Implementing Chronic Care Management (CCM) - CPT 99490

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The Need

Population-based statistics published by the Centers for Medicare and Medicaid Services (CMS) tell the story. Most Medicare beneficiaries suffer at least two or more chronic conditions causing illness of severe acuity and the numbers are increasing. Patients need better care, providers need improved methods of communication and society needs smart medical spending. Most medical spending is channeled to chronically ill Medicare beneficiaries. It's these patients who are most likely to benefit from any program that facilitates care and access to information. Studies established that ongoing continuity of care and management of chronic conditions both improve health/patient quality of life and reduce long-term care costs when crisis care is needed.

This paper summarized the Chronic Care Management Final Rule as published in the Federal Register November 2014 and is updated for revisions and clarifications issued by CMS February through May of 2015.

CMS Initiatives, Demonstrations, and New Chronic Care Codes

CMS is aware that providers expend measurable unreimbursed resources in delivering services to chronically ill patients. The value of these services to this growing patient population is acknowledged. Therefore, CMS introduced the new Chronic Care Management (CCM) code along with many experimental primary care programs designed to deliver meaningful clinical care while supporting the objectives of better patient-centered care, fewer hospital admittances, less stress for the patients/caregivers, and lower taxpayer costs.

Both the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration and the Comprehensive Primary Care (CPC) initiative include payments for services that closely overlap the scope of service for new CCM codes. To the extent of participation in these programs, providers are not eligible for CCM reimbursement. However, not all Medicare patients will be attributed to the initiative or demonstration with which a practice is associated. Providers are eligible to bill Medicare for CCM services on behalf of beneficiaries who are not attributed to the practice participation in either the MAPCP or CPC.

Effective January 1, 2015 - New Chronic Care Management – CPT 99490

Over several years, CMS recognized, measured, and attempted to address the importance of services to patients with multiple chronic disease diagnoses. The agency recognizes the burden and expense of the unreimbursed care provided by Primary Care practitioners, since the nature of this care extends beyond typical services such as Evaluation and Management or other billable codes.

Although formative ideas were discussed and ruled upon in prior years, effective January 1, 2015, CMS enforced its Final Rule acknowledging the need for a new CCM payment code (CPT 99490). This allows providers to be reimbursed for the delivery of the non-face-to-face chronic care management efforts of their clinical staff.

The Rule defines how an eligible provider will be reimbursed for furnishing these services on behalf of qualifying Medicare "Fee for Service" patients. As noted above, services delivered to patients who are treated and attributable to a special initiative or demonstration are excluded under this code.

Post-Rule Note: Eligible Medicare Advantage patients may also be offered and furnished these services; however, the provider's contract with the Plan will determine how the services must be billed.

As of this writing, no specific list of the eligible chronic conditions has been compiled, but the CMS does have a Chronic Condition Warehouse (https://www.ccwdata.org/) which provides information about the most common chronic conditions recognized by CMS.

Providing CCM May Create a New Revenue Stream

Using a typical family practice provider as an example, for 2015, the estimated average reimbursement per beneficiary per month would be $40.39.[1] The specific gross economic benefit for a particular provider will depend upon the number of qualifying patients within the practice (those with two or more chronic diseases) and how many of the qualifying patients receive a minimum of 20 minutes of non-face-to-face services within any calendar month.

Example: Medical practice has 3,000 patients of which 25% are covered by Medicare (750 patients)

- 40% of these Medicare patients have two or more chronic conditions (300 patients)
- Using the $40.39/patient reimbursement, potential revenue is $12,117/month or $145,404 per year.

For simplicity, this example assumes that 100% of qualifying Medicare chronically ill patients receive minimum qualifying services in the calendar month of the calculation.

Other benefits of implementing CCM include the opportunity to enhance staff skills, process improvement in the delivery of care to chronically ill patients, and decreased economic stress associated with providing unreimbursed services.

Which Patients Qualify for the Service?

Patients must have two or more chronic conditions expected to last at least twelve months, or until their death.

In the judgment of the physician, these chronic conditions must place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Qualifying patients must receive a minimum of 20 minutes per calendar month of clinical staff time delivering non-face-to-face services on their behalf.

For each qualifying patient, there must be a patient-centered comprehensive care plan established, implemented, revised, or monitored as part of the process of delivering the service.

Which Providers are Eligible to Bill CCM Code 99490?

Physicians (any specialty), advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse midwives are eligible to bill Medicare for CCM. Other non-physician practitioners and limited-license practitioners (e.g., clinical psychologists, social workers) are not eligible. Only one provider may bill for CCM in any calendar month.

There are also services that cannot be billed for the same month concurrently with CCM 99490, regardless of whether or not services are provided to eligible patients. Hospice, some end-stage renal disease care and home health care supervision may not be reimbursed in the same calendar month as CCM. There are specific conditions under which transitional care management can be billed in the same calendar month, but it's expected this will rarely occur.

Which Staff May Furnish CCM Services?

