David Geffen School of Medicine at UCLA and Department of Clinical Neurophysiology, Ronald Reagan UCLA Medical Center, Los Angeles, CA.

Funding information and disclosures are provided at the end of the article. Full disclosure form information provided by the author is available with the **full text of this article at Neurology.org/cp**.

Correspondence to: mnuwer@mednet.ucla.edu

Table 1 Current procedural terminology chronic care management codes

Routine code	
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month with the following required elements:
	Two or more chronic conditions expected to last at least 12 months or until the death of the patient
	Chronic conditions that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline
	Comprehensive Care Plan established, implemented, revised, or monitored
Complex codes	
99487	Complex chronic care management services with the following required elements:
	Two or more chronic conditions expected to last at least 12 months or until the death of the patient
	Chronic conditions that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline
	Establishment or substantial revision of a comprehensive Care Plan
	Moderate or high complexity of medical decision making
	60 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month
99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month (list separately in addition to code for primary procedure, 99487)

Two types of codes

Three chronic care management CPT codes are listed in table 1, separated into 2 categories. Note that the last 2 codes use the term *complex* in the title. For convenience in this article, the first code is referred to as the *routine* code, although that designation is not in general use. Note too that the complex codes are out of numerical order compared to the routine code.

Code 99487 or 99490, but not both, may be reported once per calendar month. Only one physician may submit any chronic care management code. Other qualified health care professionals, such as a nurse practitioner, may use these codes in lieu of a physician; the term physician will be used throughout this article to refer to the user of these codes. The physician assumes the care management role for that particular patient for that calendar month and usually for many months in continuity. The physician supervises and bills for the services of any of his or her clinical staff provided during that month, including services that might have been billed separately, such as by a nurse practitioner.

Complex chronic care management services include many of the same criteria as the routine chronic care management service. Table 2 shows the main differences. The complex codes require establishment or substantial revision of the comprehensive Care Plan, medical decision making of moderate to high complexity, and at least 60 minutes of clinical staff time. CMS³ decided to reimburse for only the routine code in 2015. Private payers have their own coverage plans, and some reimburse for both types of care management services. CMS will evaluate the complex code further and consider a future payment policy change. Physicians may wish to check with local third party payers about which codes they will accept.

Patients who are eligible

A patient must have at least 2 chronic continuous or episodic health conditions to be eligible for chronic care management services. Chronic is defined here as expected to last at least 12 months

Table 2 Differences between routine and complex chronic care management

	Routine code	Complex code
Current procedural terminology	99490	99487, 99489
Minimum time	20 min	60 min
Additional time allowed	No	Yes, in 30-min increments
Care Plan must be revised	No	Yes
Decision complexity	Not specified	Moderate or high
Medicare allows	Yes	No

or until the patient's death. These conditions must involve significant risk of death, acute exacerbation or decompensation, or functional decline.

To be eligible for the complex level of chronic care management services, a patient must also require medical decision making of moderate or high complexity. Complex-level patients typically use multiple medications, have limited ability to perform activities of daily living, require a caregiver, or have repeated hospital admissions or emergency department visits. Patients may be receiving ongoing therapeutic interventions, e.g., physical, occupational, or respiratory therapy or nutritional support. These patients often need:

- Coordination among specialties and services.
- Assistance in activities of daily living.
- Assistance with treatment plan adherence because of cognitive impairment.
- Help dealing with neuropsychiatric disorders (e.g., dementia or substance abuse).
- Help dealing with medical comorbidities.
- Social support with life activities or when having difficulty with access to care.

A number of neurologic patients would qualify for these chronic care management services. Qualifying for the routine service is more common. The more severely impaired patients would qualify for the complex service. Many neurologic disorders are chronic. Depression counts as a chronic problem. Patients with a single chronic disorder do not qualify; a second chronic disorder is required. Examples include the following:

- Neurocognitive or neurodegenerative disorders, e.g., amyotrophic lateral sclerosis, muscular dystrophy, Alzheimer disease, or Parkinson disease, plus a sufficient second chronic neurologic or medical problem.
- Late effects of a stroke plus a sufficient secondary chronic disorder presenting a risk for falls, fractures, and aspiration pneumonia.
- A disabling developmental disorder or a brain tumor plus intractable seizures.
- A patient with a multiple sclerosis or myasthenia gravis plus depression.

