FAQs Chronic Care Management

(For a full discussion of the topic and requirements of CCM, please see the Dulcian white papers on the subject)

In 2013, the Physician Fee Schedule (PFS) published the Final Rule with comments in which the Centers for Medicare & Medicaid Services (CMS) were clear about the commitment to support primary care practices. CMS continues to recognize care management as one of the critical components of primary care that contributes to better healthcare for individuals, reduced hospital stays, and lower public costs. Recognizing that practices already provide unreimbursed care for non-face-to-face services to very ill patients, beginning January 1, 2015 Medicare pays separately under the Physician Fee Schedule (PFS) of the American Medical Association Current Procedural Terminology (CPT) code 99490, for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions.

Physicians must use best judgement in choosing which Patients are most severely ill and which ones would most benefit from 20 minutes of non-face-to-face services performed by physicians and clinical staff. The base definition of a qualified beneficiary is a patient with two or more chronic conditions that are expected to last at least 12 months or until the death of the patient and that also place the patient at significant risk of death, acute exacerbation/decomposition, or functional decline. A comprehensive care plan must be created, monitored, and altered throughout the delivery of care. Other criteria apply and all processes and data must handled in compliance with HIPAA regulations.

In November of 2014, CMS published its Final Rule effective January 1, 2015 in the Federal Register. This regulation provided much discussion regarding reasoning and guidance on the Rule, CMS's intentions and its conclusions. However, many questions remain undiscussed or require further clarification in order for a billing provider to report services under CPT 99490. Note that as of this writing, the new code is applicable to Medicare Fee-For-Service only.

Since publishing the Final Rule, CMS clarified the issues discussed below.

The most often asked questions are addressed in this paper, which is current with the May 2015 guidance from CMS. Questions are organized into the following categories:

QUESTIONS ABOUT CCM GENERAL REQUIREMENTS

Who may bill for services provided under CPT 99490?

Physicians and non-physician practitioners such as Certified Nurse Midwives (CNMs), Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs) and Physician Assistants (PAs) who bill the Medicare Fee-For-Service Program (Original Medicare).

Only one provider may bill for CCM in any calendar month.

Will practitioners be able to use a certified Electronic Health Record (EHR) technology for which certification expires mid-year in order to bill for CCM? Can they use technology certified to the 2011 Edition to fulfill the scope of services required to bill CPT 99490 in 2015 once this technology no longer bears a "2011 Edition certified" mark?

Yes. Practitioners must use technology certified to the Edition(s) of certification criteria that is acceptable for the EHR Incentive Programs as of December 31st of the year preceding each CCM payment year. In certain years, this may mean that practitioners can fulfill the scope of services requirement using multiple editions of certification criteria.

What does 24/7 electronic access really mean?

Patient electronic data must be accessible at any time of day, any day of the week for the patient and all providers within a practice.

Does a physician need to be on call?

No, but a practice must offer 24/7 access. Response must be "timely," which generally means answering service calls or other communications from patients within 24 hours of receipt. A faster response is necessary if the nature of the call or communication is urgent relating to the patient's chronic conditions.

Does a physician need access to EHR?

- Within the practice, a physician must have 24/7 access to a patient's EHR and Care Plan. The EHR information must include everyone providing services as well as which provider's time is being counted toward the 20 minutes of CCM-billed time.
- Outside of the practice, it is not required to have EHR, but the plan must be electronically sharable;

- The patient must have access to his or her Care Plan. All members of the clinical care team within the practice are required to have 24/7 access if their time is counted toward the 20-minute minimum. This is not required for outside providers, but a Summary Care Record must be shareable with outside providers electronically through secure email, secure messaging, e-portal, but not via fax.

Does the billing practice have to furnish every scope of service element in a given service period, including those that may not apply to an individual patient?

Service elements should be included only as medically necessary, but the full scope of services should be available.

Is a new patient consent form required each calendar month or annually?

No. A new consent is only required if the patient changes billing practitioners. In this case, a new consent form must be obtained and documented by the new billing practitioner prior to furnishing the service (CY 2014 PFS final rule (78 FR 74424)). Patient consent does not have to be renewed except after a revocation. The practice is permitted to provide continued care until the month end in which the patient revokes consent. The patient must be given notice of the consent end date in writing and is effective on the month end date of the month in which the revocation occurs.

