Health Coach Intervention Sustainability Plan

Medicare Preventative Services

i. **In Office Visits, Modifiers and Add-On Codes**
   a. **Annual Wellness Visits**
      1. Medicare
         i. **Description**-Initial Preventative Physical Exam (IPPE) also known as "Welcome to Medicare" visit
         ii. **Purpose:** to review medical and social health history and preventive services education
         iii. Covered ***only once*** within 12 months of first Part B enrollment
         iv. $0 co-pay required for Medicare beneficiary
      2. **Coding**
         i. G0402: IPPE visit
         ii. G0403: ECG performed as part of IPPE visit with interpretation and report
         iii. G0404: ECG performed as part of IPPE visit without interpretation and report
         iv. G0468: FQHC visit (IPPE or AWV) that includes these as part of a bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV
      3. **Considerations for Health Coaches, CHW, MA, CDECS and SW**
         i. Medical, Social Health History, Preventative Services Education surveys and questionnaires may be completed by these ancillary staff members on the day of or telephonically/electronically prior to physically presenting to the clinic for the office visit
         ii. These staff can also gather results or dates from other providers (colonoscopies, bone density scans, mammograms, etc)
         iii. These staff can identify, through these conversations, additional preventative services i.e. smoking cessation, obesity management, DSME, described below, and begin enrollment process with patient
         iv. The documentation of the conversations with ancillary staff must be completed, dated, and signed with credentials by the providing Health Coach, CHW, MA, CDECS or SW and can then be provided to the Provider (MD, DO, NP or PA). This will then help draw attention to the out of range results for discussion and use each discipline in the most cost effective way as well as the most efficient use of the patients time.
      4. **Description**-Annual Wellness Visit
         i. Purpose: to develop or update a Personalized Prevention Plan (PPP) and perform a Health Risk Assessment (HRA)
         ii. Covered ***once every*** 12 months
         iii. $0 co-pay required for Medicare beneficiary
      5. **Coding**

i. G0438 Annual Wellness Visit with a Personalized Prevention Plan of Service, Initial Visit (post "Welcome to Medicare")
ii. G0439 Annual Wellness Visit with Personalized Prevention Plan of Service, Subsequent Visit (every visit year 3 and forward)
iii. G0468 FQHC visit (IPPE or AWV) that includes these as part of a bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV

6. **Considerations for Health Coaches, CHW, MA, CDECS and SW**
   i. Medical, Social Health History, Preventative Services Education surveys and questionnaires may be completed by these ancillary staff members on the day of or telephonically/electronically prior to physically presenting to the clinic for the office visit
   ii. These staff can also gather results or dates from other providers (colonoscopies, bone density scans, mammograms, etc)
   iii. These staff can identify, through these conversations, additional preventative services i.e. smoking cessation, obesity management, DSME, described below, and begin enrollment process with patient
   iv. The documentation of the conversations with ancillary staff must be completed, dated, and signed with credentials by the providing Health Coach, CHW, MA, CDECS or SW and can then be provided to the Provider (MD, DO, NP or PA). This will then help draw attention to the out of range results for discussion and use each discipline in the most cost effective way as well as the most efficient use of the patients time.
7. **FAQs Medicare AWVs**
   i. *Does deductible apply?* No! No coinsurance, no co-pays and no deductible. The beneficiaries also do not make progress on their deductibles either.
   ii. *Who is eligible for an AWV?* Medicare pays for 1 IPPE or "Welcome to Medicare" visit which is within the first 12 months of becoming a Medicare beneficiary. Then an AWV is covered once per 12 months thereafter.
   iii. *Can other medical services be provided on the same day as the AWV?* Generally, yes, as long as they are medically necessary. Deductible and co-insurance may apply to those services.
   iv. *How do I know which code to bill? For instance, what if their AWV was billed at another doctor?* The best method is to verify patient eligibility within their MAC.
8. **Cheat Sheet AWVs**
   i. *What is it?* Annual Wellness Visits are an opportunity to have a conversation about prevention and screening with providers. It allows the provider to have a baseline on things like depression, cognitive function, fall risk, family history and other risks. It does not involve a physical exam.
   ii. *Who is eligible?* All Medicare beneficiaries every year.
   iii. *How much does it cost?* $0 to the patient
   iv. *Why should the patient participate?* Most office visits are focused on problems. AWVs are focused on preventing problems. Medicare has

compiled a list of questionnaires that gives the provider a picture of where the patient is based on age and may can catch something early before it becomes catastrophic. It also is a great opportunity for those questions that we all save up and forget to ask when we are sick or in pain.