Physicians and clinical staff

Most care management services are provided directly by clinical staff under a physician's general supervision. General supervision means that the procedure is furnished under the physician's overall direction and control but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the nonphysician personnel who actually perform the service is the continuing responsibility of the physician.^{4,5} The physician and clinical staff oversee management and coordination of services for the patient's medical conditions, psychosocial needs, and activities of daily living.

The chronic care management services are written for use by any type of physician. Neurologists may use these codes³ when their staff provides the services and meets the reporting requirements for qualified patients. The neurologist does not need to personally manage all

The Care Plan is based on an assessment of a patient's physical, mental, cognitive, psychosocial, functional, and environmental needs and an inventory of available resources.

the chronic conditions in order to use the chronic care management codes. Instead, the managing neurologist and his or her practice staff organize appropriate care for the patient's needs. The direct care for many problems is delegated to other physicians or therapists. The neurologist may directly manage 1 or 2 neurologic conditions.

CMS considers this to be an "incident to" service. Their policy usually requires a physician to be on site when clinical staff performs billable services. In this case, CMS suspended some elements of their "incident to" policy for chronic care management services. In particular, for these services, the billing physician need only provide general supervision. The physician remains responsible for the staff's actions but does not need to be on site. Furthermore, the clinical staff does not need to be a direct employee of the billing physician.

Neurologists should assess the qualifications, competence, and licensure of clinical team members. Regulations specify that clinical staff perform these services, but they are not more specific. Some activities may require a registered nurse, whereas other more straightforward activities may be performed by a licensed vocational nurse or medical aide. States differ in clinical staff scope-of-practice standards. Medical aides or assistants are allowed more activities in some states, where they may perform assessments under physician supervision. For example, a physician may screen a patient, find evidence of depression, recommend counseling, and prescribe a medication. By telephone, clinical staff may assess the medication's side effects, check on medication compliance, help coordinate counseling appointments, and document progress in resolving findings.

Counting time

Time is counted for staff or physician time between visits. Time can be summed across several notes and staff or physician providers. A system for tracking time spent may be helpful. Total time for that calendar month must be documented in at least one note. Routine code 99490 requires a minimum of 20 minutes total time per month. Only one unit of the routine service may be coded. Less than 20 minutes may not be coded. Complex code 99487 requires a minimum of 60 minutes total time per month. Only one unit of the complex service base code 99487 may be used. The complex add-on code 99489 allows for additional time for particularly time-consuming patients. Only 1 of these 2 code types may be used in a particular calendar month. Both routine and complex chronic care management services codes cannot be used in the same month. Codes can vary between different calendar months. The patient may be at home, in a rest home, at an assisted living facility, or in the emergency department during the minutes counted. The patient may not be an inpatient, in observation care, or in a skilled nursing facility during the minutes counted.

Time counts when it is spent by a physician or clinical staff member, whether that is a resident, nurse, nurse practitioner, physician assistant, or licensed medical aide. This assumes they have the regulatory authority for the tasks performed and the ability to escalate to a backup at a higher level of competence for problems as needed. Time counts for communication with the patient, caregiver, other health care professionals, or agencies whether it is face-to-face or by telephone, e-mail, or another method. Only the physician's own and clinical staff time is counted, not other office personnel's time. Only count the time of one clinical staff member when 2 or more meet about a patient.