Is Medicare now paying separately under the PFS for remote patient monitoring services described by CPT code 99091 or similar CPT codes?

CPT 99091 involves the collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, requiring a minimum of 30 minutes of time. CPT codes 99090, 99091 and other codes cannot be billed during the same service period as CPT 99490. However per the CY 2015 PFS Final Rule (79 FR 67727), analysis of resultant monitored health data and other activities described by CPT 99091 or similar codes may be within the scope of CCM services. Therefore, these activities would count towards the minimum 20 minutes of qualifying care per month required to bill CPT 99490. Providers may not bill under CPT 99490 if such activity is the only work done. All other requirements for billing CPT 99490 must be met in order to bill using this code. Time counted towards billing CPT 99490 cannot also be counted towards billing other codes.

Do face-to-face activities count as billable time?

CPT 99490 refers specifically to activities that are non-face-to-face services, such as telephone communication, review of medical records and test results, and consultation and exchange of health information with other providers. However, per CMS, if these activities are occasionally provided by clinical staff face-to-face with the patient but would ordinarily be furnished non-face-to-face, the time may be counted towards the 20-minute minimum to bill CPT 99490. Care coordination services furnished on the same day as an E/M visit must not be counted.

QUESTIONS ABOUT BILLING:

Can the 20-minute minimum be rounded up?

No. A minimum of 20 minutes must be spent by clinical staff, providing qualified services to qualified patients.

Can time be carried over from month to month?

No.

Does the length of the calendar month make a difference in the time requirement of services?

No. This is a "calendar month" service. There must be at least 20 minutes of qualified services, regardless of whether the month is 28, 29, 20 or 31 days long.

What date of service should be used on the physician claim? When should the claim be submitted?

Most often, the service will be billed at the month end date in which services are provided. Practitioners may bill the PFS at the conclusion of the service period or after completion of at least 20 minutes of qualifying services for the service period. When the 20-minute threshold to bill is met, the practitioner may choose that date as the date of service. It is not necessary to hold the claim until the month end date.

What point of service (POS) should be reported on the physician claim?

Report the POS for the billing location (i.e., where the billing practitioner would furnish a face-to-face office visit with the patient). Accordingly, practitioners who furnish CCM in a hospital outpatient setting, including provider-based locations, must report the appropriate POS for the hospital outpatient setting). Payment for CCM furnished and billed by a practitioner in a facility setting will trigger PFS payment at the facility rate.

When can billing be done if the month-end date falls on a weekend?

Ask your practice MAC or revenue management officer. If the end of the month falls on a Sunday, determine whether services for the current month should be billed as cut off on previous Friday or the following Monday.

Can providers bill CPT 99490 for services provided to Medicare Advantage program patients?

Although Medicare Advantage is supposed to cover everything that Medicare Fee-for-Service provides, the verdict is still unclear on this topic. Certainly, separate payment under the new CPT code would not be permitted under all Medicare Advantage programs. CMS assumes that these services are accommodated in the existing fee structure of Medicare Advantage "capitated" plans. CMS has not yet responded definitively regarding this issue.

Can providers bill CPT 99490 if the beneficiary dies during the service period?

If the beneficiary dies during the service period, providers may bill as long as at least 20 minutes of qualifying services were furnished during that calendar month and all other billing requirements have been met.

QUESTIONS ABOUT TIME COUNTED TO ACCUMULATE THE 20-MINUTE MINIMUM?

Who qualifies as "clinical staff"?

CPT code 99490 requires at least 20 minutes of time per calendar month by "clinical staff" per qualified patient, in order to bill for this code. To be counted, non-face-to-face care management services must be performed by a licensed clinical staff member under the General Supervision of a physician. This includes any person with a state-issued license in a healthcare profession, as well as medical assistants credentialed by a third-party organization. Regardless of licensure or credentials, no person should provide any service beyond their training and capacity.