9. Tenncare-Annual Wellness Visits not covered but physical exams and check ups covered

b. **Depression Screening**

1. **Medicare**
2. **Description**-Medicare annual screening for adults for depression in the primary care setting that has staff-assisted depression care supports in place to assure diagnosis, treatment, and follow-up.
   - **i. Purpose**: To identify, treat and follow up with those 25% of Medicare beneficiaries 65 years and older have depression and older adults have the highest rates of suicidality than any other age group with 50-75% of those who died by suicide seeing their medical doctor within the previous month.
   - **ii. Coverage**: annually for every Medicare beneficiary
   - **iii. Cost:** $0 co-pay, Part B deductible is waived for this preventative service
3. **Coding-**G0444, Place of Service must be 11 (Office), 49 (Independent clinic), 71 (state or local public health clinic) or other appropriate location, for Rural Health Clinics if G0444 is billed it will be paid at the all-inclusive rate for qualified primary and preventative health services if provided on the same day as other services. In non-RHCs, this code can be added to AWV.
4. **Considerations for Health Coaches, CHW, MAs and CDECS-**At a minimum level, staff-assisted depression care supports consists of clinical staff in primary care office who can advice the physician of the screening results and who can facilitate and coordinate the referrals to mental health treatment. Case managers may also be involved in this code. This code does not cover counseling, medications, or treatment for results.
5. **FAQs**
   - i. **How often can this be billed?** 11 full calendar months must pass between billing.
   - ii. **Tips for billing?** This code reimburses at a fairly low rate so the best option is to combine it with the AWV or an E&M visit for diabetes or other condition. Making it part of the workflow will ensure eligible patients are not missed.
   - iii. **How can this be implemented?** There are several depression scales that can be implemented and scored easily as part of the AWV or other visits. The PHQ-9 is an easy to administer and interpret screening for depression severity. Ancillary staff could implement PHQ-2 and if positive, move to PHQ-9 with specific instructions for mild, moderate to severe symptoms, especially if administered telephonically or via telehealth prior to in-person visit. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/) PHQ-

2 and PHQ-9 are easily incorporated into AWV HRA's and online versions as well.

c. **Advance Directive Counseling**

1. Medicare
2. **Description**-Voluntary Advance Care Planning (ACP) is a face-to-face service between a Medicare provider (physician or other mid-level provider) to discuss the patient's health care wishes if they become unable to make decisions about their care. Discussions may include completing legal forms or simply discussing forms.
3. **Coverage**: There are no limits on the number of times you can report ACP for a given patient in a given time period. It is recommended that you document changes in either wishes or health status during visit for subsequent ACP discussions.
4. **Cost**: There is no coinsurance and the Part B deductible is waived when the ACP is delivered on the same day as the Medicare AWV, offered by the same provider as the AWV and is billed with the modifier 33 (Preventative Services)
5. **Coding**
    i. **99497**-Advance Care Planning including the explanation and discussions of advance directives such as standard forms with the completion of such forms when performed by the physician or other qualified health care professional; first 30 min, face to face with patient, family member and/or surrogate
    ii. **99498**-Advance Care Planning including the explanation and discussion of advance directives such as standard forms, each additional 30 minutes
6. **Considerations for Health Coaches, CHW, MAs and CDECS-**The completion of this code must be conducted with the provider; however, this service should be completed as part of the yearly Medicare AWV. If the ancillary staff are assisting either telephonically, in a triage capacity, or in a telehealth capacity to prepare the patient for the physician or other provider, ADC is an opportunity to ask questions such as—Do you have an Advance Directive or Medical Power of Attorney? When was the last time it was updated? At times, patients may be resistant to these discussions for a myriad of reasons and these staff can help to address these concerns such as this helps to make sure the patient's wishes are addressed and thought through while they are health and in a non-emergency situation, people designated for medical decisions sometimes move, pass away or relationships change so we want to make sure that we review it at least yearly with your provider.
7. **Resources**
    i. https://www.tn.gov/health/health-program-areas/health-professional-boards/hcf-board/hcf-board/advance-directives.html
    ii. https://theconversationproject.org/
    iii. https://advancedirectivestn.org/