The date of service is not yet regulated. The services are by calendar month, so each billing date must be in a different calendar month. One suggestion is to set the date of service as the last date that month on which clinical staff or physician chronic care notes were documented

Table 3 Service categories typically included in care management

Communicate with the patient, family, caretaker, or surrogate decision makers
Communicate with other health professionals
Communicate with home health agencies and community services
Collect health outcomes data and registry documentation
Educate patient, family, or caregiver to support self-management, independent living, and activities of daily living
Assess treatment regimen adherence
Support medication management
Identify available community and health resources
Facilitate access to care and services needed by the patient or family
Manage care transitions
Review the patient's status, including laboratory and other studies
Develop, communicate, and maintain a comprehensive Care Plan

and the monthly time sum was calculated and documented. This might be more easily accomplished with a single continuously accumulated monthly staff care note in an open access Care Plan, similar to the appearance of paper progress notes or nurses' notes in written hospital charts. At the close of the month, the time sum is calculated and the service is coded.

Outpatient office visits may be coded with standard evaluation and management (E/M) services. The physician may report those standard E/M codes in addition to chronic care management codes during the same calendar month. Care management time excludes any clinical staff time on a day when the physician provided an E/M service. Care management time may be reported while the patient is in an emergency department, as long as the physician does not provide an E/M service that day. Time may not be reported while the patient is inpatient or has been admitted for observation.

Services provided

Chronic care management provides for a patient's ongoing medical and psychosocial needs.⁶ The backbone of the activity is a Care Plan that organizes, establishes, implements, revises, and monitors elements of the patient's needs. The plan coordinates the care of other professionals, therapists, family, and community resources. It educates the patient or caregiver about the patient's condition, plans, and prognosis. Table 3 shows typical services that may appear in chronic care management. For the higher-level complex chronic care management, services that month must establish or substantially revise a comprehensive Care Plan about the medical, functional, and/or psychosocial problems. In comparison, routine chronic care management services may continue to implement an ongoing Care Plan without significant revision.

Practices should be prepared to work with various providers. This includes working with social service agencies and community resources as well as primary care physicians, specialists, mental health workers, and therapists. Offices should consider automated processes, streamlining care, and structured triage. Practices who take on chronic care management may gain efficiencies through scripting and process mapping for ancillary staff.

Several services are bundled into chronic care management. These services have their own separate CPT codes and may be separately coded when provided to other patients. They may not be separately coded when provided during the same month for a patient receiving chronic care management. These services include:

- Care Plan oversight services
- Prolonged services without direct patient contact

The practice must provide easy access to care and communication. Patients and caregivers must have 24 hours per day, 7 days per week access to physicians or clinical staff to address urgent needs.

- Anticoagulant management
- Medical team conferences
- Education and training
- Telephone services
- Online medical evaluation
- Preparation of special reports
- Analysis of online data
- Transitional care management services
- Medication therapy management services

Care Plan The Care Plan is based on an assessment of a patient's physical, mental, cognitive, psychosocial, functional, and environmental needs and an inventory of available resources. The Care Plan's details should be consistent with the patient's values and choices. The month's services aim to implement the Care Plan and revise it as needed. Management of the chronic conditions should include preventive care services, medication reconciliation, oversight medication compliance, and periodic assessment of the patient's physical, mental, cognitive, functional, environmental, and psychosocial needs.

This patient-centered Care Plan is comprehensive for all health problems and related psychosocial needs. A comprehensive-level office visit must be provided (e.g., outpatient established, level 4 or 5) at the time the Care Plan is established and explained to the patient and informed consent obtained. Practices may include the following in the Care Plan:

- A problem list
- Expected outcome
- Prognosis
- Measurable treatment goals
- Symptom management
- Medication management
- Planned interventions
- Plans to coordinate community or social services
- Who is responsible for which steps
- Plans for periodic review or revision of the Care Plan

The Care Plan must be documented in the electronic health record (EHR) and shared with the patient or caregiver. The plan should be reviewed with the patient, with specific discussion of its benefits and the risks if it is not used. The patient should be assured that the clinical staff will be available for ongoing communication.