In most cases, CMS believes that clinical staff will provide CCM services "incident to" the services of the billing physician (or other appropriate practitioner who can be a physician assistant, nurse practitioner, clinical nurse specialist or certified nurse midwife). Practitioners should consult the CPT definition of the term "clinical staff." In addition, time spent by clinical staff may only be counted if Medicare's "incident to" rules are met such as supervision, applicable State law, licensure, and scope of practice. For CPT 99940 only, under the Final Rule effective 1/1/2015, CMS relaxed its prior definition of "incident to" which was defined as "DIRECT SUPERVISION" of the billing provider to read "GENERAL SUPERVISION". No administrative staff may log countable time. Please note that all 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 because CMS determined that the delivery of these services is not dependent upon the nature of the employment 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.

Some differences to note between administrative and clinical time to log against the 20-minute minimum include cases when the patient calls the nurse, which can count towards the 20-minutes of time. Anything included within the plan is clinical. Other staff may help facilitate CCM services, but only time spent by clinical staff may be counted towards the 20-minute minimum time.

Does time spent on the creation of the Care Plan count toward the 20-minute minimum?

Yes. Care plan estimates, improvements, revisions or monitoring demonstrate engagement with the care plan and patients and may be counted towards the 20-minute minimum.

Is routine medication management counted as CCM time?

Yes. Issuing medication prescription refills as well as the oversight of a patient's record of taking the medication counts toward CCM time. Reconciliation and monitoring of patient self-management of medications are also scope of service requirements of CCM.

If the billing physician (or other appropriate practitioner) furnishes services directly, does their time count towards the required minimum 20 minutes of time?

Yes. These services are counted towards the 20-minute minimum.

E/M, TCM AND CCM Questions

Medicare and CPT allow billing of E/M visits during the same service period as CPT 99490. If an E/M visit or other E/M service is furnished on the same day as CCM services, how should the total time be allocated between CPT 99490 and the other E/M code(s)?

It is not generally advisable to bill CPT 99490 on the same day that E/M services are reported. Time cannot be counted twice, whether face-to-face or non-face-to-face. Medicare and CPT specify certain codes that cannot be billed for the same service period as CPT 99490. Face-to-face time that would otherwise be considered part of the E/M services furnished cannot be counted towards CPT 99490. Time spent by clinical staff providing non-face-to-face services within the scope of the CCM service can be counted towards CPT 99490. If both an E/M and CCM code are billed on the same day, modifier -25 must be reported on the CCM claim.

Medicare and CPT specify that CCM and TCM cannot be billed during the same month. Does this mean that if the 30-day TCM service period ends during a given calendar month and 20 minutes of qualifying CCM services are subsequently provided on the remaining days of that calendar month, CPT code 99490 cannot be billed that month to the PFS?

Generally, it is not permitted to bill TCM in the same period as CPT 99490. It is possible that the TCM service period ends before the end of a given calendar month AND at least 20 minutes of qualifying CCM services can be subsequently provided during that month. In most cases, CCM and TCM cannot be billed during the same calendar month.

OTHER EXCLUDED CONCURRENT CODES:

Are there any other services that cannot be billed under the PFS during the same calendar month as CPT 99490?

Yes. Medicare does not allow CPT 99490 to be billed during the same service period as home health care supervision (HCPCS G0179- G0181), hospice care supervision (HCPCS G0182), or certain end-stage renal disease, ESRD, services (CPT 90951-90970) because care management is an integral part of all of these services.

Per the PFS Professional 2015, "E/M services may be reported separately by the same physician or other qualified health care professional during the same calendar month. Care Management services include care plan oversight services (99339, 99340 ,99374, 99380), prolonged services with direct patient contact (99358,99359, anti-coagulant management (99363,99364), medical health conferences(99366, 99367,99368); education and training(98969,99444); preparation of special reports(99980); analysis of data (99090,99091); transitional care management services (99495,99496), medication therapy management services 999605,99606,99607) and, if performed, these services may not be reported separately during the month for which CCM or CCCM codes 99487,99489,99490 are reported. All other services may be reported. As stated above, do not report 99487, 99489 or 99490 if reporting ESRD (90951-90970) during the same month. If care management services are performed within the postoperative period of a reported surgery, the same individual may not report 99487, 99489 or 99490.