d. **Cardiovascular Risk Counseling**

1. **Medicare**
2. **Description**: Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
    i. **Coverage**: All patients who are competent and alert when you deliver counseling and who are counseled by a PCP or other qualified provider in a primary care setting, covered annually, *eligible for telehealth*
    ii. **Cost**: $0 copay, no coinsurance and deductible does not apply
    iii. **Components:** Counseling should include encouraging the use of aspirin for the primary prevention of CVD when the benefits outweigh the risks for men age 45-79 years and women 55-79 years, high blood pressure screening and behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advancing age and other known risk factors for cardiovascular and diet related chronic disease
3. **Coding**
    i. **G0446:** Face-to-face behavioral counseling for cardiovascular risk reduction
4. **Considerations for Health Coaches, CHW, MAs and CDECS-**Very similarly to Advance Directive Counseling, this code requires completion by a physician or other midlevel practitioner. However, cardiovascular risk factors are a critical piece of the Health Risk Assessment of the AWV. As the ancillary staff engage in this service and gather information regarding the patient's family history, preventative services, surgeries and other providers, these staff can be trained to provide the counseling points needed to fulfill this code above and reinforced by the provider during the visit.
5. **Resources and How To's**
    i. The MLN Matters recommends aspirin use and dietary counseling using the Five As approach adopted by the USPSTF to help affect behavioral health changes.

e. **Intensive Behavioral Therapy for Obesity**
1. **Medicare**
2. **Description-**IBT for obesity defined as a BMI of 30 kg/m^2 or greater for the prevention or early detection of illness or disability, includes screening, nutritional assessment and IBT to promote sustained weight loss through high intensity interventions on diet and exercise
    i. **Coverage:** Medicare covers a maximum of 22 IBT for obesity sessions in a 12 month period, 1 face-to-face visit every week for the first month, one face to face visit every other week for months 2-6 and one face to face visit every month for months 7-12 if the beneficiary meets the 3kg (6.6 lbs) weight loss requirement during the first 6 months
    ii. **Cost:** $0 coinsurance, no Part B deductible applies
    iii. **G0447:** Face-to-face behavioral counseling for obesity, 15 minutes

3. **Considerations for Health Coaches, CHW, MAs and CDECS-**This screening is easily incorporated into the HRA portion of the AWV and identified within this screening process whether done telephonically or in person prior to the provider encounter. The follow visits can be accomplished in office with ancillary staff and provider supervision

f. **Tobacco Cessation**

1. **Medicare**

2. **Description**: Recognizing the health related problems caused by smoking and tobacco use, Medicare (and other payers) covers counseling to help patients understand the benefits of tobacco cessation and take steps to do so

   i. **Requirements**-patients must be a tobacco user at the time of billing (with or without the presence of tobacco related health complication), must be competent at the time of counseling

   ii. **Coverage**-Medicare covers 2 quit attempts (8 sessions per calendar year), Medicare also covers and E&M visit on the same day if medically necessary

   iii. **Tenncare Coverage**-Tenncare now covers smoking cessation products for all beneficiaries

   iv. **Cost**-$0 coinsurance for counseling visits; however, if the quit plan involves medication, depending on the Part D medication coverage (if any) or other medication coverage, there may be payment required for nicotine replacement products, Chantix®, bupropion or other products

   v. **Other Info**: 1-800-QUITNOW, Free Coaching for Smoking Cessation for any patient, https://www.tn.gov/health/health-program-areas/fhw/tobacco.html

3. **Coding**

   i. **G0436-**3-10 minutes for asymptomatic patient, intermediate visit

   ii. **G0437-**10 minutes for asymptomatic patient, intensive visit

4. **Considerations for Health Coaches, CHW, MAs and CDECS-**This screening is easily incorporated into the HRA portion of the AWV and identified within this screening process whether done telephonically or in person prior to the provider encounter. The follow visits can be accomplished in office with ancillary staff and provider supervision.*verify with billing professionals

g. **Alcohol misuse and screening Counseling**

1. **Medicare**

2. **Description**-Medicare covers the screening for the misuse of alcohol for beneficiaries who do not meet the criteria for alcohol abuse but who do use alcohol once per year (if the beneficiary's use of alcohol does rise to the level of alcohol abuse there is different coding)

   i. **Requirements**-patients must be positive for some use of alcohol at the time of billing and visit,

   ii. **Cost**-$0 co insurance for counseling visit

3. **Coding**

   a. Medicare

i. **G0396-** Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
ii. **G0397-** Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes

b. Commercial
i. **CPT 99408**- Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes
ii. **CPT 99409**- Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes

c. Medicaid
i. **H0049**- Alcohol and/or drug screening
ii. **H0050**- Alcohol and/or drug screening, brief intervention, per 15 minutes

4. **Considerations for Health Coaches, CHW, MAs and CDECS-**This screening is easily incorporated into the HRA portion of the AWV and identified within this screening process whether done telephonically or in person prior to the provider encounter.

