Chronic Care Management in Practice: How, When, and Why to use the CCM & CCCM Codes to Maximize Provider Reimbursement

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Chronic Care Management (CCM) & Complex Chronic Care Management (CCCM) Codes

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Course Outline

- Overview of Care Management
- The Codes: CCM and CCCM
- Required Service Elements
- Practitioner Eligibility and Billing
- Patient Eligibility

Overview

- The Centers for Medicare & Medicaid Services (CMS) recognizes that care management takes time and effort
- CMS has established billing codes to account for the additional time and resources you spend assisting your Medicare patients - who may require additional help to stay on track with their treatments – in between their appointments
- Chronic Care Management (CCM) and Complex Chronic Care Management (CCCM) are critical components of primary care that contribute to better outcomes and higher satisfaction for patients
- Can be billed by specialist providers if all criteria is met

Overview

- CCM and CCCM payments can be made for services provided to patients who have **two or more chronic conditions** and who are at significant risk of death, acute exacerbation/decompensation, or functional decline
- CMS data shows that two thirds of Medicare recipients have two or more chronic conditions, which means that many of your patients may benefit from CCM and CCCM services.
  - CCM and CCCM can enable the coordinated care your patients need and deserve between visits

Overview

- CCM (sometimes referred to as “non-complex” CCM) and complex CCM (CCCM) services share a required set of service elements
- CCM and CCCM differ in:
  - The amount of clinical staff service time provided
  - The involvement and work of the billing practitioner
  - The extent of care planning performed

CCM AND CCCM CODES

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CCM AND CCCM CODES

Chronic Care Management Codes: Summary	
CPT 99490	**Chronic Care Management Services** • ≥*20 minutes of clinical staff time per calendar month* • Directed by a physician or other qualified health care professional **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 • Only one unit of service can be billed each calendar month Average 2018 reimbursement is $43 adjusted based on geography
CPT 99487	**Complex Chronic Care Management services** • *60 minutes of clinical staff time per calendar month* • Directed by a physician or other qualified health care professional **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 • Establishment or substantial revision of a comprehensive care plan • Moderate or high-complexity medical decision-making Average 2018 reimbursement is $94
CPT 99489	**Each additional 30 minutes** of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) Average 2018 reimbursement is $47
CPT G0506	If the initial CCM/CCCM visit is complex and additional billing practitioner time and effort is needed, you can use HCPCS G0506 as an **add-on to the initial visit** **Code G0506**: $64 add-on to the CCM/CCCM initiating visit, for the billing practitioner's time and effort personally providing extensive comprehensive assessment and CCM/CCCM care planning to patients, outside of the usual effort described by the initiating visit code • **Code G0506** is reportable once per CCM/CCCM billing practitioner, in conjunction with CCM/CCCM initiation

CCM & CCCM: REQUIRED SERVICE ELEMENTS

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CCM & CCCM
Required Service Elements

- Initiating Visit
- Patient Consent
- Structured Recording of Patient Information Using Certified EHR Technology
- 24 hr a day /7 day a week Access & Continuity of Care
- Comprehensive Care Management
- Comprehensive Care Plan
- Management of Care Transitions
- Home- and Community-Based Care Coordination
- Enhanced Communication Opportunities
- Medical Decision-Making

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CCM & CCCM
Required Service Elements

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Initiating Visit

- Initiation during an Annual Wellness Visit (AWV), Initial Preventive Physical Exam (IPPE), or face-to-face E/M visit (any complexity, Level 4 or 5 visit not required)
- Initiating visit is not part of CCM or CCCM, and is separately billed
  - If the CCM/CCCM initiating visit is complex, you may also report G0506 as an add-on code
- For new patients or patients not seen within “past 12 months”, provider needs to see the patient at one of the visit types below and to discuss CCM:
  - Annual Wellness Visit (AWV)
  - Comprehensive E/M (99202-99205, or 99212-99215)
  - Initial Preventive Physical Exam (IPPE)

NOTE:

- The visit will **not** count as an initiating visit for CCM or CCCM *if* the practitioner does not discuss CCM or CCCM with the patient at that visit, and/or it is not well-documented