Required practice elements

Care-related The practice must provide easy access to care and communication. Patients and caregivers must have 24 hours per day, 7 days per week access to physicians or clinical staff to address urgent needs. The contact can be to any licensed practitioner, e.g., a resident, nurse, nurse practitioner, physician assistant, or licensed medical aide. That initial contact should have backup by physicians for questions or problems above the contact person's

Table 4 Points to be covered on a chronic care management consent form

Agree that chronic care management services will be provided
Agree that this physician and practice will provide the chronic care management
Understand that no other physician may provide chronic care management during the same calendar month
Inform the patient of the right to stop chronic care management services at any time, how to do so, and the effect on services of a revocation of the agreement
Specify a duration for this consent agreement, e.g., 1 year
Notify that a copayment and deductible will apply per carrier policies and inform the patient of the expected cost
Attach a copy of the patient's Care Plan
Attach a copy of the practice's routinely available chronic care management benefits and services
Indicate the contact options, e.g., phone numbers
Authorize electronic communication with the patient and caregivers
Authorize electronic communication of medical information with other treating providers; this obtains the patient's prior authorization to share information with some individuals or facilities that they may never see in order to provide proper care to the patient
Document for the record that the chronic care management services were offered and explained and note the patient's decision to accept or decline services

competence level. Each managed patient must be assigned to a specific physician or advanced practice nonphysician designated to provide consecutive routine continuity of care appointments. Timely access to appointments must be available to follow up after an emergency department visit or facility discharge. The practice must provide enhanced opportunities for patients and caregivers to communicate with the practice by telephone, messaging, the Internet, or other modern Health Insurance Portability and Accountability Act secure methods.

An internal care management process identifies patients, tracks their needs, and organizes meeting their required services in a timely manner. The system coordinates referrals to other health care providers and to home- and community-based clinical service providers and services as needed to support the patient's psychosocial needs and functional deficits.

Regulatory Practices must use an organized method to identify patients who should have chronic care management. This may be based on a practice-initiated process or adopted from evidence-based guidelines. For example, a practice may develop a checklist of patient needs typical to that practice and then apply that checklist to individual patients to determine which need chronic care management.

The patient must consent to receive chronic care management services. This is needed in part to ensure that the patient agrees to share medical information and agrees to the monthly charges. Table 4 lists a series of items that should appear on a chronic care management consent form. No generally accepted prewritten forms are yet available. Offices will need to adapt one of their own forms for this purpose. Although the plan is officially permanent until revoked, it is reasonable to renew the plan and consent annually.

Note that the patient may revoke the Care Plan at any time. What if the patient revokes a Care Plan partway through a month? A reasonable suggestion is to code for that calendar month if the 20 minutes of management time was provided and to let any subsequent physician know that this was billed already. Note that the patient will be required to pay the copayments for the service. The Medicare-allowed payment for the routine chronic care management code is \$40–\$45 per month, and the Medicare copayment is 20% of that amount.

Practices must use an EHR system. The Care Plan must be entered into the EHR and must be accessible to all providers within the practice, including those providing care outside of normal business hours. Care team members must be able to share the Care Plan with others outside of the practice potentially involved in the patient's care. The EHR uses a standardized format across the practice to make it easier for all to use.

The EHR must be certified as meeting certain elements of meaningful use standards for the preceding calendar year's EHR Incentive Program. Such chronic care management certified EHR technology (CEHRT) has structured recording of demographics, problems, medications, and medication allergies and creates a structured clinical summary. Many other meaningful use measures are not relevant for the provision of chronic care management and CMS will not require them. For 2015, CMS allows practitioners to use EHR technology certified in either the 2011 or 2014 edition of published CEHRT criteria.⁷ These are a subset of the full meaningful use criteria, so if your system qualifies for meaningful use then it should qualify for CEHRT.

Take-home points

- Chronic care management codes reimburse for office clinical staff time.
- Neurologists may provide these services to patients with major chronic illnesses.
- A Care Plan lays out organized supervision for medical and psychosocial needs.
- The office staff coordinates among the patient's physicians, therapists, and services.
- The office staff communicates with the patient, family, and caregiver.
- Medicare allows payment for one chronic care management code; some third party payers accept all 3 codes.