The time logged by clinical staff providing aspects of CCM services can be counted and logged toward the CCM time requirement at any time of the day, any day of the week, any day of the calendar month for any qualifying patient, provided that the clinical staff are under the general supervision of the billing practitioner. No administrative staff time may be logged. Note that any necessary face-to-face care must be under the direct supervision of the physician or other practitioner.

The Final Rule relaxed the "Incident to" requirements of delivering non-face-to-face services under this code as CMS determined that the delivery of these services is not dependent upon the nature of the employment

[1] This amount may change with Congressional modifications to the Sustainable Growth Rate (SGR) formula.

or contractual relationship between the clinical staff and the provider. The close working relationship renders a requirement of a direct employment relationship or direct supervision unnecessary. It is also true that services are frequently provided outside of normal business hours or while the physician is away from the office during normal business hours.

CCM Providers Must Provide the Required Scope of Service

1. **Initiate CCM during an AWV, IPPE or comprehensive E/M visit (Clarified May 2015)**
   CCM must be initiated during an AWV, IPPE or comprehensive E/M visit that is billed under the PFS E/M codes. This must be a face-to face encounter for a comprehensive evaluation/wellness visit/ exam and must meet the following requirements:
   - The provider must inform the patient during the visit about CCM, the scope of CCM services, and the necessity of informed patient consent.
   - Patient consent does not have to be obtained during this visit.
   - This encounter must occur prior to the initiation of billing for CCM services.
   - The visit is billable under E/M and NOT CCM codes.

   If CCM is not discussed during this visit, it cannot count as the initiating visit for CCM.

2. **Obtain and share written beneficiary consent**
   Practices must use a systematic approach to identify patients requiring CCM services and those who qualify as CCM beneficiaries. In order to ensure that the beneficiary is aware of important features of CCM, they must sign a written consent form for the provider. The provider must ensure that the beneficiary understands how the CCM will be implemented and the fact that there can only be one provider of CCM service during any one calendar month. They must be told that the provider with be paid and that they have the responsibility for any copayments or deductibles. Additionally, the provider must obtain the patient's permission to share health information with other providers for purposes of care coordination. It must be clear that the patient has the option to discontinue CCM by revoking consent. The consent form should include information about the acceptable methods of revoking consent. Revocation may be oral, but the provider must deliver written acknowledgement of the revocation and the effective date of revocation to the patient.

   Providers must give patients copies of the consent form in writing or electronic access through a web portal. Providers must include consent forms as part of the patient's certified Electronic Health Record (EHR). If consent is revoked, the effective revocation date is the end of the calendar month in which the revocation occurred.

3. **Use a certified EHR**
   In order to file CCM claims, providers must coordinate care, facilitate transition of care between providers, maintain an electronic care plan in an EHR certified as of December 31st of the calendar year prior to the PFS payment year [2], and ensure that patients and providers have electronic access to the specified care provided.

   The EHR technology utilized by a provider must be CCM Certified [2] to meet the final core technology capabilities (structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary). Additionally, whenever a service element references a health or medical record, CCM-certified technology must be used to fulfill that service element. If both CCM-certified technology and other methods are available to the practitioner referencing the health or medical record, practitioners may only use the certified capability.

   Core clinical patient data must be stored in certified EHR technology. The Summary Care Record must be available for electronic transmission for purposes of care coordination. Fax transmission is not allowed. The EHR must include the beneficiary consent, plan of care, and communication among

[2] See the 2011 or 2014 edition of EHR Incentive Program certification criteria

providers (care coordination). Many current EHR tools are not capable of supporting CCM delivery so multiple tools may be needed to meet the CMS requirements. It's not necessary for providers outside of the practice to use the certified EHR but there must exist enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary's care. This includes direct access and also the use of secure messaging, internet, or other asynchronous non-face-to-face consultation methods. Fax transmission MAY NOT be used.

The CMS goal is to achieve maximum efficiency, not to satisfy Meaningful Use (MU). MU measures are not all relevant to the requirements of the provision of CCM services, and the practitioner may not have sufficient certified technology to support all of the necessary or relevant Meaningful Use objectives and measures under the EHR Incentive Programs.

4. Create, perform, monitor, revise, and share a Patient-Centered Care Plan

The electronic Patient-Centered Care Plan is one that reflects the patient's values and must be based on the environmental, psychological, functional, and physical needs of the patient. The plan must be updated regularly (annually at a minimum). Information contained should include details of all practitioners and suppliers of care as well as their assessments of the patient's condition and status with regard to the chronic illnesses. The patient's overall health issues and plan for self-management should also be described within the care plan. Medication review, medication reconciliation, and patient self-management of medications must be evaluated and recorded. The practice must engage and educate patients and caregivers.