II. **Preventative Service Programs**

a. **Diabetes Self-Management Education/Training**

i. **Medicare**

ii. **Description**-Medicare refers to Diabetes Education as DSMT or Diabetes Self-Management Trianing. It is a preventive service that helps patients manage their diabetes and prevent additional complications. DSMT providers cooperate to offer patients with Type 1 or Type 2 diabetes services that include educating and empowering Medicare beneficiaries to better manage and control their conditions, reduce hospitalizations and complications and reduce costs.

1. **Accreditation:** CMS approves accreditation by 2 organizations. *Accreditation must occur prior to any payment to DSMT organizations or providers*.
    a. The American Diabetes Association (ADA)
    b. The Association of Diabetes Care and Education Specialists (ADCES)
2. **Coverage:** Medicare Part B may cover up to 10 hours of initial DSMT (1 hour of individual training and 9 hours of group training). Medicare beneficiaries may qualify for 2 hours of follow up training each year if it takes place in a calendar year after the year the initial training was provided. *Initial DSMT is a once in a lifetime Medicare benefit. (Group is defined as 2-20 people)*
3. **Cost:** Patients are responsible for the 20% co-insurance and the Part B deductible applies. Many Medicare supplements cover this 20%.
4. **Important Note:** DSMT requires that a doctor (MD/DO) or qualified non-doctor practitioner refers the patient to DSME.

iii. **Coding and Billing**

1. **Codes**

a. G0108-Diabetes outpatient self-management training services, individual, 30 minutes
b. G0109-Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes
c. GQ-modifier for asynchronous telecommunications system
d. 02-Place of Service Code for telehealth

2. **DSMT Entities**
    a. Clinics
    b. DMEPOS
    c. FQHC
    d. Health Dept
    e. Home Health Agency
    f. Hospital (Outpatient only)
    g. Pharmacy (must be a part B provider)
    h. Skilled Nursing Facility
3. **DSMT Providers**
    a. Clinical Nurse Specialists
    b. Clinical Social Worker
    c. Nurse Practitioner
    d. Physician
    e. Physician Assistant
    f. Psychologist, Clinical
    g. Registered Dietitian/Nutrition Professional
4. **Excluded from Billing for DSMT**
    a. CDECS (stand alone)
    b. End-stage Renal Facility (Dialysis Center)
    c. Hospice Service
    d. Hospital Inpatient Service
    e. Nurse (billing alone)
    f. Nursing Home
    g. Pharmacist (billing alone)
    h. Rural Health Clinics

iv. **Considerations for CHWs, MAs and Health Coaches**-Specific roles within diabetes education programs are recommended and can be very beneficial for programs. This position paper gives specific tasks and resources. Working in conjunction with CDECS under the supervision of a provider and within a clinic a CDECS or a combination of a CDECS and CHW/MA or Health Coach could functionally operate this service after referral from within the clinic with a fair amount of autonomy.

v. Helpful Cheat Sheet found here

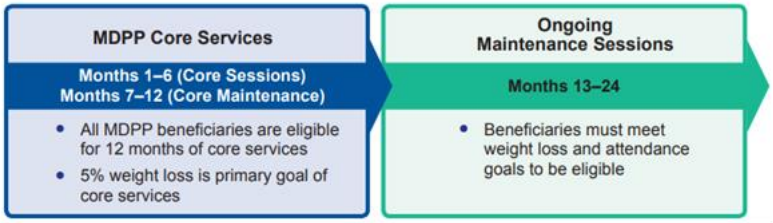
b. **National Diabetes Prevention Program (Prediabetes)**

i. **Medicare**

ii. **Description:** an evidence-based behavior change intervention using a CDC-approved, group-based, classroom-style curriculum that teaches long-term dietary change, increased physical activity, and strategies for weight control. Coaches, such as trained community health professionals,

conduct these interventions designed to prevent or delay progression to type 2 diabetes. **

