

A Step-by-Step Guide to Implementing Chronic Care Management for CPT 99490

WEST HEALTHCARE

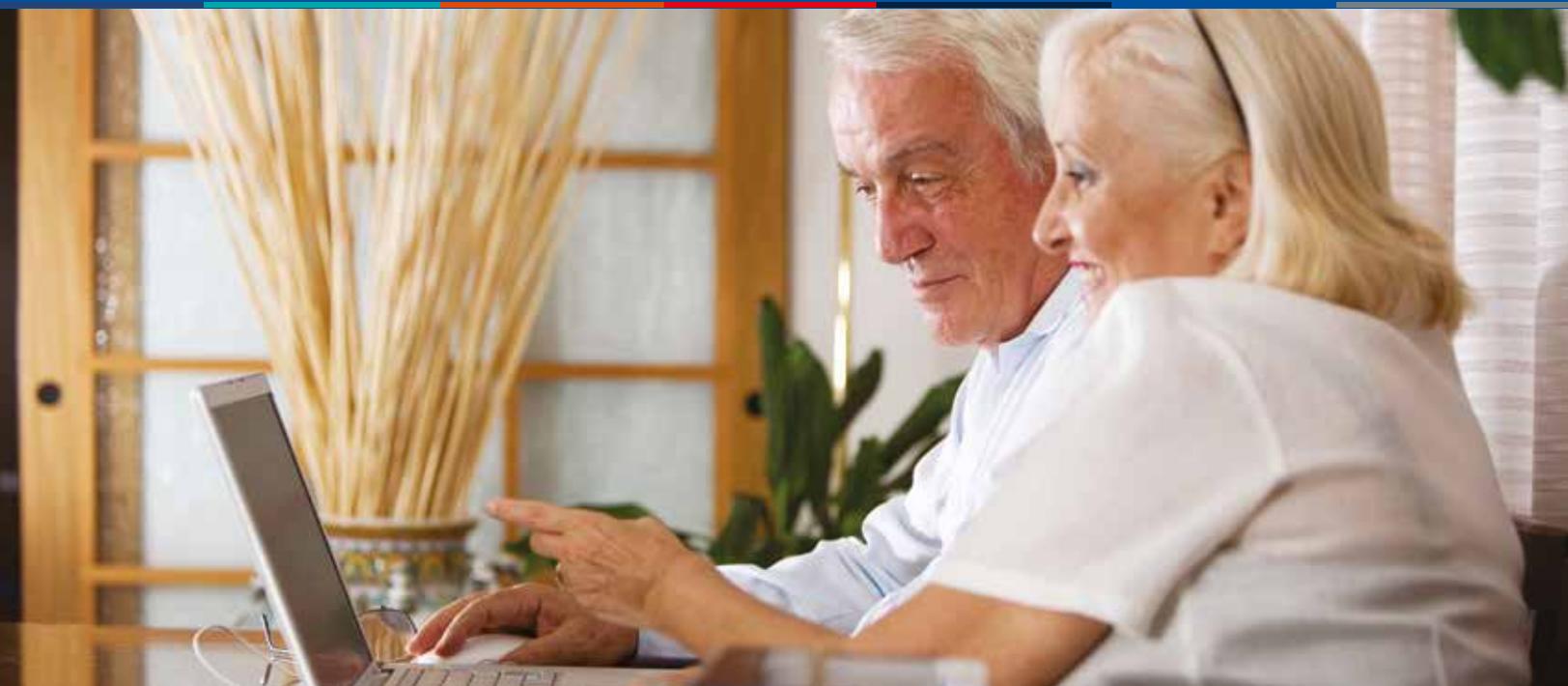


Chronic Care Management Overview

Chronic Care Management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have two or more significant chronic conditions. In addition to office visits and other face-to-face encounters, which must be billed separately, these services include communication with the patient and other treating health professionals for care coordination (both electronically and by phone), medication management, and providing accessibility 24 hours a day to patients and other treating physicians or clinical staff. The creation and revision of electronic care plans is also a key component of CCM.

- The designated CCM clinician (MD, PA, NP) must establish, implement, revise, or monitor and manage an electronic care plan that addresses the physical, mental, cognitive, psychosocial, functional, and environmental needs of the patient as well as maintain an inventory of resources and supports that the patient needs. Thus, the practice must use a certified EHR to bill the CCM code.
- Only one clinician can bill for CCM services for a particular patient. Therefore, it may be necessary to coordinate with sub-specialists who may be providing a significant amount of care and treatment for one or more of the patient's conditions. Since many patients have multiple physicians, it is important for patients to understand that only one physician will be able to bill for CCM services.