CCM & CCCM
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Patient Consent

- Provider must inform the patient:
  - Of the availability of CCM or CCCM services
  - That only one practitioner can provide and be paid for these services during a calendar month
  - The patient has the right to stop the CCM or CCCM services at any time (effective at the end of the calendar month)
- Providers should document in the patient's medical record that the required information was explained, and whether the patient accepted or declined the services
- Written/signed patient consent is no longer required but is highly recommended

CCM & CCCM
Required Service Elements

- Initiating Visit
- Patient Consent
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Structured Recording of Patient Information Using Certified EHR Technology

- To capture CCM and CCCM, the provider is required to use certified EHR technology* and must capture:
  - Demographics
  - Problems
  - Medications
  - Medication allergies
- This information **must** be entered in the EHR and **must** inform the care plan and care coordination

*Learn more from the CMS website.

Reference: Center for Medicare & Medicaid Services. EHR Technology. CMS Website. Certified EHR Technology. https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Certification.html Accessed June 5, 2018.

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CCM & CCCM
Required Service Elements

- Initiating Visit
- Patient Consent
- Structured Recording of Patient Information Using Certified EHR Technology
- **24/7 Access & Continuity of Care**
- Comprehensive Care Management
- Comprehensive Care Plan
- Management of Care Transitions
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24/7 Access & Continuity of Care

- In order to bill for chronic care management, the practice must provide patients and caregivers with 24/7 access to qualified health care professionals or clinical staff to address urgent needs
- Practice must provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments

CCM & CCCM
Required Service Elements

- Initiating Visit
- Patient Consent
- Structured Recording of Patient Information Using Certified EHR Technology
- 24 hr a day /7 day a week Access & Continuity of Care
- **Comprehensive Care Management**
- Comprehensive Care Plan
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Comprehensive Care Management

- Care management for chronic and complex conditions including:
  - 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

CCM & CCCM
Required Service Elements

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Comprehensive Care Plan

- Creation, revision, and/or monitoring of an electronic plan of care that tracks health issues
- Elements include:
  - A physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment
  - An inventory of resources and supports
  - A comprehensive care plan for all health issues with particular focus on the chronic conditions being managed
- The plan of care should be reviewed periodically and shared with other providers as appropriate
- Care plan information must be electronically captured, and readily available to share with the patient and other care providers involved in the patient's care
- *A copy of the plan of care **must** be given to the patient and/or caregiver*

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Management of Care Transitions

- There must be evidence of management of care transitions, between and among health care providers and settings, including, but not limited to:
  - Referrals to other clinicians
  - Follow-up after an emergency department visit
  - Follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Create and exchange/transmit continuity of care document(s) in timely manner with other practitioners and providers

CCM & CCCM
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Home- and Community-Based Care Coordination

- Provider **must** coordinate with home- and community-based clinical service providers
- Documentation of communication between and among home- and community-based providers regarding the patient's psychosocial needs and functional deficits must be evident in the patient's medical record

CCM & CCCM
Required Service Elements

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- **Enhanced Communication Opportunities**
- Medical Decision-Making

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Enhanced Communication Opportunities

- Patients and their caregivers **must** have enhanced opportunities to communicate with their practitioner regarding the patients care by one or more of the following:
  - Telephone access
  - Secure messaging
  - Internet
  - Other secure methods

CCM & CCCM
Required Service Elements

- Initiating Visit
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- **Medical Decision-Making**

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Medical Decision-Making

- Complex CCM (CCCM) services require moderate to high-complexity medical decision-making by the provider, whether a physician, physician assistant, nurse practitioner or clinical nurse specialist

PRACTITIONER AND ENTITY ELIGIBILITY & BILLING

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Entity Eligibility

- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Hospitals, including Critical Access Hospitals (CAHs)
- Physician Practices

Note: *Only one Physician, Non-Physician Provider (NPP), RHC or FQHC, and one hospital, can bill for CCM and CCCM for a patient during a calendar month*

Reference: Center for Medicare & Medicaid Services. Chronic Management Services. CMS Website. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf. Accessed June 4, 2018.

