Side-by-Side Comparison of Medicare Wellness and Care Coordination Services

Providing the Medicare wellness and care coordination services described below allows a practice to **optimize fee-for-service revenue,** while improving quality and decreasing total cost of care. These services will also help financially support other population health management initiatives.

	Annual Wellness Visits (AWV)	Chronic Care Management** (CCM)	Advanced Care Planning (ACP)	Transitional Care Management (TCM)
Financial Importance	Initial Preventive Physical Exam (IPPE) G0402 $169* Initial AWV G0438 $174* Subsequent AWV G0439 $118* Supports patient assessment, patient-directed goal setting, and development of a comprehensive care plan. The AWV is 100% covered—no copay nor deductible for eligible beneficiaries.	**Monthly payment opportunity** CPT code 99490 $42* Non-complex CCM 20-minute timed service provided by clinical staff to coordinate care across providers and support patient accountability. CPT code 99491 $83* 30 minutes of CCM provided by a physician or other qualified health care professional per calendar month and must account for all care management work for the month. CPT code 99491 cannot be reported in the same calendar month as CPT code 99487, 99489, and 99490. CPT Code 99487 $92* Complex CCM 60-minute timed services provided by clinical staff to substantially revise or establish moderate to high-complexity decision-making. G0506 (Add on code to be reported with another patient encounter code during which the physician or NP/PA initiates CCM with a patient.) $63* Initiating chronic care by a comprehensive assessment and development of a care plan by physician or NP/PA during an office visit in which CCM is initiated. May only be billed once.	CPT code 99497 $86* First 30 minutes (minimum 16) CPT code 99498 $76* Add-on for additional 30 minutes Opportunity to discuss patient and caregiver's wishes concerning end-of-life care. No copay for Medicare beneficiaries if done during AWV.	CPT code 99495 $166* Moderate-to-high complexity CPT code 99496 $234* High complexity Sets up a safe and successful patient transition from a hospital or other health care facility to a community setting.
Operational Advantages	AWV helps with empanelment and attribution of Medicare beneficiaries. Establishes or strengthens rapport with the patient and/or caregiver. Chance to introduce TCM, CCM, and ACP to the patient.	Reduces telephone calls to the practice by developing a regular communication channel for CCM patients. Regular monthly payment will support additional clinical staff hours or positions. Time for staff to provide patient education and answer medical questions.	No limit on the number of times ACP can be billed for a given beneficiary during a given time period. Opportunity for patient to communicate and/or document wishes for family. Increased patient engagement and satisfaction in their care.	Increases patient satisfaction by reducing risk of readmission by improving care and meeting patient's needs. Service requires face-to-face visits with primary care provider and team in 14 days for moderate complexity (99495) or seven days for high complexity (99496). Prompt follow-up decreases unnecessary readmissions and reduces total cost.
Clinical Outcomes	Improves quality of care by identifying and closing care gaps and developing a care plan. Provides overall assessment and plans personalized preventive needs and early interventions. Opportunity to update the clinical record to reflect current problem list and diagnosis coding for hierarchal condition category (HCC) risk scoring and risk stratification. Planning access to needed care will decrease emergency room visits and hospitalizations and drive down cost.	Decreased hospitalizations/emergency room (ER) visits will decrease cost of care through prevention and early intervention. Improved follow through and implementation of personalized care plan; increasing dedicated staff time will close care gaps. Improves communication and care coordination across health care professionals and settings. Improves patient engagement and accountability with regular communication with care team.	Decisions on end-of-life care are documented in the medical record. Likelihood patient and/or caregiver's wishes for end-of-life care will be upheld. May decrease total cost of care since patients may opt for palliative care options in a home setting instead of costly invasive, aggressive, or health facility choices.	Improved continuity of care through: Medicine reconciliation and answering beneficiary/caregiver questions to support safe and successful transitions. Review of hospital and pending diagnostic tests/treatments ordered. Improved coordination across the medical community. Establishing or reestablishing referrals with community providers/services to support patient's behavioral health or health-related social needs.

* Medicare and Medicare Advantage payment varies by geographical location. Check with your local Medicare Administrative Contractor (MAC) or plan for local/contracted rates. Values from Medicare Physician Fee Schedule 2019.

** Medicare Advantage plans may or may not pay for Chronic Care Management separately, as monthly care management support includes this service. You will need to verify the benefit with the specific plan.

Different approaches to help your practice get started

AWV

- Tell staff AWV can be provided to all Medicare Part B patients.
- Use this service to identify patients who would benefit from a discussion regarding their self-management goals.
- Choose those patients the staff has identified as highest risk (patient is unstable or may be more likely to need additional services or have recently been to the ER).
- Use this service to risk stratify your patient population.
- Use this service to document diagnoses and conditions to accurately reflect patient severity of illness (HCC) and risk of high-cost care.

CCM

- Identify Medicare Part B patient with at least two or more chronic conditions expected to last 12 months or until the death of the patient.
- Prioritize patients at highest risk of hospitalization or who have recently been/are regularly seen in the ER.
- Start with patients that regularly call into the clinic to manage symptoms or with medical questions.
- Identify patients that may be mostly likely to benefit from care management based on the number of specialists involved in their care or who have limited social or local family support.
- Identify patients dually eligible for traditional Medicare and Medicaid (not managed Medicaid) or with secondary insurance coverage.
- Identify volume needed to hire additional part-time or full-time staff, and then prioritize eligible patients.

ACP

- Identify patients and families in which you have a strong rapport.
- Start with patients scheduled for AWV. (No patient copay if offered with AWV.)

TCM

- Identify hospitals and emergency departments (EDs) responsible for the majority of patients' hospitalizations. With the shared goal of decreased readmissions, develop a relationship with those hospitals to improve timeliness of notification allowing practices to reach out to patients within two working days of discharge.
- Add this service to decrease cost of care by reducing unnecessary readmissions.
- Add this service after AWV and CCM, as the volume and associated revenue of this service is hard to anticipate.

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