The CCM code is generally intended for use by the clinician who is providing the majority of the coordination services, which is typically the primary care physician. However, certain specialists may be able to provide the services needed to qualify to bill the CCM code – but never in the same month as the primary care physician.



Key Definitions



ELIGIBLE PROFESSIONAL (EP)

The CCM code can only be billed by a physician, advanced practice registered nurse, clinical nurse specialist, or physician assistant.

CHRONIC CONDITION

CPT states that patients must have “2 chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.”

COMPREHENSIVE CARE PLAN

This is an electronic summary of the physical, mental, cognitive, psychosocial, functional, and environmental assessments, including: recommended preventive care services; medication reconciliation with review of adherence and potential interactions oversight of patient self-management of medications; an inventory of clinicians, resources, and supports specific to the patient, including how the services of agencies or specialists unconnected to the designated physician's practice will be coordinated; and the assurance of care appropriate for the patient's choices and values.

CLINICAL STAFF

Licensed clinical staff members (including APRN, PA, RN, LCSW, LPN, clinical pharmacists, and “medical technical assistants” or CMAs) who are directly employed by the clinician (or the clinician's practice) or a contracted third party and whose CCM services are generally supervised by the clinician, whether provided during or after hours. Thus the “incident to” rules do not necessarily require that the clinician be on the premises providing direct supervision.

CONTACT-BASED CARE

To count the time towards the required 20 minutes of non-face-to-face care, the care must be “contact initiated.” This could be patient-doctor, patient-nurse, doctor-doctor, pharmacy-doctor, lab-doctor, or other contact regarding or by the patient via phone or electronic communication. General planning time or care coordination does not count unless it is initiated based on a contact and/or results in a patient or patient-related contact. For example, if the pharmacist calls the physician's office because the patient reported a rash, this time counts. If the physician's office spends time running reports of all participants who are due for a flu shot or an A1C check, the time does not count. When a clinician calls and speaks to the patient and then coordinates care, the time counts. In-person visits, including group visits, do not count toward the CCM code.

CERTIFIED EHR TECHNOLOGY

For 2015, the CCM code must be provided by a certified EHR that satisfies either the 2011 or 2014 edition of the certification criteria for the EHR Incentive Programs with the following core technology capabilities:

- Structured recording of demographics, problems, medications, and medication allergies.
- Creation of a summary of care record that can be maintained and accessed at any time.

Billing Requirements

- Under CPT code 99490, the 2015 average reimbursement is \$42.60, adjusted based on geography.
- Only one clinician can furnish and be paid for CCM services during a calendar month. The clinician who is providing the primary care to the patient is the one who can bill. Usually this will be the primary care physician, but some specialists may be serving as the patient's primary care physician.
- Copayments (coinsurance and deductibles) DO apply.
- The following codes cannot be billed during the same month as CCM (CPT 99490):
 - Transition Care Management (TCM) – CPT 99495 and 99496
 - Home Healthcare Supervision – HCPCS G0181
 - Hospice Care Supervision – HCPCS G9182
 - Certain ESRD services – CPT 90951-90970
- If other E&M or procedural services are provided, those services will be billed as appropriate. That time can NOT be counted toward the 20 minutes for CCM. If time – such as from a phone call – leads to an office visit resulting in an E&M charge, that time would be included in the billed office visit, NOT the CCM time.



To find payment information for a specific geographic location, access the Medicare PFS Look-Up tool on the CMS website:
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup>

Patient Consent

- The practice must have the patient's written consent in order to bill for CCM services.
- Document patient consent, if they declined to participate, or indicated participation elsewhere (and if so, with whom).



A sample consent form is provided at the end of this document.

Documentation

- Document 20 minutes of non-face-to-face clinical staff time.
- A practice can insource or outsource the delivery of CCM services for its patients. In either case, the practice will need to establish a consistent system of documentation based on its own physical, staffing, and EHR configurations. Consideration should include documentation of care provided by both internal and external individuals (such as for call coverage), who and how care will be documented in the record, and how to document time spent delivering various aspects of care and care coordination. It is possible that there will not be a CCM code billed for every patient every month, since some months may not generate 20 minutes of care coordination.
- If after hours care is provided by a clinician who is not part of the practice, such as for call coverage, that individual must have access to the electronic care plan (other than by facsimile). The care plan may be accessed via a secure portal, a hospital platform, a web-based care management application, a health information exchange, or an EHR to EHR interface.
- Services can be provided "incident-to" the designated clinician if the CCM services are provided by licensed clinical staff employed by the clinician or practice who are under the general, not necessarily the direct, supervision of the designated clinician. The normal "incident-to" documentation requirements apply.
- Contracted clinicians count as long as they have access 24/7 to the patient's electronic record and are under the general supervision of the CCM physician or "eligible practitioner."