1. **CDC Recognition**: Programs must use a CDC approved curriculum with approved topics, have the ability to offer the program within 6 months of approval, be committed to deliver the program over at least 1 year including at least 16 sessions during the first 6 months and at least 6 sessions during the last 6 months, must have the ability to submit patient progress which includes attendance, weight loss and physical activity every 6 months, sessions must be taught by trained lifestyle coaches (licensed or nonlicensed), at least 35% of participants prediabetes diagnosis must be confirmed with blood tests or have a history of gestational diabetes. This recognition process allows programs to bill CMS and commercial payers, employer groups as well as Medicaid programs.
2. **Purpose:** To prevent and delay progression to type 2 diabetes which has been shown to reduce the incidence of diabetes by 71 percent in persons over age 60 years.
3. **Coverage:** may last up to 2 years. The first year includes 6 months of weekly core sessions followed by 6 months of monthly core maintenance sessions. All beneficiaries are eligible for all 12 months of the core services. The second year consists of monthly ongoing maintenance sessions. They may be eligible for the second year of services based on their attendance and weight loss.
4. **Cost:** There are no costs to the participants.
5. **Eligibility:**
    a. Results from one blood test from the last year (Hemoglobin A1c 5.7-6.4%, Fasting plasma glucose 110-125 mg/dL, oral glucose tolerance test 140-199 mg/dL)
    b. BMI of at least 25, 23 if self-identified as Asian
    c. No history of type 1 or type 2 diabetes, exception of history of gestational diabetes
    d. No end stage renal disease (ESRD)
    e. Has not received Medicare Diabetes Prevention Program services previously



iii. **Coding and Billing:** MDPP payment is contingent upon beneficiary participation and performance.

1. **G9873:** MDPP core session attended during months 1-6 approximately 1 hour and adheres to CDC approved DPP curriculum

2. **G9874*:** 4 total MDPP cores sessions were attended under the MDPP Expanded Model (EM). Core Session during months 1-6 of services, 1 hour in length, adheres to CDC approved DPP curriculum
3. **G9875*:** 9 MDPP core sessions furnished during months 1-6 of services, approximately 1 hour in length, adheres to CDC-approved DPP curriculum
4. **G9876*:** 2 core maintenance sessions (MS) attended in mon 7-9 under Expanded model, approximately 1 hour in length, CDC approved curriculum, beneficiary did not achieve at least 5% weight loss (WL) from base line
5. **G9877*:** 2 core MS attended by beneficiary in months 10-12 under Expanded Model, beneficiary did not achieve at least 5% weight loss
6. **G9878*:** 2 MS attended by beneficiary in months 7-9 in the expanded model, 1 hour in length, using CDC approved DPP curriculum, beneficiary achieved at least 5% weight loss from baseline weight
7. **G9879*:** 2 core maintenance sessions in months 10-12 under the expanded model, approximately 1 hour in length and adheres to a CDC approved DPP curriculum for maintenance sessions, beneficiary achieved at least 5% weight loss from his/her baseline
8. **G9880:** MDPP beneficiary achieved at least 5% weight loss from his/her baseline weight in months 1-12 of the MDPP services under the Expanded Model, This is a one-time payment available when the beneficiary achieves at least 5% weight loss.
9. **G9881:** MDPP beneficiary achieved at least 9% weight loss from his/her baseline weight in months 1-24 under the Expanded Model. This is a one-time payment available when the beneficiary achieves at least 9% weight loss from baseline.
10. **Coding for identification of prediabetes**

iv. **Considerations for CHWs, MAs and Health Coaches:** CDC-recognized organizations that deliver the DPP program are responsible for billing as opposed to the individual lifestyle coaches leading the classes. Both lay and licensed health care professional may be trained as lifestyle coaches and lead classes. DPP and the corresponding CPT codes 0403T and 0488T do not require supervision of a licensed physician or non-physician provider.

