Network Notification

Notice Date:	**April 16, 2018**
To:	**Ohio Health Partners**
From:	**CareSource®**
Subject:	**Care Coordination Codes Reminder**
Effective Date:	**March 1, 2018**

In the enclosed memo from the Ohio Department of Medicaid (ODM), ODM informed CPC practices **that the use of care coordination codes is not permitted as of March 1, 2018**.

Please ensure your practice complies with the notice requirements. Claims paid on or after March 1, 2018, that include care coordination codes will be subject to recovery by CareSource, and the recovery amount will be adjusted from future claim payments.

Please refer to the enclosed memo and frequently asked questions for more guidance regarding the new requirements, as well as contact information. You can also contact the CareSource Provider Services team at **1-800-488-0134.**

OH-P-1441

From: Marjorie.Yano@medicaid.ohio.gov [mailto:Marjorie.Yano@medicaid.ohio.gov]
Sent: Monday, February 26, 2018 4:02 PM
Subject: Ohio CPC - Use of Care Coordination Codes

Good Afternoon,

This email is to provide information to Ohio CPC practices regarding the use of care coordination does and to notify you that as of March 1, 2018, practices participating in CPC shall not submit claims for Medicaid patients using care coordination and transitional care coordination codes: 99490, 99495, and 99496. All CPC practices are receiving additional PMPM compensation for providing care coordination services for your patients, as such, billing to these codes is not permitted. This notice on billing codes applies to all Medicaid patients, not only those attributed to your practice for purposes of CPC.

The managed care plans are also being notified of this change. The Ohio Department of Medicaid and MCPs may take all appropriate actions to ensure compliance with this notice and may require repayment by any practices that use these codes improperly.

Thank you for your understanding and compliance with these guidelines as we continue to refine the CPC program model. We are happy to answer any questions you might have.

Thanks,

Marjorie Yano

Payment Innovation Director
Ohio Department of Medicaid
614-752-2576 (o)
614-381-3535 (c)
marjorie.yano@medicaid.ohio.gov

Clarification on Care Coordination Code Guidance for Ohio CPC Practices

Exclusions from the guidance (practice, patient, physician, claims)

Question	Answer
We are enrolled in the Ohio Medicaid CPC under the billing ID XXXXXXX. If I understand the email below correctly, starting March 1, 2018 we cannot bill codes: 99490, 99495, and 99496 for any of our locations that use the above billing ID, is that correct? We are only performing CPC program functions at one of our locations, however the billing ID we are registered under encompasses several other practices within our organization so I wanted to confirm that we cannot bill the above codes at any location under our registered billing ID.	That is correct. A CPC practice is defined at the Medicaid billing ID level, and these codes should not be used by any CPC practice. Practices with separate Medicaid billing IDs that are not participating in Ohio CPC may continue using these codes.
Currently 3 of our locations are receiving additional PMPM compensation. One was effective in 2017 and 2 beginning in 2018. Are we be able to submit claims for our other locations who are not being compensated?	A CPC practice is defined at the Medicaid billing ID level, and these codes should not be used by any CPC practice. Practices with Medicaid billing IDs that are not participating in Ohio CPC may continue using these codes.
Is it just the practice primary care sites that should not bill the care coordination codes? Our organization has primary care sites but we also have additional sites not related to primary care, so I am unclear as to whether the non-primary care sites would be able to bill those codes since it's just the primary care component that is listed as the CPC practice. Any clarifications you could provide on this issue would be very much appreciated.	A CPC practice is defined at the Medicaid billing ID level, and these codes should not be used by any CPC practice. Practices with Medicaid billing IDs that are not participating in Ohio CPC may continue using these codes.
Does this notice apply only to primary care physicians? As you know, our organization has many employed specialists. We are wondering if the notice below applies to our specialists as well. It is a little complicated because we have the same tax ID number.	This guidance applies at the Medicaid billing ID level, not at the physician level. This guidance applies regardless of who the physician is.
If an organization has all of their PCPs under one group (type 21), if the organization has non-CPC practices with mental health professionals who would like to use the care coordination codes, would they would need to break out to their own type 21?	This guidance applies at the Medicaid billing ID level, not at the physician level. This guidance applies regardless of who the physician is, so any non-CPC practices with the same Medicaid billing ID as a CPC would not be able to use the care coordination codes regardless of how their PCPs are grouped. If the practice wanted to be able to continue using those codes, they would need to break out non-CPC practices into a separate Medicaid billing ID.

