Chronic Care and Wellness Services
Telehealth Visit Toolkit

This toolkit includes tip sheets that takes a look at the traditional delivery methods of common primary care visits and how they may look when converted to a telehealth platform. Tips sheets in the packet include the following: Annual Wellness Visit, Chronic Care Management Services, and Transitional Care Management Services.

If you have questions or would like support on this topic please reach out to your local AHEC practice support team.

We can help!
Annual Wellness Visit (Medicare Service)

- **Why do them?**
  Medicare’s Annual Wellness Visit (AWV) is a way for your practice to keep patients as healthy as possible. As health care moves from volume- to value-based models, the AWV addresses gaps in care and enhances the quality of care you deliver. A personalized prevention plan created for the Medicare beneficiary is a way to improve patient engagement and promote preventive health care.

- **What are they?**

<table>
<thead>
<tr>
<th>Medicare Coverage of Physical Exams-Know the Differences</th>
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<tbody>
<tr>
<td><strong>Initial Preventive Physical Examination</strong></td>
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<tr>
<td>Review of medical and social health history, and preventative services education.</td>
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<tr>
<td>✓ Covered only once, within 12 months of Part B enrollment</td>
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<tr>
<td>✓ Patient pays nothing (if provider)</td>
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⇒ **NOTE: This is not a physical exam**
Medicare Part B covers an AWV if performed by a:
- Physician (a doctor of medicine or osteopathy)
- Qualified non-physician practitioner (PA, NP, RN, health educator, or certified clinical nurse specialist)
- Medical Professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of medical professionals directly supervised by a physician (doctor of medicine or osteopathy)

⇒ **NOTE: Medicare does pay for focused problem based exams and many providers use a 25 modifier to “add” an exam to the AWV.**
The provider may determine that a problem focused exam is necessary at the time of the AWV.
- If so, the patient should be informed of the need for this visit (this may be done virtually under the waver).
- The patient may have responsibility for coinsurance and part B deductible for this part of the visit while the AWV portion is covered completely
- A separate after visit summary for the Acute care should be provided as well as the “written plan of care” for the AWV.
**Telehealth Delivery of Annual Wellness Visit**

- Providers or designated supervised staff are contacting the patient using a telehealth platform to conduct the AWV. Non COVID environment – patient must go to an approved “Originating site” to receive services. During COVID patient may receive services at home on a smartphone or other device.

- Providers are encouraged to run registry reports out of their EHR to determine who is in need of an AWV to ensure services.

- Providers are encouraged to provide patient education, screenings such as annual alcohol misuse screening, annual depression screening and high risk assessment. Other counseling services such as smoking cessation services, Brief behavioral counseling for alcohol misuse and behavioral counseling for obesity.

- Providers are required to include components required for an initial AWV and subsequent AWVs as listed in the MLN AWV Fact Sheet. To include height, weight and blood pressure which can be self reported during COVID or you can use last recorded vitals in the patient chart.

- Providers are encouraged at the beneficiary's request to provide Advanced Care Planning along with the AWV.

- Vaccinations, vitals and other screenings are to be provided at a face to face office visit subsequent to the AWV.

**Telehealth Billing**
- Billing during COVID has expanded to include their home as a place of approved service. Please see the link to CMS 1135 Waiver below. Annual Wellness Visits completed via Telehealth are paid at parity as an office visit.

**Telehealth Special Considerations**
- May 1, 2020 CMS approved AWV to be provided during COVID using Audio only. Please see link below.
- Benefits to Telehealth AWVs have discussed such visual of home and environment (falls risk and family dynamics), SDOH food insecurity and discussing what is in the fridge? Also, discussion with combining an AWV at the same time as a Home Health visit for a more robust visit.

**Resources**
- CMS Telehealth Services Fact Sheet
- CMS MLN AWV Fact Sheet
- 1135 Waiver Billing Information
- CMS Telehealth Webpage and April 30, 2020 update to Telehealth and Audio only CPT codes
- Mid Atlantic Telehealth Resource Center
Chronic Care Management
(Medicare Service)

- **What and Why do them?**
  - Chronic care management includes any care provided by medical professionals to patients who have chronic diseases and conditions. A disease or condition is chronic when it lasts a year or more, requires ongoing medical attention or limits the activities of daily life. It includes physical conditions like diabetes or mental conditions, like depression. **The goal of chronic care management is to help patients achieve a better quality of life through continuous care and management of their conditions.**

- **Tradition Delivery for Chronic Care Management Services**
  - Chronic care management involves a comprehensive care plan that includes:
    - a record of the patient’s chronic conditions and problem list,
    - symptoms,
    - goals,
    - health care providers (including specialists and home health services),
    - medications,
    - any other services needed to manage their condition