v. **Resources:**

1. **Measure, Act, Partner (MAP) Method:** to help develop the most sustainable model for practices
3. **Coverage Toolkits**
4. **State of Tennessee Beneficiary Coverage**
5. **Recognized DPP Providers in State of Tennessee**

c. **Transitional Care Management**

i. **Medicare**

ii. **Description**-These services are provided when a beneficiary is discharged from a higher level of care to their home or lower level of care to

help make sure the transition is effective, the patient receives appropriate care, gaps in care are closed and the patient is more closely monitored

iii. **Eligibility and Consent**

1. Patients transitioning from an inpatient hospital setting like acute, psychiatric, long-term care, skilled nursing, rehab hospital, or observation status to the patient's own home, rest home, community mental health center, or assisted living facility
2. The practitioner must obtain consent before furnishing or billing for TCM (consent may be verbal or written but MUST be written in the medical record

v. **Timeframe**

1. TCM services may be offered *within the 30 day period starting on the date when the beneficiary is discharged from inpatient care and continuing for the next 29 calendar days*
    a. **Interactive Contact** within 2 days of discharge date, the provider initiates direct and interactive communication with the patient (telephonic, in person or electronic). This contact may include scheduling a follow up appointment but must also address the types of services the patient had during admission, what discharge diagnosis was and what follow up services are needed
    b. **Initiating Visit**-3 TCM components (interactive contact, face to face visit and non-face to face services comprise the set of services that may be provided beginning on the day of discharge through day 30
        i. **Face to face visit**-required face to face time must be furnished under minimum direct supervision (supervision of auxillary staff by billing practitioner)
        ii. **Non face to face services**-may be furnished under general supervision (the billing practioner provides overall direction and control, but their direct physical presence is not required during the provision of services

vi. **Coding and Billing**

1. **99495**-Moderate complexity medical decision making during the service period, face-to-face visit within 14 calendar days of discharge
2. **99496**-High complexity medical decision making during the service period
3. **G2025**-FQHC for moderate or high complexity

vii. **Considerations for CHWs, MAs and Health Coaches:** TCM programs as outlined by Medicare and other payers are perfectly designed for incorporating clinical staff. The interactive contact is recommended to be conducted by the clinical staff mentioned above. In order to run an efficient service and to meet timelines set for billing and coding, recommend that a specific or a several specific (depending on demand) clinical and auxillary staff be dedicated to checking the primary

care clinic's attributed patients who are admitted to area hospitals. During which time the staff member could contact the patient, family member or designated person to schedule appointment, discuss reason for admission and begin the process of gathering documentation for TCM face to face appointment. Auxillary staff can also perform non face to face services as well as appointment readiness services.

viii. **Other-**TCM is an appropriate visit to re-evaluate Advance Care Planning and bill for the corresponding codes as well

ix. **Resources**

1. https://www.nachc.org/wp-content/uploads/2020/04/Payment-Reimb.-Tips_TCM-April-2021.pdf
2. https://geiselmed.dartmouth.edu/dcpbrn/wp-content/uploads/sites/54/2020/02/Implementing-Transitional-Care-Management-in-Primary-Care-Daniel-Moran-MSN-APRN.pptx

d. **Chronic Care Management**

ii. **Medicare**

iii. **Description**-at least 20 minutes minutes of clinical staff time coordinating care for Medicare beneficiaries, with 2 or more chronic conditions with an intent of preventing more costly and complicated problems related to chronic conditions

iii. **Eligibility and Exclusions**-Patients are eligible for CCM if they have 2 or more chronic conditions, have seen their provider within the last 12 months, and consent verbally or in written form to the program. Patients are excluded from CCM if they have End Stage Renal Disease, are currently enrolled in Hospice Care, are receiving Home Health Care or are receiving CCM from another provider.

iv. **Coverage**-Medicare covers CCM at 80% leaving 20% coinsurance as the patient responsibility; however, many Medicare supplements cover this coinsurance. The average reimbursement for CCM is around $40 (in fee-for-service clinics) total leaving around $8 for the patient responsibility if not covered by supplement, Medicaid or other payer

v. **Coding and Billing**

1. **99490**-Chronic Care Management (20 min) provided by clinical staff directed by physician or other qualified health care professional per calendar month
2. **99491**-Chronic Care Management (30 min) provided personally by physician or other qualified health professional
3. **99487**-Complex Chronic Care Management Services (60 min) of clinical staff time directed by physician or other qualified health professional
4. **99489**-Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional

vi. **Rural Health Clinics-**initiating visit must be conducted under indirect supervision whereas fee-for-service clinics may outsource all parts of CCM

vii. **Considerations for CHWs, MAs and Health Coaches-**Auxiliary staff are well equipped to provide all of the services under the supervision of a qualified health provider including monitoring and contacting patients as needed**.**

e. **Remote Patient Monitoring**

i. **Medicare**

ii. **Description-**Remote Patient Monitoring includes providing the beneficiary with an FDA cleared device for monitoring a health parameter that is monitored in real time by clinical staff, when deviations from expected results are obtained, interventions can be made, at least 16 readings from each device must

iii. **Coding and Billing**

1. **99453-**One-time device set up
2. **99454-**Monthly device provision
3. **99457-**Device monitoring and patient communication
4. **99458-**Additional 20 minutes of service

iv. **Description-** – Use of digital technologies to collect health data from patients in one location and electronically transmit that information securely to providers in a different location (data can include vital signs, weight, blood pressure, blood sugar, pacemaker information, etc.)