APPENDIX: CASE EXAMPLE

A 55-year-old woman with a 10-year history of multiple sclerosis (MS) is cared for by her neurologist, who also follows her depression and hypertension. The neurologist is her main physician for most medical problems. She also sees a counselor for her depression. Her MS has progressed to the point where she no longer is able to work and she is now on Medicare. The neurologist has discussed with the patient how her MS and depression pose a risk of acute exacerbation or functional decline. Together the neurologist and patient developed a Care Plan that involves medications and counseling for depression, medication to limit MS progression, and interventions with physical and occupational therapy for the MS limitations on her activities of daily living. The office nurse answers the patient's and her family's questions about available community resources, medication adherence, and dealing with side effects. Office staff members ensure that other health care professionals are kept informed of the patient's status and request information from them. The family and patient know how to reach the office at any time and how to get an expedited appointment. A written Care Plan, based on the above elements and other details, is entered into the office's electronic health record. An informed consent is signed in which the patient agrees to the service. The agreement includes the elements in table 4. During the month, the physician and nurses make notes about actions and discussions, including the time taken for each. Each month a note, referring to the other notes of actions taken during the month, summarizes the total time taken that month. Code 99490 is billed at the end of the month if the physician plus all the clinical staff documented a total of 20 minutes or more of phone, email, reporting, or otherwise unbilled face-to-face services during that month.

REFERENCES

1. American Medical Association. Current Procedural Technology (CPT) 2015. Chicago, IL: American Medical Association Press; 2014.
2. Martin JB, Moses H III. Planning the future of neurology: crisis or opportunity. *JAMA Neurol* 2015; 72:141–142.
3. Medicare Learning Network. Chronic Care Management Services Fact Sheet. Available at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>. Accessed May 18, 2015.
4. 42 CFR 410.26-Services and supplies incident to a physician's professional services: Conditions. Available at: <https://www.law.cornell.edu/cfr/text/42/410.26>. Accessed May 18, 2015.
5. 42 CFR 410.32-Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions. Available at: https://www.law.cornell.edu/cfr/text/42/410.32#b_3_ii. Accessed May 18, 2015.

6. Edwards ST, Landon BE. Medicare's chronic care management payment—payment reform for primary care. *N Engl J Med* 2014;371:2049–2051.
7. The Office of the National Coordinator for Health Information Technology. Certified Health IT Product List. Available at: <http://onchpl.force.com/ehrcert?q=chpl>. Accessed May 18, 2015.

AUTHOR CONTRIBUTIONS

Drafting/revising the manuscript. Study concept or design.

STUDY FUNDING

No targeted funding reported.

DISCLOSURES

M. Nuwer serves as Honorary Consulting Editor for *Clinical Neurophysiology* and on the editorial boards of *Journal of Clinical Neurophysiology*, *Practical Neurology*, and *Neurology: Clinical Practice*; receives publishing royalties for *Intraoperative Neurophysiologic Monitoring* (Cambridge Press, 2010); is a Board member of Corticare; receives research support from NIH, CDMRP, and National Multiple Sclerosis Society; and has participated in medico-legal cases. Full disclosure form information provided by the author is available with the **full text of this article at Neurology.org/cp**.

Related articles from AAN physician and patient resources

Neurology® Clinical Practice

Capturing incentives and avoiding penalties: The carrot and the stick

August 2013;3:341–347.

Neurology® ● Neurology.org

Shining light on Medicare's values: The Medicare physician data release

April 28, 2015;84:1730–1731.

Neurology Today® ● Neurotodayonline.com

Medicare Plans to Reimburse Physicians for Advance Care Counseling Neurologists Weigh in on Next Steps

August 20, 2015;15:1, 12–13.

IN PRACTICE: Can I Charge for Emails, Telephone Calls, Forms, and Other Tasks Outside Traditional Billing Codes?

October 2, 2014;14:22–24.