The care plan must be detailed and should typically:

a. List of health issues, prognosis, likely outcome, goals of treatment
b. Describe the management of symptoms and preventive care
c. Describe of planned interventions and list of persons responsible for each
d. Record medication reconciliation:
    i. Structured recording of medications and medication allergies
    ii. Medication reconciliation with review of adherence and potential interactions
    iii. Oversight of patient self-management of medications
e. Describe community/social services ordered
f. Provide a coordination plan with other providers
g. Schedule for periodic reviews or plan revisions

CCM services are by definition non-face-to-face services and therefore do not include home or domiciliary visits or community based care.

Access to the care plan must be electronic, 24/7, to all members of the care team, patients, and providers outside of the practice. Paper copies of and/or electronic access to the plan must be provided to the patient and documented in the certified EHR technology.

It is not required that practitioners use a specific electronic technology to meet the requirement for 24/7 access to the care plan or its transmission, only that they use an electronic technology other than fax.

Likewise, it is not required that practitioners use a specific electronic technology to meet the requirement to share care plan information electronically with other practitioners and providers who are not billing for CCM. Practitioners may meet this sharing requirement by methods explained above. HIPAA standards apply.

Time spent updating the care plan may be logged as part of the CCM time requirement.

5. Provide continuity of care - patient access to CCM care

The practice must have an internal care management function to enable patients identified as qualifying for CCM services to start receiving them in a timely manner. Each patient must be provided the ability to make successive routine appointments with a designated practitioner or member of the

care team. Patients must be able to contact a qualified clinician on the care team 24/7, for any urgent care needs within a reasonably timely manner. Access to care management services 24/7 means providing the beneficiary with a means to make timely contact with health care providers in the practice to address his or her urgent chronic care needs regardless of the time of day or day of the week.

6. **Provide 24/7 access to the patient's clinical data**
   Core clinical patient data must be stored in a certified EHR technology and available 24/7 to the patient and providers. The Summary Care Record must be available for electronic transmission for purposes of care coordination. Fax transmission is not allowed. The EHR must include the beneficiary consent, plan of care, and communication among providers (care coordination). It's not necessary for providers outside of the practice to use the certified EHR. Telephone, use of secure messaging, internet or other asynchronous non face-to-face consultation methods may be used. Fax transmission MAY NOT be used.

7. **Provide chronic care management**
   Care management for chronic conditions includes the following:
   - systematic assessment of the beneficiary's medical, functional, and psychosocial needs
   - system-based approaches to ensure timely receipt of all recommended preventive care services
   - medication reconciliation with review of adherence and potential interactions
   - oversight of beneficiary self-management of medications
   - continuous tracking and updating of the electronic care plan and the patient's electronic care record using the certified EHR.

8. **Provide care transition**
   Management of care transitions between and among health care providers and settings includes referrals to other clinicians, follow-up after emergency department visits, and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities. CCM providers must arrange for follow-ups after any Emergency Room visits. TCM services must be arranged after discharge (but usually can't be billed in addition to CCM in the same month). Referrals to other physicians and specialists must be coordinated and all information shared with the members of the health care team (as laid out in the care plan).

9. **Provide care coordination**
   CCM providers need to coordinate with all home or community-based providers (aides, hospice, outpatient therapy, medical equipment, nutrition, transportation, etc.) and to document all communications using CCM-certified technology.

CPT 99490 is for Chronic Care Non-Face-to-Face Services

CCM providers must arrange for a minimum of 20 minutes of non-face-to-face care management services to each qualified patient beneficiary. These services may include preventive services, monitoring of patient's mental, physical, and social condition, medication review, etc. These services may be performed by licensed clinicians such as RNs, LPNs, APRNs, PAs, LSCWs and other certified or credentialed medical assistants under the general supervision of the billing clinical staff. All parties within the practice must have access to the patient's electronic medical record. Those outside the practice must have secure access to the patient's care plan and clinical data.

Non-face-to-face care should be documented in the patient's record and include the names and credentials of all personnel providing services, brief descriptions of the services provided, and the dates and times (start/stop) of the services. Different services may be added together to meet the 20-minute minimum requirement but multiple personnel providing services at the same time can only be counted as one. The time spent furnishing CCM services can only be counted once and for only one purpose. Each discrete service can be billed only once. Time cannot be carried over from month to month or rounded up.

Practitioners who engage in remote monitoring of patient physiological data of eligible beneficiaries may count the time they spend reviewing the reported data towards the monthly minimum time for billing the CCM code, but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device.

Implementing CCM in Your Organization

Dulcian personnel can help your organization create a cost-effective and well thought out implementation of Chronic Care Management (CCM). Using our time-tested business rules approach, we can turn complex regulations and guidelines into flexible, user-friendly software to manage your patients' chronic care as well as your office's associated billing, record keeping, and documentation. The resulting system will be able to handle workflow design, care plan development, patient communication, and billing. Our services include training of your personnel to effectively and efficiently use the completed system.

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Sources:

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Book 2 of 2 Books, Pages 67547–68092
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Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule,
CY 2015 Medicare PFS Final Rule

Department of HHS, CMS, Medical Learning Network
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