v. **Eligibility-**Patients must have 1 or more chronic conditions (monitored by device provided). Patient must consent verbally or in written form and must be documented in the patient chart.

vi. **Coverage-**RPM is covered by Medicare at 80% and 20% coinsurance is left for the patient's responsibility but this is often covered by the Medicare supplements, Medicaid or other payers; however if that is not an option that will remain as the patient responsibility.

vii. **Considerations for CHWs, MAs and Health Coaches-**Auxiliary staff are well equipped to provide all of the services under the supervision of a qualified health provider including monitoring and contacting patients as needed**.**

viii. **Resources**

TennCare Preventative Care Benefits and Coverage

1. Amerigroup

2. No-cost optional program for eligible members enrolled to incentivize health behaviors in the Benefit Reward Hub
    - $20 for high blood pressure medication refills
    - $20 for antidepressant medication management
    - $40 for ADHD medication management
    - $50 for breast cancer screenings
    - $20 for adult wellness visits
    - $50 for childhood wellness visits
    - $25 for getting your child's immunizations (shots) on time
    - $25 for getting your adolescent's immunizations (shots) on time
    - $50 for a diabetic retinal eye exam
    - $10 for a diabetic A1c screening
    - $25 for pregnant members who go to a prenatal visit in their first trimester or within 42 days of enrollment
    - $50 for new moms who go to their postpartum visit 7-84 days after delivery
    - $5 for a diabetes management quiz
    - AWV Equivalent-**no copays for preventative health**
        - Check up for adult
            - Cholesterol screening
            - Colorectal Screening
            - Osteoporosis Screening
            - STD or STI screening
            - Blood glucose screening
            - HIV/AIDS screening
            - EKG
            - TB screening
            - PAP smears
            - Immunizations
    - Population Health-beneficiaries may use these services if well, have a chronic condition or have an acute episode
        - Chronic Condition Education
        - Smoking/Nicotine Cessation
        - Weight Management
        - Care Management Services-provided telephonically by Americgroup Nursing Staff, available at 1-800-600-4441

2. United Healthcare Community Plan
    - AWV Equivalent-no copays for preventative health
        - Checkups for adults
            - Cholesterol screening
            - Colorectal Screening
            - Osteoporosis Screening
            - STD or STI screening

- Blood glucose screening
- HIV/AIDS screening
- EKG
- TB screening
- PAP smears
    - Beginning at age 21 on a "regular basis"
- Immunizations
- Mammograms
    - Ages 35-40, minimum of once
    - Ages 40-50, every 2 years, more often if needed
    - Ages 50 and older, yearly (these may be increased based on family or cancer history)

- Tennessee Population Health-covered in special circumstances
    - Chronic Condition Education
    - Smoking/Nicotine Cessation
    - Weight Management
    - Care Management Services-provided telephonically by UnitedHealthcare Community Plan Nursing Staff, available at 1-800-690-1606
- Diabetes Self Management Education is covered for Tenncare members under the Tennessee Patient Centered Medical Home model and the compensation is died to ongoing financial support and an opportunity for an annual outcome payment based on quality and efficiency performance. 37% of Tenncare members are attributed to one of these primary care practices

Commercial Insurance for Tennessee State Employees (Blue Cross Blue Shield-mostly Baptist health care system and west TN/Cigna-mostly Methodist and coverage in more state-wide coverage)

