# CHRONIC CARE MANAGEMENT TOOL KIT
## What Practices Need to Do to Implement and Bill CCM Codes

### Understanding CCM

Chronic Care Management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions. In addition to office visits and other face-to-face encounters (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 being accessible 24 hours a day to patients and any care providers (physicians or other 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 <u>electronic care plan</u> 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 CCM codes.
- Only one clinician can bill for any particular patient therefore it may be necessary to coordinate with the sub-specialists who may be providing a significant amount of care and treatment to one or more of the patient's conditions. It will be important that the patients understand only one of their likely multiple physicians will be able to bill for CCM services.

These codes are generally intended for use by the clinician who is providing the majority of the care coordination services, which most often would be the primary care internist. However, certain specialists may be able to provide the services needed to qualify to bill the CCM codes, *but never in the same month as the primary care physician*.

### Definitions:

- Eligible professional (EP) – The CCM codes 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." CMS did not provide guidance as to what diagnoses would meet this definition.

- Comprehensive Care Plan – This is an electronic summary of the physical, mental, cognitive, psychosocial, functional, and environmental assessments, a record of all recommended preventive care services, medication reconciliation with review of adherence and potential interactions and oversight of patient self-management of medications, an inventory of clinicians, resources, and supports specific to the patients, including how the services of agencies or specialists unconnected to the designated physician's practice will be coordinated. Including assurance of care appropriate for patient's choices and values.
- Clinical staff – Licensed clinical staff members (including APRN, PA, RN, LSCSW, 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 20-minutes of non-face-to-face time, 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 doesn't 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 office because the patient reported a rash, then the time counts. If the office spends time running a report of all participants due for a flu shot or an A1C check, that time doesn't count. When they call and speak to the patient and then coordinate care, then that time would count. In-person visits, including group visits, do not count toward CCM codes.
- Certified CCM technology – CCM codes must be provided by a certified EHR.

**Codes:**

- CPT code 99490 – CCM services, at least 20 minutes per month. The 2018 average reimbursement is $42.84 adjusted based on geography.
- CPT code 99487 – Complex CCM services, 60 minutes of clinical staff time per month. Average 2018 reimbursement is $94.68.
- CPT code 99489 – Complex CCM services, each additional 30 minutes of clinical staff time per month. Average 2018 reimbursement is $47.16.
- HCPCS code G0506 – Care Planning for Chronic Care Management. 2018 reimbursement is $64.44.
- CPT code 99091 – Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time (for 2018 pending anticipated changes in CPT coding). 2018 average reimbursement is $58.68.

**Billing:**

- The practice must have the patient's written or oral consent in order to bill for CCM services (see Attachment 2).

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- 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 internist, but some specialists may be serving as the patient's primary care physician.
- Copayments (coinsurance and deductibles) DO apply, unless performed at the same time as the Annual Wellness Visit.
- 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.  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.

**Documentation:**

- Document patient consent, if they declined to participate, or indicated participation elsewhere (and if so, with whom). Oral consent is acceptable until the next time the patient comes to the office, when they should sign the written consent (but it is not required).
- Document 20 minutes of non-face-to-face clinical staff time.  Each practice will need to develop its own consistent system of documentation based on its unique physical, staffing, and EHR configuration.  Consideration should include documentation of care provided by both internal and external (such as for call coverage) individuals, who and how care will be documented in the record, and how to document time spent doing different aspects of care and care coordination.  It is quite possible that there will not be a CCM code billed for every patient every month, 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, such as covering clinicians or locum tenens, count as long as they provide the information in a timely manner, which can be done by electronic means including fax.

# How to Implement CCM Codes

**Step 1:** Identify the patients

- Use your EHR to search for patients that have 2 or more chronic conditions. Run reports sorted by physician.  Each physician can then review his/her report and cross off anyone he/she does not think is 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; and
    - Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- Initially, you may wish to focus on a small number of specific diagnoses, such as diabetes, COPD, CVD, and/or A-fib. Create a log of participating CCM patients [Attachment 1]

**Step 2:** Designate a personnel for each identified patient – primary clinician, nurse, and other staff helping with enrollment, consents, and scheduling.

- Patient should be able to access "successive routine appointments" with the designated clinician.
- Other licensed clinical staff can provide services "incident to" the primary clinician, as long as the primary provide is providing general supervision.