Practitioner Eligibility

- Physicians
- Non-physician practitioners (NPP) *may* bill CCM services including:
  - Clinical Nurse Specialists (CNSs)
  - Nurse Practitioners (NPs)
  - Physician Assistants (PAs)
- The CCM and CCCM service is **not** within the scope of practice of limited license providers such as clinical psychologists, podiatrists, or dentists, although practitioners may refer or consult with such physicians and practitioners to coordinate and manage care

Clinical Staff Appropriate for 'Incident To' Reimbursement

- Clinicians whose time may be counted as "incident to":
  - Registered dietician
  - LMSW
  - BSW
  - Licensed Clinical Social Worker (LCSW)
  - MSW
  - Certified Medical Assistant (CMA/MA)
  - Registered Nurse (RN)
  - Licensed Practical/Vocational Nurse (LP/VN)
  - Pharmacist (Pharm)
  - Physical Therapist (PT)
  - Occupational Therapist (OT)
  - **Note:** Can count time spent by Advanced Practice Providers (NP, CNS, PA) who are not billing independently

Reference: Michigan Government, Advisory Board. Chronic Care Management FAQ. Michigan Government Website. https://www.michigan.gov/documents/mdhhs/CCM_Medicare_FAQ_605785_7.pdf. Accessed June 2, 2018.

Billing Specifics

- Do not use From / To billing dates
- CCCM has a benefit cap of 360 minutes of care (6 hours) per calendar month
- E/M visits are still billable outside of the CCM/CCCM time
  - Do not count the billable time twice!
- Tracking provider and clinical team time will be the biggest challenge
- Supplemental insurance/Medicaid will coordinate benefits with Medicare.
  - Patients could potentially be responsible for their deductible or coinsurance

Billing Appeals

- CCCM billed over 360 minutes will be denied and will require provider appeal for a review and reconsideration for payment
- CCCM appeals require:
  - Consent
  - A signed care plan
  - Chart notes of CCM initiating visit
  - Case notes of all clinical activity
  - Certification of Time Spent signed by practitioner (recommended)

Billing Prohibitions

- CCM or CCCM may **not** be reported during the same period as the following:
  - G0181/G0182 (home health care/hospice supervision)
  - 90951-90970 (end-stage renal disease management)
  - 99495/99496 (transitional care management, 30 days)
  - Care Plan Oversight (CPO) Codes
  - Prolonged non-face-to-face services E/M codes

PATIENT ELIGIBILITY

Patient Eligibility for CCM & CCCM

- Patients must meet the following conditions:
  - Multiple (**two or more)** chronic conditions expected to last at least 12 months or until the death of the patient
  - Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Patients must be enrolled in Medicare
- Patients must live in the United States
  - CCM services are not covered if provided to patients that are located outside of United States (e.g. expatriates or Medicare recipients on vacation outside of the country)

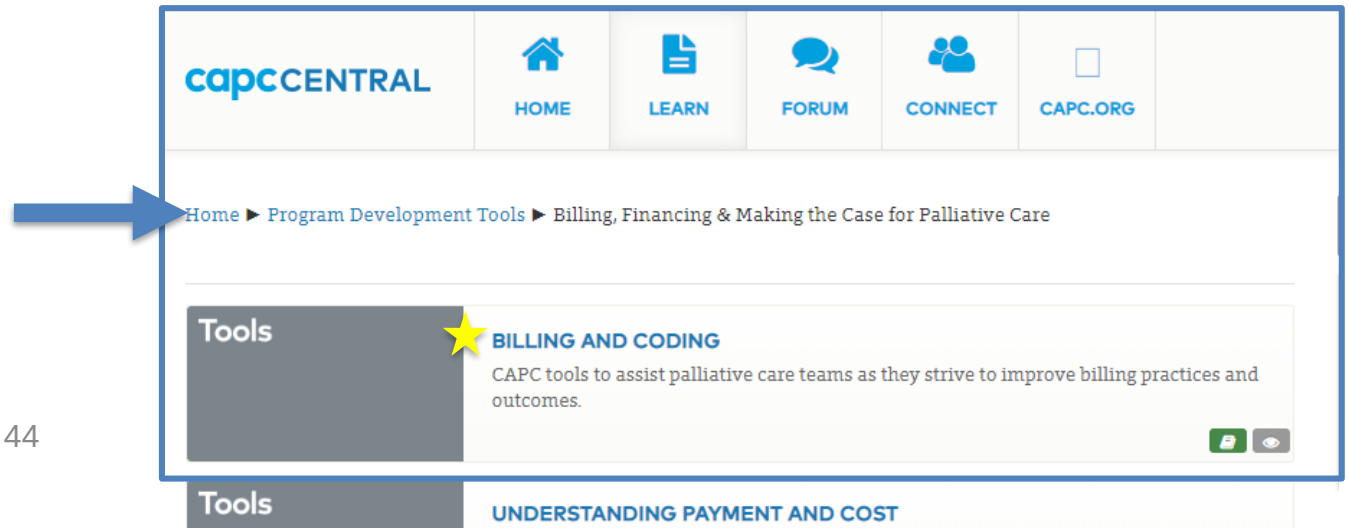
Reference: Center for Medicare & Medicaid Services. Chronic Conditions Overview. CMS Website. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/. Accessed June 3, 2018.

