Chronic Care Management (CCM) Services Handout

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Presented by: WPS Medicare

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Procedure Code

- The procedure code is 99490
- The CPT description is:
  - 99490 Chronic Care Management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements.
    - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
    - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
    - Comprehensive care plan established, implemented, revised, or monitored.
    - (Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately)
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Pricing

- CMS established a physician fee schedule amount
  - Facility and non-facility pricing available
- The service is subject to the limiting charge for non-participating providers
- The patient is responsible for deductible and coinsurance
- Service is billed as a monthly charge when the 20 minutes of service are met
- Services can only be billed once per calendar month

Who Can Perform Service

- Physicians
- Non-Physician Practitioners
- Clinical staff under general supervision, when incident to requirements met

- The clinical staff providing the service is an individual acting under the supervision of a physician or other practitioner, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician or other practitioner or the same entity that employs or contracts with the physician or other practitioner and meets any applicable requirements to provide the services, including licensure, imposed by the state in which services are being furnished
- The services can be provided under general rather than direct supervision
  - The supervising physician or other practitioner does not have to be in the same office suite as the person providing the service when services are provided outside the normal business hours
  - The supervising physician or other practitioner need not be the same physician or other practitioner that determined the care plan
- The CPT book has the definition of clinical staff

Scope of Services

- The provision of 24-hour-a-day, 7-day-a-week access to address the patient's acute chronic care needs
  - The patient must be provided with means to make timely contact with health care providers in the practice
- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments
- Care plan includes:
  - Systematic assessment of the patient'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 patient self-management of medications
- Create a patient-centered care plan document to assure care is provided in a way that is congruent with patient choices and values
  - Care plan is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and inventory of resources and supports
  - Comprehensive plan of care for all health issues and typically includes, but is not limited to the following elements
    - Problem list
    - Expected outcome and prognosis
    - Measurable treatment goals
    - Symptom management
    - Planned interventions
    - Medication management

- Community/social services ordered
- How the services of agencies and specialists unconnected to the billing practice will be directed/coordinated
- Identify the individual responsible for each intervention
- Requirements for periodic review and when applicable, revision of the care plan
- Full list of problems, medications and medication allergies in the electronic health record (EHR) must inform the care plan, care coordination and ongoing clinical care

➢ Management of care transitions
  - Including referrals to other clinicians
  - Follow-up after the patient's visit to an emergency department
  - Follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
  - Facilitate communication of relevant patient information through electronic exchange of a summary care record with other health care providers regarding these transitions
  - Have qualified personnel who are available to deliver transitional care services to the patient in a timely way to reduce the need for repeat visits to emergency departments and readmission to hospitals, skilled nursing facilities or other health care facilities

➢ Coordination with home and community based clinical service providers required to support the patient's psychosocial needs and functional deficits
  - Communication to and from home and community based providers must be documented in the patient's medical record

➢ Enhanced opportunities for the beneficiary and any relevant caregiver to communicate with the practitioner regarding the beneficiary's care through the following methods (not an all-inclusive list):
  - Telephone
  - Secure messaging
  - Internet
  - Other asynchronous non face-to-face consultation methods

➢ Inform the beneficiary of the availability of CCM services and obtain the patient's written agreement for the services

➢ Receive authorization from the patient of the electronic communication of the patient's medical information with other practitioners

➢ Document in the medical record all elements of CCM were explained and offered
  - Notate the patient's decision to accept or decline the service

➢ Provide the patient with a written or electronic copy of the care plan
  - Document in the electronic medical record that this was provided to the patient

➢ Inform the patient of the right to stop the CCM services at any time

- Change to be effective at the end of the calendar month
- Identify the effect of the revocation of the agreement

- Inform the patient only one practitioner can furnish and be paid for CCM services
- Effective care management can only be accomplished through regular monitoring of the patient's health status, and through frequent communication and exchanges of information with the patient and other health care providers
- Practitioners who engage in remote monitoring of patient physiological data may count the time spent reviewing the reported data toward the monthly minimum, but may not include the total time the patient spends under monitoring or wearing a monitoring device

Electronic Health Record (EHR) Requirement

- Technology must be certified under the Office of National Coordinator (ONC) Health Information Technology (IT) Certification Program
- Certification criteria acceptable for purposes of the EHR incentive payment as of December 31st of the previous year.
- EHR must meet the final core technology capabilities
  - Structured recording of demographics
  - Problems
  - Medications
  - Medical allergies
  - Creation of structured clinical summary
- Must use the EHR to fulfill the CCM scope of service requirements whenever the requirements reference a health or medical record
- For 2015, the policy allows practitioners to use EHR technology certified to either the 2011 or 2014 edition(s) of certification criteria
- Must be available at all times to practitioners "within the practice"
  - Meaning those whose minutes would count toward billing CCM services even outside of normal business hours
- All members within the practice must have electronic access to the electronic care plan at all times
- Sharing of information with other practitioners must be accomplished electronically (excluding facsimile)
  - Remote access to an EHR
  - Web-based access to a care management application
  - Web-based access to a health information exchange service that captures and maintains care plan information, secure messaging, or participation in a health information exchange
  - There is no specific electronic technology requirement for sharing information

Restrictions to Payments

- Providers may not bill both CCM and the following
  - Care plan oversight
  - Transitional care management
  - Other procedure codes billed on the same date as CCM as identified in the national correct coding initiative (NCCI) files
- Services are subject to the global surgery package
  - Services will not be reimbursed to the same physician or member of the same group with the same specialty within the post-operative period
- Only one practitioner can bill for any given calendar month
- Patients whose CCM start later in the month must still meet the 20 minute guideline; it is not pro-rated

Models and Demonstrations

- Providers participating in the multi-payer advanced primary care practice (MAPCP) and comprehensive primary care (CPC) may not bill CCM for patients attributed to their practice for the purpose of the above models
- Providers may bill CCM services for those patients not attributed to their practice for the above models
- If CCM services are billed by one provider and MAPCP/CPC payment made to another provider, the MAPCP/CPC will be retracted
  - CCM requires positive patient consent and therefore takes priority
- CCM services may result in a patient being attributed to the practice
  - Providers will no longer bill CCM services if the patient is attributed to the practice

Other

- There is no restriction on providing other medically necessary evaluation and management (E/M) or other services during the same month CCM is billed
- Time spent in the E/M or other service cannot be counted as part of the CCM
- Only one unit of time may be counted even if multiple members of the care team are involved
- There is no specific chronic conditions as long as the definition is met
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- There is no restriction on provider specialty
- There is a minimum of 20 minutes, time cannot be rounded up

- There is no additional units of service billed for additional time
- Patient resides at home, or in a domiciliary, rest home, or assisted living facility
  - This excludes those patients in a skilled nursing facility or nursing home
- Services are initiated through the initial preventive physical examination (IPPE), annual wellness visit (AWV) or comprehensive E/M visit.