Care management may not be reported in any calendar month during which the clinical staff time requirements are met. If care management resumes after a discharge during a new month, start a new period or report TCM services. Do not report 99487, 99489, 99490 for any post discharge care management services for any days within 30 days of discharge, if reporting TCM, Transitional Care Management services, codes 99495, 99496, except as stated above."

OTHER CMS MODELS AND CCM

Does the practice participation in a CMS Model or Initiative necessarily disqualify i t from billing for CCM CPT 99490?

No. Participants in the CMS Multi-Payer Primary Care Practice (MAPCP) Demonstration and the Comprehensive (CPC) Initiative cannot bill CCM for patients who have been attributed to them for purposes of these programs. The practice may report CPT 99490 for all patients not attributed to the practice through these models. Check with your MAC.

OUTSOURCING CCM SERVICES

Can CCM services be subcontracted to a case management company?

Yes. Services can be subcontracted if all of the "incident to" and other rules for billing CCM to the PFS are followed.

What if the clinical staff employed by the case management company is located outside of the United States?

There is a regulatory prohibition against payment for non-emergency Medicare services furnished outside of the United States (42 CFR 411.9).

If a physician arranges to furnish CCM "incident to" services to his/her patients using a case management entity outside of the billing practice, does the billing physician ever need to see the patient face-to-face?

Yes. 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). As provided in the CY 2014 Final Rule (78 FR 74425), this face-to-face visit is not part of the CCM service and can be separately billed to the PFS. This visit is required before CCM services can be provided directly or under other arrangements. The billing practitioner must discuss CCM with the patient at this visit. The face-to-face visit included in transitional care management (TCM) services (CPT 99495 and 99496) qualifies as a comprehensive visit for CCM initiation. CPT codes that do not involve a face-to-face visit by the billing practitioner are not payable by Medicare If the practitioner furnishes a comprehensive E/M, AWV, or IPPE and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.

FACILITY, HOSPITAL, SNF, Outpatient Prospective Payment System (OPPS) and CCM QUESTIONS

CPT code 99490 is payable to hospital outpatient departments (provider-based locations) under the hospital OPPS. Can physicians practicing in these departments or in hospital-owned locations (but not provider-based) also bill this code to PFS?

If a patient resides in a community setting and the CCM service is provided by or "incident to" services of the billing physician (or other appropriate billing practitioner) working in or employed by a hospital, CPT 99490 can be billed to the PFS. Payment is made at the facility rate (if all other billing requirements are met), which is now approximately $9.00 less than the non-facility rate (i.e., the payment made to a physician practicing in an outpatient office setting).

As stated in the CY 2014 PFS Final Rule, the resources required to provide care management services to patients in facility settings significantly overlap with care management activities by facility staff that are included in the associated facility payment. Therefore, CPT 99490 cannot be billed to the PFS for patients who reside in a facility that receives payment from Medicare for care of that beneficiary (see 78 FR 74423), regardless of the location of the billing practitioner because the payment made to the facility under other payment systems includes care management and coordination.

Billing practitioners in hospital-owned outpatient practices that are not provider-based departments are working in a non-facility setting, and may therefore bill CPT 99490 and be paid under the PFS at the non-facility rate. However, CPT 99490 can only be billed for CCM services furnished to a patient who is not a patient in a hospital or skilled nursing facility (SNF) and who does not reside in a facility receiving payment from Medicare for that beneficiary.

Can CPT be billed if the services are delivered in an assisted living facility or nursing home?

No. CPT may not be billed if the facility is receiving payment under a facility charge or Medicare Part A. If the facility is receiving payments under Part A, you may not bill for CCM if the patient resides and receives care in an Assisted Living facility or Nursing Home.

Are hospital outpatient departments (HOPDs) eligible to bill using CPT code 99490 under the OPPS?