- Preventative-recommended health care services for women
    - Annual well-woman exam
    - Screening for gestational diabetes
    - Human papillomavirus testing
    - STI counseling (annually)
    - Screening and counseling HIV (annually)
    - Contraception and counseling (as prescribed)
    - Breastfeeding support, supplies and counseling (in conjunction with birth)
    - Interpersonal and domestic violence (annually)
- Prostate screening annually for men who have been treated for prostate cancer with radiation, surgery or chemotherapy and for men over the age of 45 who have enlarged prostate nodules or other irregularity noted on rectal exam. PSA covered for men over age 50 and transrectal ultrasound covered with elevated PSA.
- Other preventative services covered based on age and aligned with the Affordable Care Act uspreventiveservicestaskforce.org
    - Adult annual physical exam-age 18 and over
    - Alcohol misue and counseling-screening and behavioral counseling interventions to reduce alcohol misuse, including pregnant women

- CBC with differential, urinalysis, glucose monitoring-age 40 and over or earlier based on MD recommendations or medical necessity
- Cholesterol screening
- Colorectal screenings in adults with fecal occult blood testing, sigmoidoscopy, or colonoscopy
- Depression screening for adolescents and adults
- Healthy diet counseling for medical conditions other than diabetes, limited to three isits per plan per year
- Mammogram screenings
- Routine osteoporosis screening
- Tobacco use counseling-including tobacco cessation interventions for non-pregnant adults who use tobacco products and augmented, pregnancy-tailored counseling to those pregnant women who smoke, limited to 12 per plan

- Tobacco Cessation Products
  - Tobacco quit aids including Chantix, Bupropion, generic gum, patches, lozenges, Nicotrol oral and nasal inhalers are covered with no co-pay, up to 12 week courses of treatment per calendar year with no lifetime maximum when written by a licensed clinician
- Incentives for Wellness for Member and Spouse-up to $500 deposited into the employee's paycheck
  - ParTNers for Health Wellness Program-Online personal or group coaching, or telephonic for chronic conditions-no copay, mobile app, email, health assessment, tips and trackers
    - Asthma
    - CHF
    - CAD
    - COPD
    - http://go.activehealth.com/wellnesstn
  - Diabetes Prevention Program (DPP)-no copay, must be 18 years or older
    - Administered by Livongo online program, call 1-888-5999-7483

Ambetter Plans (Available through TN Healthcare.gov Exchange)

- AWV Equivalent-Wellness Exams includes personal history, blood pressure, BMI, physical exam, preventive screening and counseling
  - Ages 18-21 covered annually
  - Ages 30-49 covered every 1-3 years depending on risk factors
  - Ages 50-65+ covered annually
- Skin Cancer Screening-periodic total skin exam every 3 years at the discretion of your healthcare provider
- Breast Cancer Screening-Annual clinical breast exam and monthly self exam, mammogram screening recommended once every 2 years
- Cervical Cancer Screening-initial pap test ever 3 years beginning at age 21, if 30 years or older either pap every 3 years alone or every 5 years screening with high risk HPV testing, women 65 and up may stop screening
- Testicular and Prostate Cancer-clinical testicular exam at each health maintence visit and monthly self-exam
- Abdominal Aortic Aneurysm-Men between the ages of 65 and 75 that have ever smoked

- Cholesterol-all adults every 5 years
- Diabetes Screening-every 3 years or earlier if risk factors present
- Bone Mass Density Test-Once between ages 40-49 if risk factors present, once or more often depending on risk factors ages 50 and up
- STD/STI Screening-annual screening for sexually active patients under 25, annually for patients age 25 and over, HPV is for 45 and under if not previously vaccinated
- TB screening-screenings recommended for latent TB for those at increased risk
- Immunizations
- Domestic and Interperson Violence Screening and Counseling-Recommended for all women with a routine screening and counseling by network provider
- Special considerations for community healthworkers, health coaches, MAs, and diabetes educators-recommend conducting all screenings telephonically or in person in triage stage prior to provider interacting with patient as well as making sure that all available screenings are conducted on the applicable patients to ensure all codes applied for billing purposes
- Note-these preventative codes should be $0 copay; however, most Ambetter plans are high deductible (some for 2021 are up to $8600 so many patients may avoid care), the ancillary staff targeted could help outreach efforts for these patients to receive the wellness aspects of their insurance coverage
- Chronic Care Management-similarly to Tenncare and to the state employee health insurance program, CCM is provided by Ambetter employees. Patients can get access to this care by calling 1-833-709-4735. The conditions specifically mentioned include:
    - Depression
    - Asthma
    - Coronary Artery Disease
    - Diabetes
    - HTN
    - High Cholesterol
    - Low Back Pain
    - Smoking/Tobacco Cessation
    - Telehealth