Four Steps to Implementing the CCM Code



1 IDENTIFY & RECRUIT ELIGIBLE PATIENTS

- Use the EHR to search for patients who have 2 or more chronic conditions. Run reports sorted by physician. Each practice can then review the report and eliminate individuals who do not appear to be a good fit for the CCM program.
- The patient must have 2 or more chronic conditions that have the following required elements:
 - Multiple (2 or more) chronic conditions that are expected to last at least 12 months or until death.
 - Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- When just starting out with implementing a CCM program, you might focus on a small number of specific diagnoses, such as diabetes, COPD, CVD, and/or A-fib.
- Contact the patient through an outreach campaign or discuss the CCM program during a regularly scheduled visit to drive education and awareness about the importance of managing chronic disease.
- Consider a dedicated phone line that would be answered by staff with specific knowledge of the CCM program. This line can be forwarded to on-call clinician after hours.



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2 EDUCATE & ENROLL

- Educate patients and encourage them to participate using an invitation letter combined with a written consent to participate. A sample is attached at the end of this document.
 - Explain the value of the program, how the program works, and the fact they can decline, transfer, or terminate at any time.
 - Provide information on how they can terminate or transfer.
 - Authorization of electronic communication of medical information with other clinicians (as allowed by state and local rules and regulations).
 - Provide the designated physician's name as well as the name of the CCM nurse.
 - Explain the monthly scheduled nurse assessment visit, which should be treated like a regular visit, even though it will occur by phone.
 - Explain how and when the bills will be generated and what the patient's obligation is for payment of coinsurance and deductibles.
- Review the participation agreement with the patient and validate their understanding by obtaining their signature on the consent form.
- Record in the electronic chart that CCM was explained and written consent obtained to accept or decline services, from whom (name of clinician), receive electronic care plan, and of the right to stop CCM services at any time.

3 ENGAGE & ACTIVATE

- Provide care management for chronic conditions, including:
 - Provide systematic assessment of the patient's medical, functional, and psychosocial needs.
 - Ensure timely receipt of all recommended preventive care services.
 - Perform medication reconciliation with review of adherence and potential interaction.
- Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports.
- As appropriate, share the comprehensive care plan with other clinicians and providers.
- Provide patient with the written or electronic copy of their comprehensive care plan.
 - Using the patient portal is a low cost way to deliver the care plan, so encourage all participating patients (or their designated caregiver) to join and become familiar with use of the portal.
- Document the time spent
 - Set up a system that can keep track of time spent on non-face-to-face services provided, including:
 - Phone calls and email communication with patient.
 - Time spent coordinating care (by phone or other electronic communication) with other clinicians, facilities, community resources, and caregivers.
 - Time spent on prescription management and medication reconciliation.

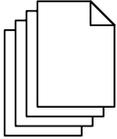


Using the patient portal is a low cost way to deliver the care plan, so encourage all participating patients (or their designated caregiver) to join and become familiar with use of the portal.

4 BILL FOR REIMBURSEMENT

- Validate that the requirements were met for each patient each month.
- Submit CCM billing under CPT code 99490.

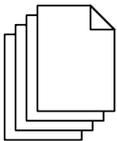
Resources



FREQUENTLY ASKED QUESTIONS ABOUT BILLING MEDICARE FOR CHRONIC CARE MANAGEMENT SERVICES

CCM must be initiated by the billing practitioner during a comprehensive Evaluation & Management (E/M) visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the CCM service and can be separately billed to the PFS, but is required before CCM services can be provided directly or under other arrangements.

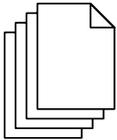
[https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment for CCM Services FAQ.pdf](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment%20for%20CCM%20Services%20FAQ.pdf)



CHRONIC CARE MANAGEMENT SERVICES FACT SHEET

The CCM scope of service is extensive and includes structured data recording, the development of a patient-centered care plan, and 24/7 access to care management services.

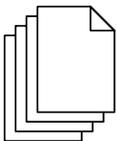
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>



CHRONIC CONDITIONS AMONG MEDICARE BENEFICIARIES CHARTBOOK

The majority of Medicare beneficiaries suffer from multiple chronic conditions, including high blood pressure, depression, heart disease, and diabetes. This increasing prevalence has expanded the need for high-quality, coordinated care in order to measurably improve patient health outcomes.

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook.html>



CHRONIC CONDITIONS OVERVIEW

The Centers for Medicare & Medicaid Services (CMS) analyzes the chronic conditions and their impact on the healthcare system. This information can be used to identify high-risk patients, and inform providers on how to approach and manage these issues.