Patient Eligibility: Settings

- CCM and CCCM are reimbursed in both facility and non-facility settings
- The billing practitioner should report the Place of Service (POS) for the location where he or she would ordinarily provide face-to-face care to the beneficiary
- For more information on facility vs non-facility POS see: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf

CAPC Central Resources

- Billing Toolkit ★
  - CCM & CCCM Codes
    - Billing and Coding for Chronic Care Management (CCM) & Complex Chronic Care Management (CCCM) Codes



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Care Management Services Comparison Table

	CCM	CCCM	CPO	TCM
Eligible Patients	Multiple chronic conditions expected to last 12 months, or until the death Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline	Multiple chronic conditions expected to last 12 months, or until the death Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline Moderate or high complexity medical decision making	Requires complex multidisciplinary care Is enrolled with Hospice or HHA Face- to- face encounter with provider in last 6 months	Post discharge from facility Medium to high medical complexity
Setting	All settings Bill POS where patient would normally be seen	All settings Bill POS where patient would normally be seen	Home Domiciliary Assisted living	Home Domiciliary Assisted living
Eligible providers	MD, NPP (NP, PA, CNM, CNS) Entities – RHCs, FQHCs	MD, NPP (NP, PA, CNM, CNS)	MD, NPP	MD, NPP (NP, PA, CNS, CNM)
Required components	1. Patient consent 2. Comprehensive care plan 3. Coordination of care 4. Enhanced communications 5. Certified EHR	1. Patient consent 2. Comprehensive care plan 3. Moderate to high complexity medical decision making 4. Coordination of care 5. Enhanced communications 6. Certified EHR	1. 30 minutes of time 2. Must be billed by calendar month	1. Contact within 2 days 2. Face- to- face visit on day 7 (99495) or day 14 (99496)

This table can be downloaded from CAPC Central as well using this link.

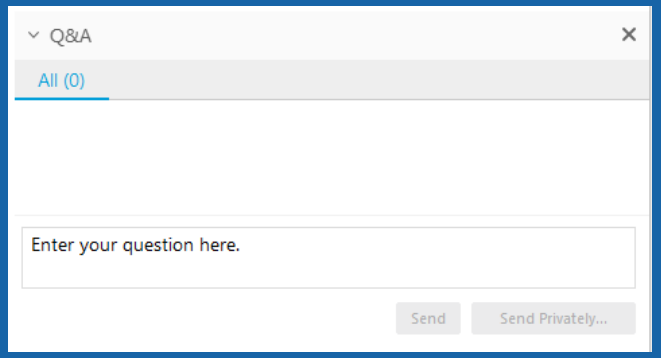
Care Management Services Comparison Table (continued)

	CCM	CCCM	CPO	TCM
"Incident to" billing	Yes	Yes	No* NP must be working with the MD who signed the Plan of Care	Yes
Documentation requirements	1. Consent 2. Comprehensive care plan	1. Consent 2. Comprehensive care plan 3. Electronic communications 4. EHR	1. Develop or revision of care plans 2. Review of records 3. Adjust medications 4. Coordinate care 5. Document time spent 6. Record HHA or Hospice NPI # on claim	1. Dates of service 2. Medical decision making
Exclusions	TCM Hospice or Home Health services ESRD services	TCM Hospice or Home Health services ESRD services	TCM service ESRD services Global surgical period	CPO ESRD services Prolonged non face- to-face codes Hospice or Home Health services Global surgical period CCM/CCCM

This table can be downloaded from CAPC Central as well using this link.

Questions?

Please type your question into the questions pane on your WebEx control panel.



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