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CMS' Chronic Care Management Program Overview

Increasing Practice Revenue & Improving Patient Care

CMS' chronic care management (CCM) incentive program, which went into effect January 2015, is good news for primary care practitioners and others who provide chronic care management. Now you can be paid for care you're likely already providing under CMS' new chronic care management program.

The agency developed the policy to pay separately for non face-to-face care management services for patients with two or more chronic conditions. The CMS final rule updates payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2015. According to CMS parameters for the program, physician practices can charge approximately $42 per month for 20 minutes of non face-to-face chronic care activity per patient.

Make sure you understand the parameters of the program so you can receive your reimbursement. You must also explain the program to your patients and have them sign an agreement that outlines what you will provide.

CCM service must include:

- Access to CCM services 24/7, which means providing beneficiaries with a means to make contact with healthcare providers to address urgent chronic care needs
- Continuity of care with a designated practitioner or member of the care team that the patient is able to have routine appointments
- Care management for chronic conditions including systematic assessment of patient's medical, functional, and psychosocial needs, and system-based approaches to ensure timely receipt of all recommended preventive care services, medication reconciliation, and oversight of patient self-management of medications
- Creation of a patient-centered care plan to assure that care is provided in a way that is in agreement with patient choices and values
- Management of care transitions between and among healthcare providers and settings
- Coordination with home and community-based clinical service providers
- Enhanced opportunities for a beneficiary and caregiver to communicate with the practitioner.

The billing requirements include:

- Inform the patient about the CCM services and get their written agreement to have the services provided (*see sample form from AMA on page 5*).
- Document in the patient's medical record that all of the CCM services were explained and offered to the patient and note the patient's decision
- Provide the patient with a written or electronic copy of their care plan

- Inform the patient of the right to discontinue CCM services at any time
- Inform the patient that only one practitioner can furnish and be paid for these services during the 30-day period.

Why should medical practices participate in CCM?

The program is beneficial to both physicians and patients:

- Improved health outcomes
- More focus on disease prevention
- Patients return home from the hospital sooner
- Improved management of chronic diseases
- Creating a more coordinated healthcare system
- Increases revenue for physician practices

By investing in prevention and treatment of the most common chronic diseases, the U.S. could decrease treatment costs significantly. Effective public health policies that focus on management of chronic diseases lead to improved health with lower healthcare spending, less school and workplace absenteeism, increased economic productivity and an improved quality of life.

In a recent study, the CDC found that chronic diseases are responsible for 7 of 10 deaths each year, and treating people with chronic diseases accounts for 86% of our nation's healthcare costs. 133 million Americans experience at least one chronic disease, and more than two thirds of Medicare spending goes to patients with five or more chronic diseases.

By offering incentives to manage patients with multiple chronic illnesses, CMS is providing an opportunity to improve the quality of healthcare and cut costs. The new fee is part of a broader multi-year strategy to recognize and value primary care and care management services. The fee covers management of patients with multiple complex chronic conditions that are expected to last at least 12 months, or until death and that put the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Key Facts:

- CCM pays approximately $40 per patient per month.
- There may be some patient responsibility.
- Medicare Advantage plans will have to cover CCM.
- Physicians, advanced NPs, PAs, clinical nurse specialists, and certified midwives can bill Medicare for CCM.
- Transitional care management, home healthcare supervision, hospice care supervision, and certain end stage renal disease services in the month billed are not covered.
- CCM is not recognized as an RHC (Rural Health Center) service.
- Providers can contract with a third party to provide non face-to-face care management services.

How to participate in the program

Identify patients in your practice that qualify. This includes fee for service Medicare patients that will likely have multiple chronic conditions for at least 12 months, or until death of the patient, the patient is at significant risk of death, acute exacerbation/decompensation, or functional decline. Have them sign a consent form to participate in the program which becomes part of their medical record. (*sample from from AMA on page 4*)

Physicians can only bill in months when there's activity. Specialists can also bill under this code if they are providing CCM. If the patient's primary care physician is a key referral source. You can expect that they will want to bill for CCM. Defer to the primary provider for this service, as it will preclude their claim. Contact and inform the identified patient that they qualify and that you will be providing them with this service.

- **Create a care plan.** Provide the patient with a written or electronic copy of the care plan and include it in their medical record. CMS has not provided a consent form (*sample from from AMA on page 4*).

- **The Patient Consent Form must include** an agreement to electronic communication of patient information with other treating providers for purposes of care coordination, with details about what chronic care management services are and how they are accessed, details about how patient information will be shared with providers on the care team. Information on cost sharing, which applies to these services even when they are not provided face-to-face in the practice.

- **Provide 20 minutes or more of non face-to-face chronic care management per month per patient.** CMS has established a payment rate of $42.60 for CCM that can be billed up to once per month per qualified patient for 20 minutes of non face-t-oface services to qualified Medicare beneficiaries who have multiple, significant, chronic conditions (two or more). Chronic care management services include regular development and revision of a plan of care, communication with other treating health professionals, and medication management.