Yes. CPT code 99490 is payable under the OPPS when certain requirements are met. The billing physician or practitioner directing the CCM services must meet the requirements to bill CCM services under the PFS, when the CCM service is furnished in the physician's office or the hospital outpatient department. The OPPS (Outpatient Prospective Payment System) provides payment to the HOPD (Hospital Outpatient Departments) when the hospital's clinical staff furnishes the service at the direction of the physician (or other appropriate practitioner). Payment under OPPS represents only payment for the facility portion of the service. Payment for the physician's (or other appropriate practitioner's) time directing CCM services in the HOPD setting is made under the PFS at the facility rate.

What are the requirements to bill CCM under the OPPS?

CPT code 99490 is a physician-directed service that is only payable under the OPPS when the hospital's clinical staff furnishes the service at the direction of the physician (or other appropriate practitioner).

Specifically, a hospital outpatient department may bill and be paid for CCM services furnished to eligible hospital outpatients under the OPPS if the hospital's clinical staff furnishes at least 20 minutes of care management services under the direction of the physician (or other appropriate practitioner) during the calendar month and the billing physician or practitioner directing the CCM services satisfies the billing requirements for CPT code 99490 under the PFS including the following requirements:

- Patient Eligibility—Patient has multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- Patient Agreement— Patient consent to receive CCM services has been obtained by the practitioner and documented in the medical record.
- CCM Scope of Service Elements including Structured Data Reporting, Care Plan, Access to Care, and Care Management of the patient are furnished by the hospital.
- Hospital furnished the CCM services using a certified version of an EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year (referred to as "CCM certified technology"). The hospital must also meet the requirements to use electronic technology in providing CCM services, such as 24/7 access to the care plan, and electronic sharing of the care plan, and clinical summaries (other than by fax) as required in the 2015 Final Rule.

How does CMS define a "hospital outpatient" for whom a hospital may bill CCM services (CPT code 99490)?

Hospital outpatient is defined as a patient that is registered in the hospital records as an outpatient and who receives services (rather than supplies alone) from the hospital. Since CPT code 99490 refers to non face-to-face services, the patient will typically not be a registered outpatient when receiving the service. The hospital's clinical staff must provide at least 20 minutes of CCM services under the direction of the billing physician or practitioner. Because the beneficiary has a direct relationship with the billing physician or practitioner directing the CCM service, the beneficiary must be informed that the hospital would be performing care management services under their physician or other practitioner's direction.

When CCM services are furnished by a physician in a hospital outpatient department, can the physician and the hospital both bill Medicare for the CCM service?

Yes, if certain conditions are met. Specifically, when CCM services are furnished to an eligible patient by a physician in a hospital outpatient department, the physician may bill Medicare for CPT code 99490 under the PFS reporting place of service (POS) 22 (outpatient hospital), which indicates that PFS payment should be made at the facility rate. The hospital may bill for CPT code 99490 under the OPPS.

Can more than one hospital bill and be paid for furnishing CCM services if the patient has been a registered hospital outpatient at more than one hospital over a 12-month span? If only one hospital can bill and receive payment for CCM services, which hospital is allowed to bill?

Only one physician or practitioner is allowed to bill under the PFS for CPT 99490 during a calendar month service period. Accordingly, only one hospital is allowed to bill and be paid for CPT code 99490 for a particular beneficiary during a calendar month service period. The hospital billing for CPT code 99490 under physician direction must have access to the patient's consent to receive CCM services documented in the patient's medical record. The patient may choose a different practitioner to furnish CCM at the conclusion of the service period, at which time the practitioner assuming the provision of CCM services must have the patient consent for CCM services documented in the patient's medical record. A new consent form must be documented in the patient's medical record prior to furnishing the service.

Is CPT code 99490 payable to provider-based hospital outpatient departments under the hospital OPPS? May a hospital-owned practice that is not provider-based bill OPPS for CCM services?

A hospital-owned practice that is not provider-based is not part of the hospital and is therefore not eligible to bill for services under OPPS. However, the physician (or other qualifying practitioner) practicing in the hospital-owned practice may bill under the PFS for CCM services furnished to eligible patients, provided that all PFS billing requirements are met.

What is the supervision level for CCM services furnished in a hospital setting?

CPT code 99490 is assigned a general supervision level under the OPPS when furnished in a hospital setting. General supervision means that the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. General supervision of those who perform the procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.