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<tr>
<th>Medicare</th>
<th>Non-Medicare</th>
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<td>Medicare allows billing separately for CCM and has guidelines to follow:</td>
<td>For Non-Medicare chronically ill patients, face-to-face visits are usually scheduled every 3 months with a provider.</td>
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<tr>
<td>o Chronic care management consists of reviewing the patient’s medical record for twenty minutes or more per month: reviewing the care plan, contacting the patient via telephone if possible, medication reconciliation, discussing any visits during the month to the ER, hospital, or specialist, checking appointment status, and any pending referrals.</td>
<td>o <strong>Payers other than Medicare do not have separate codes for Chronic Care Management.</strong></td>
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<td>o Documentation in the patient’s chart is required.</td>
<td>o Patients call the office as needed between appointments or send questions/concerns through the patient portal.</td>
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<td>o Most EHRs maintain a list, or report, of Medicare CCM patients that can be continuously worked.</td>
<td>o Patients with chronic conditions may be considered “high-risk”, and may be contacted more frequently during a pandemic or flu season.</td>
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<tr>
<td>o Face-to-face visits are usually scheduled every three months, and lab testing may be performed.</td>
<td>o A list or report can be run based on diagnoses, and an employee assigned to contact them.</td>
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Chronic Care Management

- **Telehealth Delivery for Chronic Care Management Services**
  - During the current pandemic, visits can be conducted virtually through an audio-visual platform, or telephonic if the patient does not have audio capability. Lab testing may be ordered and the patient may “drive through” if offered at the practice, or come into the office briefly for lab testing only. *Medicare CCM is not affected during the pandemic as patient contact is via telephone (between regularly scheduled appointments)*.

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<th>Telehealth Billing</th>
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<tr>
<td>99490</td>
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<tr>
<td>99491</td>
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<td>99487</td>
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<td>99489</td>
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*G05011 should be added to RHC and FQHC claims (either alone or with other services) for Medicare CCM

**Billing for Non-Medicare Telehealth** There are no specific codes. Office visit codes 99201-99215 should be used.

- **Telehealth Special Considerations**
  - During a Pandemic or flu season, patient access via telehealth can help with compliance.

- **Resources**
  - CMS MLN Chronic Care Management Information
  - CMA Medicare Fee for Service Payment, FAQs for FQHC and RHC
Transitions of Care (Medicare Service)

- **What and Why do them?**
  - These are visits with a primary care provider that take place within 30 days of a patient being discharged from an acute-care facility. Transitions of Care (TCM) visits ensure that patients/caregivers have the resources needed to smoothly transition between healthcare settings. The goal of TCM is to reduce preventable readmissions by coordinating services for all medical conditions, identifying and addressing psychosocial needs, and arranging for assistance with activities of daily living.

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<th>Benefits to the Practice</th>
<th>Benefits to Your Patients</th>
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<tr>
<td>✓ Improved awareness of discharges.</td>
<td>✓ Reduced risk of preventable readmissions.</td>
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<tr>
<td>✓ Opportunity to utilize discharge reports to inform post-hospitalization care.</td>
<td>✓ Better experience of care during care facility transitions.</td>
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<tr>
<td>✓ More opportunities to improve patient outcomes via interaction with care team and better documentation of transitions.</td>
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<tr>
<td>✓ Boosts practice revenue.</td>
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- **Traditional Delivery of Transitions of Care Services**

Who needs a TCM visit?
- Who has been discharged recently?
- How do you get that information?

Prepare for the visit
- Who will make the initial call?
- Who will do the visit?
- What needs to be done beforehand i.e. medication reconciliation?

Contact patients within 2 business days of their discharge
- What is your in office workflow?
- Patient scheduling
- Visit documentation

Complete the TCM visit
- Notify provider this is a TCM visit
- Complete medication reconciliation
- Pay attention to documentation i.e. date of patient's discharge, date of 1st contact with patient, level of complexity, place of service
Transitions of Care

- **Telehealth Delivery of Transitions of Care Services**
  - During the pandemic, the provider portion (qualified clinician) can be done virtually under the waiver. Provider responsibilities include: Review the discharge, Evaluate need for follow-up, testing or additional treatment, Interact with consulting providers, Educate, Referrals, Assist in scheduling. The clinical staff can complete the communication responsibilities via telehealth. Under the direction of a physician, clinical staff can provide coordination, medication reconciliation, education, resources, and facilitation of access needs.

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<th>In-office and Telehealth Billing</th>
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<td>99495</td>
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<td>99496</td>
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The following codes may not be billed during the 30-day period covered by the TCM code: Based on Medicare 2020 Physician Fee Schedule Final Rule
- Care plan oversight (G0181 and G0182)
- Prolonged services without direct patient contact (99358, 99359)
- Home and outpatient INR monitoring (93792-93793)
- End stage renal disease services (90960, 90961, 90962, 90966, 90970)
- Analysis of data (99091)
- Complex chronic care coordination services (99487, 99489)
- Medication therapy management services (99605-99607)
- Chronic Care Management (CCM) services and TCM service periods cannot overlap

Effective 01/01/2020: G0511 may be billed with Transitional Care Management (99495, 99496)

- **Telehealth Special Considerations**
  - None

- **Resources**
  - American Academy of Family Practice: [FAQ on Transitional Care Management](#)
  - American College of Physicians: [What Practices Need to Know about Transition Care Management Codes](#)
  - Rural Health Information health: [Transitional Care Management](#)
  - HealthInsight Quality Innovation Network: [Transitional Care Management Implementation Guide](#)
  - HealthInsight Quality Innovation Network: [TCM Checklist](#)
  - NC HIEA Information: [Get Connected](#)