Billing questions and programmatic impacts

Question	Answer
Can you please provide more information regarding what specific Medicaid products this change covers?	The specific procedure codes this change covers is the reporting of CPT codes 99490, 99495, and 99496. CPT code 99490 is for the reporting of chronic care management services provided per month for individuals with two or more chronic conditions that are expected to last at least 12 months or until patient's death. These chronic conditions place the patient at significant risk or functional decline, and a comprehensive care plan has been established, implemented and reviewed for these patients. CPT codes 99495 and 99496 are for the reporting of transitional care management services provided to patients whose medical and or psychological problems require complex medical decisions during transition of care from an inpatient facility setting (hospital, nursing facility, skilled nursing facility) to a community setting (home, assisted living, senior housing). The reporting of this procedure code requires a face-to-face visit with the patient during specified timeframes as well as providing additional services such as patient and or caregiver education, setting up additional community support services, and scheduling assistance for any needed professional and or community services. All of the services provided within these specified procedure codes are similar to the care coordination requirements that CPC practices should be providing as well as receiving PMPM payments for attributed members.
Does this mean we are not to make the non-face to face discharge call for Medicaid pts.?	CPC practices are required to meet 8 activity requirements for participation in the program. One of these requirements is "Follow-up after hospital discharge." It is the expectation that all CPC practices are meeting this requirement. Acceptable evidence for meeting this requirement includes evidence of either calls made as follow-up after hospital discharge or in-person appointments. Details about the requirement can be found on the Medicaid website.
Are the expectations still the same that patients will have the TCM call completed post hospital discharge, and that the patient will still be seen in the office within a few additional days?	CPC practices are required to meet 8 activity requirements for participation in the program. One of these requirements is "Follow-up after hospital discharge." It is the expectation that all CPC practices are meeting this requirement. Details about the requirement can be found on the Medicaid website. This requirement for CPC Practices is slightly different from the TCM follow-up, but generally

	covers the need to connect with patients after a hospital stay.
Should a claim be dropped to Medicaid at all for the TCM follow up visit? If so, are we allowed to drop a standard E/M established level of service? ….Or what code should be included on the claim?	Whether or not a different code, such as E/M, might be appropriate to use instead of TCM depends on the specific scenarios in which you are using TCM codes. However, in general they are used when there is not direct patient contact, and therefore E/M codes would not be appropriate to use in their place. In cases where there is not an appropriate alternative code to submit to Medicaid for the transitional care management activities, no claims should be submitted.

Dual-eligible and MyCare members

Question	Answer
Does this apply to patients with Medicaid as secondary?	The guidance applies to submitting care coordination code primary claims to Medicaid; there is no change to what you may submit to other payers. For Medicare-Medicaid dual eligible patients with Medicare as the primary payer, in cases where the Medicare primary paid amount does not fully cover the cost, ODM will still receive crossover claims electronically from Medicare after Medicare processes them, and may pay co-insurance and any applicable deductible amounts.
Does this mean that the patient will have to pick up any copay leftover by Medicare for dual eligibles (Medicare-Medicaid) or are those handled differently? Cost share for CCM (G0511) may be as high as $25 for certain patients	The guidance applies to submitting care coordination code primary claims. In cases where the Medicare primary paid amount does not fully cover the cost, ODM will still receive crossover claims electronically from Medicare after Medicare processes them. Medicaid may pay co-insurance and any applicable deductible amounts on these claims. So dual-eligible patients would not be responsible for leftover Medicare copays; Medicaid would pick up that cost.
Do we still bill those Medicare TCMs, CCMs (99495,99456, G0511) if they have a Medicaid secondary?	The guidance applies only to claims that may be submitted to Medicaid. There is no change to what you may bill to Medicare. In cases where the Medicare primary paid amount does not fully cover the cost, ODM will still receive crossover claims electronically from Medicare after Medicare processes them, and may pay co-insurance and any applicable deductible amounts.
As a health system participating in the Medicaid CPC program, we are inquiring as to whether or not we are able to bill for the Transitional Care Management codes for the MyCare members? We are seeking clarity in determining if the McCare patients are included in the CPC program. Obviously it is	You should contact your MCP for further information about their guidance on billing for MyCare members, given that there are no MyCare members in FFS and ODM's guidance applies only to how claims may be submitted to Medicaid for FFS members. We have instructed MCPs that if they adopt similar policies on care coordination codes as

our intent to comply with the billing restriction as it applies to CPC.	ODM, they should treat opt-out MyCare members as Medicaid members for purposes of whether claims may be submitted, and opt-in MyCare members as Medicare primary/Medicaid secondary Duals for purposes of whether claims may be submitted. ODM's guidance on Duals is that care coordination codes may still be submitted to Medicare. In cases where the Medicare primary paid amount does not fully cover the cost, ODM will still receive crossover claims electronically from Medicare after Medicare processes them, and may pay co-insurance and any applicable deductible amounts.

Other questions

Question	Answer
Are you getting a lot of questions about this? I was wondering why this is coming up as a concern? Just curious.	ODM had received questions regarding the use of these particular codes by CPC practices, and, upon review, saw that all of the services provided within these specified procedure codes are similar to the care coordination requirements that CPC practices should be providing. Because CPC practices receive additional PMPM compensation for providing these care coordination services to patients, guidance was issued that these codes may not be used.
You mentioned Managed Care Plans are being notified of this change…. to your knowledge are they going to follow the same guideline?	We have notified the managed care plans so that the same guidance can be followed across payers.