Chronic Care Management

What is Chronic Care Management (CCM)?

The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals. CCM allows healthcare professionals to be reimbursed for the time and resources used to manage Medicare patients' health between face-to-face appointments.

CCM services may be furnished for Medicare patients with two or more chronic conditions who are at significant risk of death, acute exacerbation/decompensation, or functional decline.

CCM activities include those that support comprehensive care management for patients outside of the office setting. Services include interactions with patients by telephone or secure email to review medical records and test results or provide self-management education and support. Services also include interactions with the patient's other healthcare providers to exchange health information, as well as management of care transitions and coordination of home- and community-based services. CCM requires that patients have 24/7 access to physicians or other qualified healthcare professionals or clinical staff to address urgent needs.

In addition to physician offices, CCM services can be provided by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs). The following healthcare professionals can bill for CCM services:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Certified Nurse Midwives
- Clinical Nurse Specialists

Only one practitioner/facility per patient may be paid for CCM services for a given calendar month. Services may be furnished by the billing healthcare professional as well as clinical staff that meet Medicare's "incident to" rules (https://www.ecfr.gov/cgi-bin/text-idx?SID=f461785b651ded576b73a3c7dfc4ee73&mc=true&tpl=/ecfrbrowse/Title42/42cfr410_main_02.tpl).

To initiate CCM services, the provider is required to complete an initial face-to-face visit, obtain verbal or written consent of the patient, and develop a comprehensive care plan in the electronic health record (EHR). Note that CCM services are subject to the usual Medicare Part B cost sharing requirement.

For more information, please review the following CMS resources:

- Care Management (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management)
- Connected Care: The Chronic Care Management Resource (https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/chronic-care-management)
- Connected Care Health Care Professional Toolkit (https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/connected-hcptoolkit.pdf)
- Chronic Care Management (CCM) Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-

Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf), December 2019

- Chronic Care Management Services Fact Sheet (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf), CMS Medicare Learning Network, July 2019

Why provide CCM to patients?

Both patients and providers may benefit from CCM services. Providers may have previously provided CCM services to patients; however, the CCM billing code allows for an opportunity to receive payment for these services. Patients will receive a better coordinated team of healthcare professionals to help them stay healthy, a comprehensive care plan to set and track progress towards health goals, and support between regular face-to-face visits. Providers will not only receive payment for providing care coordination, but may also improve practice efficiency, and patient compliance and satisfaction. CCM aligns well with the patient-centered medical home (PCMH) model, accountable care organization (ACO), and other alternative payment models.

How do I identify patients who would benefit from CCM?

Your strategy for identifying patients who are eligible should be tailored to your practice processes. Some providers identify patients who qualify for CCM during a regular office visit or Annual Wellness Visit (AWV). Other providers and practices use their EHR to identify patients that qualify for CCM prior to a patient visit. An AWV, Initial Preventive Physical Exam (IPPE), or other face-to-face visit with the billing practitioner can be used to initiate CCM.

How can I educate patients about CCM and what to expect?

CCM requires patient consent be obtained, providing an opportunity to explain and engage the patient in the goals and activities of CCM. When obtaining patient consent, the patient should be aware of the 20% cost sharing requirement for each month of CCM service. Verbal or written consent must be documented in the EHR and include the following:

- CCM services are available and cost-sharing is applicable,
- Only one of the patient's providers can provide and bill for CCM services each month, and
- The patient has the right to stop CCM services at any time.

Informed consent is only required once prior to initiating CCM services or if the patient chooses to change the billing provider for CCM services.

What are the billing codes for CCM?

CCM requires an initiating visit with the billing provider. This visit includes most standard face-to-face Evaluation and Management (E/M) visit codes, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE). The initiating visit is only required for new patients or patients not seen by the provider in the previous year. HCPCS Code G0506 is an add-on code to the CCM initiating visit that describes the work of the billing practitioner in a comprehensive assessment and care planning to patients outside of the usual effort described by the initiating visit code.

Once the initiating visit is complete, and the patient has consented to CCM, the following codes can be billed for each month of service (see the Physician Fee Schedule Search (https://www.cms.gov/medicare/physician-fee-schedule/search) for the value of each code):

- CPT Code 99490: At least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional per calendar month, spent on activities to manage and coordinate care for Medicare and dual eligible beneficiaries with two or more chronic conditions that are expected to last at least 12 months or until death

- CPT Code 99491: Chronic care management services, provided personally by a physician or other QHP, at least 30 minutes of physician or other QHP time, per calendar month
- CPT Code 99487: Complex CCM that requires an established, implemented, revised, or monitored comprehensive care plan, moderate or high complexity medical decision making, and 60 minutes of clinical staff time
- CPT Code 99489: Add-on code to complex CCM (CPT 99487) for each additional 30 minutes of clinical staff time
- HCPCS Code G0511: RHCs and FQHCs only should use this code for CCM when the requirements for CPT codes 99490, 99487, 99491, or 99484 are met
- HCPCS Code G0512: Psychiatric collaborative care model (CoCM) code for RHCs
- CPT Code 99439 (NEW code for 2021, replaces HCPCS Code G2058): Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. In the CY 2021 Medicare Physician Fee Schedule Rule (https://www.federalregister.gov/public-inspection/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part), CMS finalized that this code may be billed concurrently with TCM when reasonable and necessary.

CCM requires cost sharing by the patient (about $8/month for CPT code 99490). Patients are responsible for the usual Medicare Part B cost sharing if they do not have a Medigap or other supplemental insurance plan that will cover 100% of Part B cost sharing. Most Medicare-Medicaid dual eligible beneficiaries are exempt from cost sharing. Contact your state Medicaid office for coverage information on deductibles/coinsurance for Medicare services for dual eligible beneficiaries.

