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

Cheyenne Balsley
Finance Director, ResolutionCare

Andy Esch, MD, MBA
Consultant, Center to Advance Palliative Care

November 29, 2018
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Chronic Care Management (CCM) & Complex Chronic Care Management (CCCM) Codes
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
### Chronic Care Management Codes: Summary

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Required Elements</th>
<th>Average 2018 Reimbursement</th>
</tr>
</thead>
</table>
| 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) | | $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
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
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
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- Enhanced Communication Opportunities
- Medical Decision-Making
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

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
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
➔ **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
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.
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
➔ Home- and Community-Based Care Coordination
➔ Enhanced Communication Opportunities
➔ Medical Decision-Making
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
- Management of Care Transitions
- Home- and Community-Based Care Coordination
- Enhanced Communication Opportunities
- Medical Decision-Making
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

➔ 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
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
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
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
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
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➔ Management of Care Transitions
➔ Home- and Community-Based Care Coordination
➔ Enhanced Communication Opportunities
➔ Medical Decision-Making
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

→ 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
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
➔ Patient Consent
➔ Structured Recording of Patient Information Using Certified EHR Technology
➔ 24 hr a day /7 day a week Access & Continuity of Care
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➔ Medical Decision-Making
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
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

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

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)

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
<table>
<thead>
<tr>
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<th>CCM</th>
<th>CCCM</th>
<th>CPO</th>
<th>TCM</th>
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<tbody>
<tr>
<td>Eligible Patients</td>
<td>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.</td>
<td>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.</td>
<td>Requires complex multidisciplinary care. Is enrolled with Hospice or HHA. Face-to-face encounter with provider in last 6 months.</td>
<td>Post discharge from facility. Medium to high medical complexity.</td>
</tr>
<tr>
<td>Eligible providers</td>
<td>MD, NPP (NP, PA, CNM, CNS). Entities – RHCs, FQHCs.</td>
<td>MD, NPP (NP, PA, CNM, CNS).</td>
<td>MD, NPP.</td>
<td>MD, NPP (NP, PA, CNS, CNM).</td>
</tr>
<tr>
<td>Required components</td>
<td>1. Patient consent. 2. Comprehensive care plan. 3. Coordination of care. 4. Enhanced communications. 5. Certified EHR.</td>
<td>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.</td>
<td>1. 30 minutes of time. 2. Must be billed by calendar month.</td>
<td>1. Contact within 2 days. 2. Face-to-face visit on day 7 (99495) or day 14 (99496).</td>
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This table can be downloaded from CAPC Central as well using this link.
# Care Management Services Comparison Table (continued)

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<tr>
<td><strong>“Incident to” billing</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>No*</td>
<td>Yes</td>
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<tr>
<td><strong>Documentation requirements</strong></td>
<td>1. Consent</td>
<td>1. Consent</td>
<td>1. Develop or revision of care plans</td>
<td>1. Dates of service</td>
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<tr>
<td></td>
<td>4. EHR</td>
<td>5. Document time spent</td>
<td>6. Record HHA or Hospice NPI # on claim</td>
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<tr>
<td><strong>Exclusions</strong></td>
<td>TCM</td>
<td>TCM</td>
<td>TCM service</td>
<td>CPO</td>
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<td>Hospice or Home Health services</td>
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<td>Global surgical period</td>
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<td>CCM/CCCM</td>
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Questions?

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