**Step 3:** Design a CCM process and schedule.

- Set up appointment codes for new visits and nurse assessment calls as needed.
- As enrollment increases, consider designating time frames for clinician visits and nurse calls (new and subsequent).
- Assign CCM nurse(s) and staff to assist with enrollment, consents, scheduling, and other related CCM activities.
- Consider a dedicated phone line that would be answered by designated CCM staff and forwarded to on-call clinician after hours.

**Step 4:** Inform the Patient

- Invite patients to participate using an invitation letter and written consent to participate. [Attachment 2]
    - Explain how it works and that they can decline, transfer, or terminate at any time
    - Provide information on how to terminate or transfer
    - Authorization of electronic communication of medical information with other clinicians (as allowed by state and local rules and regulations)
    - Provides designated physician's name as well as the CCM nurse.
    - Explains the monthly scheduled nurse assessment visit, which should be treated like a regular visit even though it will occur by phone.

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- o Explains how and when the bills will be generated and what the patient's obligations are for payment of coinsurance and deductibles.
- Review participation agreement with patients and validate their understanding (in person or via phone)
- Record in the electronic chart that CCM was explained and written or oral 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.

**Step 5:** Create and Document a Comprehensive Care Plan

- Care management for chronic conditions should include:
    - o A systematic assessment of the patient's medical, functional, and psychosocial needs;
    - o System-based approaches to ensure timely receipt of all recommended preventive care services;
    - o Medication reconciliation with review of adherence and potential interactions; and
    - o Oversight of beneficiary self-management of medications.
- 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.

**Step 6:** Provide the patient with the written or electronic copy of the 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.

**Step 7:** Document the Time Spent (see "Documentation" on p. 2)

- Set up a system that can keep track of time spent on non-face-to-face services provided, including:
    - o phone calls and email with patient;
    - o time spent coordinating care (by phone or other electronic communication) with other clinicians, facilities, community resources, and caregivers; and
    - o time spent on prescription management/medication reconciliation.

**Step 8:** Termination from program [Attachment 3]

- Document death, transfer of patient to another clinician, or termination from the CCM plan for any reason (e.g., non-payment of copays? Patient wants another physician to be in charge of their CCM such as the oncologist or cardiologist or rheumatologist or whatever specialist might apply to the more intensive chronic condition?)

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### *Sample Log of CCM Patients*

| Patient Name | Primary Clinician | Date Enrolled | Care Plan Review Date | Date Terminated | Notes |
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Dear Patient,

As a patient with two or more chronic conditions (_____list conditions_____), you may benefit from a new program that [_____name of practice_____] offers 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]___.  Sometimes 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.

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_____

_____ _____
Patient Signature                                     Date

*Sample Welcome Letter and Visit Checklist*

Dear Patient:

Congratulations for taking a step toward managing your health by participating in the
[       name of practice        ] Chronic Care Management (CCM) program. CCM is a new model of care designed
to improve the coordination of your health care with an emphasis on your overall well-being.

We believe that to achieve this goal there must be a **partnership** between the patient and their medical
provider. By remaining involved in the decisions regarding your health, health care and lifestyle, we can
develop a stronger relationship with you.

***BEFORE YOUR NEXT CCM NURSE ASSESSMENT CALL PLEASE USE THIS HANDY CHECKLIST***

- ☐ Make a list of any questions you have about your health including questions about dietary recommendations and lifestyle.
- ☐ Inform the CCM nurse of any other health care providers that you have visited in the last month and the reason why you visited them. This includes urgent care or the ER.
- ☐ Have a list of all of your prescribed medications ready, over-the counter, herbal and dietary supplements. Inform the CCM nurse of any refills that you require.
- ☐ Inform the CCM nurse of any new problems that may have developed in the last month.
- ☐ Confirm the date of your next CCM nurse assessment call as well as the date of your next office visit with us.
- ☐ As a reminder, please use the dedicated phone number that was provided to you during your first CCM nurse assessment call so you can call us after hours if necessary, this provides you 24/7 access to your physician or to the covering physician partner.
- ☐ Register for our patient portal.  This is a good way to communicate with your doctor and CCM nurse as well as to view your care plan.
- ☐ If you want to designate a caregiver to have access to your record, please ask our office for the forms to sign.

With continued partnership in the CCM program, we hope to optimize your health, increase your quality of life
and prevent hospitalization.

We look forward to continuing to serve you.

Sincerely,

*__Sample Chronic Care Management Stop Form__*


As of [insert last day of current calendar month], I have decided to terminate participation in the Chronic Care Management program.  I understand that any services provided in the future regarding any of my conditions will have to be in-person and that I will no longer be charged for the Chronic Care Management codes.


_____          _____
Patient Signature                                                                     Date