

Patient Financial Liability FAQ

- 1. When initiating CCM services with Medicare patients, the first question patients have is "How much will this cost me?" Informed consent is very important so what is best way to provide cost sharing details with patients so that they can make an informed decision about accepting CCM services?**
 - Patient consent should be structured to ensure a patient is aware of applicable cost sharing. Patients should be informed that CCM services are subject to a 20% copay (estimated at \$8 a month). Patients can reach out to their specific Medicare plans for additional detail.

- 2. This is especially problematic with advantage plans and determining how much of deductible has been met. Is there a good way to verify patient out of pocket cost before they agree to CCM?**
 - Patients should be informed that CCM services may be subject to a 20% copay (estimated at \$8 a month). However, patients should reach out to their specific Medicare plans for additional detail as many Medicare Advantage plans cover CCM services at no cost to the patient.

- 3. Can you please confirm that Medicare patients will have cost sharing associated with Transitional Care Management billing? If so, and since the physician's reimbursement is higher for this service, compared with other office visits, do patients need to consent to TCM services?**
 - TCM services are subject to the patient's individual Medicare plan. 20% beneficiary co-payment applies. The Part B deductible and coinsurance apply. Formal patient consent is not required for TCM services.

- 4. So, not only do we have to contact all these patients who are being discharged, but now we have to find a way to document a yearly consent, track it, before calling our patients who are coming out of the hospital and then we are going to be penalized for not contacting enough patients when they come out of the hospital because I would assume most patients are not really going to want to pay an additional fee after coming out of the hospital. Is this true?**

- The requirements for TCM services include:
 - The services are required during the beneficiary's transition to the community setting following particular kinds of discharges;
 - The health care professional accepts care of the beneficiary post-discharge from the facility setting without a gap;
 - The health care professional takes responsibility for the beneficiary's care; and
 - The beneficiary has medical and/or psychosocial problems that require moderate or high complexity medical decision making.
- Documentation of consent is specific to CCM, not TCM.
- There is no penalty from CMS Medicare for not providing TCM services.

5. Please repeat the slides on Medigap and coverage for CCM services between Medicare and Medicare.

- **Does Medigap cover the beneficiary cost sharing for CCM Services?**
 - If services are covered under Medicare Part B, Medigap insurers do not have authority to deny the coinsurance, copayments or other benefits that are payable on behalf of the beneficiary under the provisions of the Medigap insurance contract.
- **Does Medicaid cover the beneficiary cost sharing for CCM for dually eligible beneficiaries?**
 - The majority of dually eligible beneficiaries (approximately 64%) are Qualified Medicare Beneficiaries who will not be responsible for CCM cost sharing.
- **Does Medicare Advantage cover the beneficiary cost sharing for beneficiaries?**
 - Physicians treating patients enrolled in Medicare Advantage plans cannot bill for services using CCM codes unless the contract between the plan and the physician specifically provide for such coverage.
 - If a Medicare Advantage beneficiary chooses an out-of-network physician to provide CCM services, then that physician can bill for those services using the CCM code. In this scenario. Patients would be responsible for the out-of-Network cost-sharing.

6. Can you bill the 99490 when you don't get to enough time to bill 99487?

- 99490 is for Chronic Care Management. 99487 is for Complex Chronic Care Management. For each calendar month, a beneficiary should be classified as eligible for complex or non-complex chronic care management. Both types of services cannot be billed simultaneously.

- CPT code 99490 (non-complex CCM) describes a minimum number of minutes of service (there is no maximum). Therefore, the practitioner may only bill one unit and one-line item of CPT 99490 per calendar month. Also only one practitioner can bill CCM per service period, and must report either complex or non-complex CCM (not both). Practitioners should report complex CCM (under CPT 99487, 99489) if the higher service times for complex CCM are met, the problems addressed by the billing practitioner during the month require moderate to high complexity medical decision-making, and the comprehensive care plan is established or substantially revised.

7. The issue of whether Medical Assistant can make those outreach calls may be covered in the FAQ's but there is still a lot of confusion, since we were originally told that they could but there was mention that they had to be licensed, is that true?

- In Michigan, Medical Assistants are able to make outreach calls for TCM services.