How is CCM documented in an electronic health record (EHR)?

Documentation of time and furnished services are essential for billing. CMS requires structured recording of patient health information; a certified EHR meets this requirement. The following should be documented in the EHR:

- Patient consent,
- Comprehensive care plan, including, but not limited to, a problem list, measurable treatment goals, planned interventions, medication management, and interaction and coordination with outside resources and practitioners and providers, and
- At least 20 minutes of non-face-to-face clinical staff time per month

Some practices have CCM documentation built into their EHR's outpatient record. Other practices have implemented specialized software to track time and ensure all of the required components for CCM billing are met. Some software have the ability to not only track documentation, but also send reminders to the provider, patient, and their caregivers. A few practices have chosen to track CCM manually.

Who in my practice should I engage when designing and implementing CCM?

Implementing CCM in your practice requires broad support, beginning with leadership and the *medical staff*. Successful implementation requires a cultural change and is supported by clearly defined roles and workflows for everyone on the care team. Working with *coding* and *billing* staff before implementing CCM is important for developing complete documentation and systems to bill for the service. Consider working with *health information technology* staff to identify or develop how patient contacts will be captured in the EHR. Engage other members of the care team, such as pharmacists, social workers, dietitians, nurses, and others who will have contact with the patient.

How should I schedule staff to provide CCM services?

Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Nurse Midwives can bill for CCM services. In addition, licensed clinical staff employed by the billing provider or practice under general supervision of the provider can provide CCM services. These "incident to" requirements apply to licensed clinical staff.

Practices have taken varied approaches to providing care coordination (/toolkits/care-coordination). The decision to hire new staff for CCM depends on how many patients a practices determines will likely elect CCM. First, the practice should determine how many patients are eligible for CCM. Next, the practice should determine how many of those patients will realistically elect CCM. A smaller practice may choose to assign existing staff to coordinate CCM. A larger practice may choose to hire a full-time staff member, such as a registered nurse (RN) care coordinator, to manage CCM, along with other services such as Transitional Care Management (TCM) and Annual Wellness Visits (AWVs). CCM services can be subcontracted to case management companies, but the case management must meet "incident to" requirements and should be integrated with the care team.

CCM requires 24/7 access to care. Practices have taken varied approaches to meeting this requirement. Many practices with relationships to their local hospital use emergency department or inpatient staff to meet after-hours needs. Independent practices have chosen to contract with 24/7 call services.

It should be noted that all care team members providing CCM services must have access to the electronic care plan. For example, after-hours clinicians or locum tenens, who are not part of the practice must have access to the care plan.

Are there care management services specific to behavioral health?

Under Medicare, CMS allows physicians, non-physician practitioners, RHCs, and FQHCs to bill for behavioral health integration (BHI) services they furnish to beneficiaries over a calendar month. This includes both General BHI and the Psychiatric Collaborative Care Model (CoCM). Psychiatric CoCM billing codes for physicians and non-physician practitioners are CPT codes 99492, 99493, and 99494. RHCs and FQHCs can only bill HCPCS code G0512 for Psychiatric CoCM. Physicians and non-physician practitioners may bill CPT code 99484 when meeting the requirements for BHI not considered Psychiatric CoCM. RHCs and FQHCs can only bill HCPCS code G0511 for BHI.

Are there any special considerations for Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) billing for CCM?

RHCs and FQHCs can only bill for CCM and General BHI using HCPCS Code G0511, either alone or with other payable services. The payment amount for HCPCS Code G0511 is set at the average of the national non-facility PFS payment rates for CCM, General BHI, and Principal Care Management (PCM). If CCM is billed with other payable services, it is paid separately and not factored into the RHC or FQHC payment rate.

Prior to 2022, RHCs and FQHCs could not bill for CCM and TCM services, or another program that provides additional payment for care management services (outside of the RHC all-inclusive rate (AIR) or FQHC prospective payment system (PPS) payment), for the same beneficiary during the same time period. For calendar year 2022 and beyond (https://www.federalregister.gov/documents/2021/11/19/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part), CMS will allow RHCs and FQHCs to bill concurrently for care management services. This means that, going forward, RHCs and FQHCs can provide CCM, TCM, and other care management services for the same beneficiary in the same service period.

Are there any special considerations for Critical Access Hospital (CAH) billing for CCM?

Critical Access Hospitals can bill for Medicare Part B for CCM services. The patient should be assigned to an outpatient billing provider. All billing requirements remain.

Are there care management services for beneficiaries with one chronic condition?

Beginning in 2020, CMS is introducing Principal Care Management (https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other) (PCM) services to provide comprehensive care management for beneficiaries with a single, high-risk condition. Other CCM codes continue to require that patients have two or more chronic conditions. In rulemaking for calendar year 2020, CMS indicated that "A qualifying condition will typically be expected to last between 3 months and 1 year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline." These services are billable under CPT codes 99424-99427 and HCPCS code G0511 for RHCs and FQHCs.

Resources

- Chronic Care Management Services (https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf), Centers for Medicare & Medicaid Services, July 2019
- Chronic Care Management (CCM) Services (https://med.noridianmedicare.com/web/jeb/specialties/em/chronic-care-management-ccm), Noridian Healthcare Solutions, June 2019
- Medicare (CMS) Chronic Care Management Webinar (https://www.michigan.gov/-/media/Project/Websites/mdhhs/Folder3/Folder26/Folder2/Folder126/Folder1/Folder226/Chronic_Care_Management_Deck_20170615.pdf), The Advisory Board, June 2017
- Medicare Benefit Policy Manual - RHC and FQHC Update - Chapter 13 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf), Centers for Medicare & Medicaid Services, April 2021
- Behavioral Health Integration Services (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf), Centers for Medicare & Medicaid Services, March 2021

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