- **Patients must have 24/7 access to their healthcare providers.** CCM services and coordination of care among providers must be available to discuss chronic care needs and ensure continuity of care with their primary physician.

CPT codes for CCM program

Until the launch of the CCM incentive program, there have not been separate codes to bill for CCM services. Medicare pays separately under the Medicare Physician Fee Schedule (PFS) under American Medical Association Current Procedural Terminology (CPT) code 99490, for non face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. The instruction and limitations are in the AMA's CPT book.

Physicians can bill for the services using the CPT codes 99490, 99487, and 99489. The CMS plans to make a bundled payment for 99487 and 99489, according to the rule. The codes apply only to Medicare patients with two or more significant, chronic conditions.

CPT 99490: 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. Payment for CPT code 99490 is based on the valuation of similar care management services (the non face-to face portion of TCM services).

CPT 99487: Complex chronic coordination services; first hour of clinical staff time directed by a physician or other qualified healthcare professional with no face-to-face visit, (once) per calendar month.

CPT 99589: Each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month (list separately in addition to code for primary procedure). The first hour of time is defined as 31 to 74 minutes. Time is not recorded on the day the patient has an evaluation/management visit with the provider.

Use of EHR required. In addition to securing written consent from the beneficiary and providing at least 20 minutes of non face-to-face care management services per calendar month, practices will be required to use a certified EHR, maintain an electronic care plan, ensure beneficiary access to the care.

For the EHR requirement, CMS notes that they continue to believe: “That it is necessary to require the use of EHR technology that has been certified under the ONC Health IT Certification Program as requisite for receiving separate payment for CCM services, to ensure that practitioners have adequate capabilities to allow members of the interdisciplinary care team to have timely access to the most updated information informing the care plan.”

If your medical practice does not have an EHR, PracticeAdmin integrates with leading EHR solutions, and can refer you to an EHR partner. You can also ask your billing services provider for recommendations.

CCM Sources & Resources

- CMS Chronic Care Management Services http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf
- CMS education transcript http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-02-18-CCM-Transcript.pdf
- CMS maintains a Chronic Condition Warehouse (CCW)
- American Medical Group Association Summary of Key Provisions Medicare Physician Fee Schedule Proposed Rule for Calendar Year 2015
- Revisions to Payment Policies Under the Physician Fee Schedule

- American College of Physicians https://www.acponline.org/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf
- CMS PPT Medicare Learning Network (MLN) http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-02-18-Chronic-Care-Presentation.pdf
- MDeverywhere.com http://www.mdeverywhere.com/chronic-care-management-worth-reimbursement-physicians/

About PracticeAdmin

PracticeAdmin's medical billing and PracticeAdmin's HIPAA-compliant Practice Management (SaaS) solution provides you with a powerful platform to manage patient data and claims between your PM and EMR systems. It is a more efficient and cost effective web-based system for scheduling patients, performing complex medical billing, and reporting on all the areas of your billing services. We also offer accounts receivable software and digital document management software. We have an established solution and partnerships with billers and practices of all sizes. Learn more at www.practiceadmin.com. Call 844-269-4780 to schedule a demo.

Sample Patient Consent Form for Chronic Care Management

*(*This is a sample form. It does not constitute legal advice.)*

By signing this agreement, you consent to have _____ (referred to as “Provider”), provide you with Chronic Care Management services (referred to as “CCM Services”) as outlined below. CCM services are being offered to you because you have been identified by your physician to have been diagnosed with two (2) or more chronic conditions which are expected to continue for at least twelve (12) months and which place you at significant risk. Your provider will discuss with you the specific services that will be available to you and how to access them.

CCM services include:

- 24hour, 7 days a week access to a healthcare provider who can address acute chronic care needs
- Systematic assessment of your health care needs
- Processes that assure that you receive timely preventative care services
- Medication reviews and oversight
- A plan of care covering your health issues
- Management of care transitions among healthcare providers Your Provider must:
- Explain and offer all the CCM services that are applicable to your conditions.
- Provide you with a written or electronic copy of your care plan.
- Provide you with a written confirmation of the revocation of the agreement with the effective date.

By signing this agreement, you agree to the following:

- You consent to the provider to provide CCM services to you.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM services to you during 30 day period.
- You understand that cost sharing will apply to CCM services.

You may be billed for a portion of CCM services even though CCM services will not involve a face-to-face meeting with the provider. Beneficiary Rights The Provider will provide you with a written or electronic copy of your care plan. You have the right to discontinue CCM services at any time by revoking this agreement effective at the end of the then current thirty (30) day period of services. You may revoke this agreement verbally or in writing. Upon receipt of your revocation, the provider will give you written confirmation of revocation.

Beneficiary
Signature: _____
Print Name: _____
Date: _____

Beneficiary’s representative or caregiver
Signature: _____
Print Name: _____
Date: _____