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions>

ABOUT WEST HEALTHCARE

West helps healthcare providers, payers, employers, pharmacy organizations, and ACOs optimize communications, drive better patient activation, and lower the overall cost of delivering care. Whether you want to increase immunization and screening rates, reduce hospital re-admissions for patients with chronic disease, or improve the patient experience and operational efficiency in your patient access centers, the West Engagement Center™ is the communication linchpin for engaging and activating patient populations across the entire care continuum.

Medicare Chronic Care Management 99490 Checklist & Consent



PATIENT INFORMATION

Name: _____

MRN: _____ Date: _____

CHRONIC CONDITIONS

MINIMUM OF 2 TO QUALIFY

- | | | |
|---|--|---|
| <input type="checkbox"/> Alzheimer's disease and related dementia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Arthritis (Osteoarthritis & rheumatoid) | <input type="checkbox"/> Chronic Obstructive Pulmonary Disease | <input type="checkbox"/> Ischemic heart disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Autism spectrum disorders | <input type="checkbox"/> Heart failure | |

CHECKLIST OF REQUIREMENTS

- | | |
|---|--|
| <input type="checkbox"/> Care Plan created and made available to patient electronically | <input type="checkbox"/> Provide 20 minutes of non-face-to-face care management each month |
| <input type="checkbox"/> Care Plan is uploaded to the certified EMR | <input type="checkbox"/> Note that transitional care services, home healthcare supervision, hospice care supervision or certain end-stage renal disease services cannot be administered the same month as CCM services |
| <input type="checkbox"/> Review co-payment requirement | <input type="checkbox"/> Explain that patient information may be shared with other providers during the coordination of care services |
| <input type="checkbox"/> Explain how to discontinue service | <input type="checkbox"/> Annual Wellness Visit, Initial Preventive Physical Examination or Comprehensive Evaluation and Management Visit completed |
| <input type="checkbox"/> Assign a Care Coordinator | |
| <input type="checkbox"/> Explain that only 1 Physician can bill these services in a given month | |
| <input type="checkbox"/> Provide 24 x 7 access to care | |

MESSAGING TO PATIENT

- Our goal is to make sure you get the best care possible from everyone that is involved with your care. This program better enables us to coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan.
- Medicare allows us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year and you can discontinue it any time.
- While Medicare pays a significant portion, there is a co-pay of \$_____.

Dear [Patient Name],

As a patient with two or more chronic conditions ([list conditions]), you may benefit from a new program that [name of practice] is now offering to all Medicare patients. Our goal is to make sure you get the best care possible from everyone that is involved with your care. We can help coordinate your visits with other doctors, facilities, lab, radiology, or other testing; we can talk to you on the phone about your symptoms; we can help you with the management of your medications; and we will provide you with a comprehensive care plan. Medicare will allow us to bill for these services during any month that we have provided at least 20 minutes of non-face-to-face care of you and your conditions. You must provide your consent to participate once a year.

Your assigned clinician in charge of your care is [insert clinician name]. Other staff from our practice will talk to you or handle issues related to your care, but please know that your assigned clinician will supervise all care provided by our staff or clinicians who may be involved in your care.

You agree and consent to the following:

- As needed, we will share your health information electronically with others involved in your care. Please rest assured that we continue to comply with all laws related to the privacy and security of your health information.
- We will bill Medicare for this chronic care management for you once a month. The fee for this service allowed by Medicare is [insert allowed fee], of which your portion will be [insert copayment amount]. Although you may or may not come into the office every month, your account will reflect this charge and you will be responsible for payment. Our office will have a record of our time spent managing your care if you ever have a question about what we did each month.
- Only one physician can bill for this service for you. Therefore, if another one of your physicians has offered to provide you with this service, you will have to choose which physician is best able to treat you and all of your conditions. Please let your physician or our staff know if you have entered into a similar agreement with another physician/practice. You have a right to:
 - ▶ A comprehensive Care Plan from our practice to help you understand how to care for your conditions so that you can be as healthy as possible.
 - ▶ Discontinue this service at any time for any reason. Because your signature is required to end your chronic care management services, please ask any of our staff members for the CCM termination form.
 - ▶ 24 × 7 access to medical care

Our goal is to provide you with the best care possible, to keep you out of the hospital, and to minimize costs and inconvenience to you due to unnecessary visits to doctors, emergency rooms, labs, or hospitals. We know your time and your health is valuable and we hope that you will consider participation in the program with our practice.

I agree to participate in the Chronic Care Management program: **Yes** **No**

Signature: _____ Date: _____