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Chronic Care Management (CCM) Services

Presented by Noridian Part B Medicare
Provider Outreach and Education
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ACRONYM	DESCRIPTION
AWV	Annual Wellness Visit
E/M	Evaluation and Management
F2F	Face-to-Face
MACRA	Medicare Access & CHIP Reauthorization Act
MLN	Medicare Learning Network
MPFS	Medicare Physician Fee Schedule
POC	Plan of Care

https://www.cms.gov/apps/acronyms/

Agenda

- Chronic Care Management (CCM) Overview and 2017 Updates
- Eligible Beneficiaries and Providers
- Scope of Service
- CCM Billing
- Noteworthy Information & Resources

Objective

- To give providers tools and information about the Chronic Care Management (CCM) program and how to bill appropriately once per calendar month

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Chronic Care Management (CCM) Overview & 2017 Updates/Changes

CCM Overview

- Chronic Care Management
  - Started January 1, 2015
  - CMS recognized CCM contributes to better health and care while focused on patient
  - Reimburses “eligible provider” for non face-to-face care coordination services
    - With a host of specialists and other clinical staff
  - Monthly biller = provider who wrote POC
    - 1 practitioner (Part B) and 1 hospital only (Part A)

CCM Overview 2

- Furnished to eligible beneficiaries/patients with multiple chronic conditions (diabetes, hypertension, etc.)
- Comprehensive care plan established, revised, implemented and monitored
- Includes time spent by clinical staff
  - Without direct physician supervision
  - General supervision if “incident to” met

CCM Overview 3

- Typically, CCM will include activities that not ordinarily furnished either F2F or covered by Medicare separately
  - Review of medical records
  - Test results review
  - Exchange of health information
  - Coordination of other practitioners
  - Telephone communications

CCM Updates/Changes

- Separate payments with codes describing CCM for patients with greater complexity
- 2017 has several changes to remove potential barriers and administrative burdens
  - To furnish and bill these important services
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html

F2F Visit Requirement Removal

- 2017 only requires one of these initiating visits for new patients or patient not seen within 1 year prior to starting CCM
  - AWV, IPPE or E/M
- Established patient can be set up via telephone or email
  - Removing F2F visit
- Previously, every patient needed prior visit

Patient Consent – Shared Info

- Prior patient consent - 2017 verbal accepted
  - Removing written requirement
  - Document patient's agreement in record
- Explanation of CCM service and availability
  - Offer CCM service to patient, document discussion and patient's accept/decline decision
  - Inform patient only one practitioner can furnish
  - Explain coinsurance/any unmet deductible applied
- No formal CMS form – create at office

2017 CCM Technology Relaxed

- Certified Electronic Health Record (EHR) technology “standards”
  - Access to electronic patient records, plan of care, medical, functional and psychosocial needs
  - Communicate with other treating professionals
  - No specific technology needed
- Requires “timely access” electronic sharing
  - Removed the 24/7 basis
- Fax approved to communicate care plan
  - Removes electronic care plan only requirement

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Eligible Beneficiaries

Eligible Population

- Beneficiaries with multiple (two or more) chronic conditions
  - List on next 2 slides
- Expected to last until patient death with beneficiary at
  - Significant risk of death
  - Acute exacerbation
  - Decompensation
  - Functional decline
- May cover approximately 2/3 of all Medicare beneficiaries per the CDC

Chronic Conditions

- Alzheimer's disease and related dementia
- Arthritis
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Chronic Obstructive Pulmonary Disease
- Chronic Kidney Disease (CKD)

Chronic Conditions* [2]

- Depression
- Diabetes
- Hepatitis
- High Cholesterol
- Hypertension
- Stroke
- http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions

*Not all inclusive list

Medicaid/Medigap Cost Share

- Medicare-Medicaid dual-eligible patients to have access to CCM
  - Over 11.4 million dually eligible
  - Check with your state Medicaid
- Medigap insurers providing standardized copayment plans
  - Agree to accept and cover copayment

Patients Outside of US

- CCM services not covered if provided to patients or by individuals located outside of United States
- Regulatory prohibition against payment for non-emergency Medicare services furnished outside of the United States
- Per 42 CFR 411.9

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Eligible Providers

Billing Provider

- Patients new to practice or physician hasn't seen within past 12 months", provider needs to see patient with one of these work:
  - Annual Wellness Visit (AWV)
  - Comprehensive E/M
  - Initial Preventive Physical Exam (IPPE)
- Visit will **not** count as initiating visit for CCM
  - If practitioner does not discuss CCM with patient at that visit and not well documented

Billing Practitioners Eligible

- Physician (MD/DO)
- Certified Nurse Midwife (CNM)
- Clinical Nurse Specialist (CNS)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Specialists (Neurology, Oncology, Urology, Cardiology, etc.)

Clinical Staff Eligible

- Eligible to contribute time only to monthly CCM, if “incident to”, state scope of license & licensure met
  - ACO physicians
  - Medical Assistants
  - Nurses
  - Pharmacists
  - Technicians
  - Therapists

Clinical Staff Eligible 2

- Pharmacists employed by physician/ASC may count (e.g. medication management)
  - Cannot bill direct for services
- Accountable Care Organization (ACO)
  - Not Medicare eligible to bill; however, employed physicians/NPPs may count time
- Community Health Workers
  - Physician employees may count time

Registered Nurses (RNs)

- RNs can **not** provide initial POC
  - May participate
  - Not initiate, update and modify plans
  - LPN/RN may document their services toward the monthly CCM
- Any clinician (e.g. RN, CMA, etc.) may count their “time” toward 20/60 minutes
  - Other than clerks or other non-medical staff

Case Management Companies

- Billing physician/NPP may arrange to have CCM services provided if clinical integration among care team
  - External clinical staff (e.g. case management company) if “incident to” met
- Note: This work cannot be delegated or subcontracted to any other individual outside of the US

Practitioners Not Eligible

- Cannot bill, but may refer/consult
  - Clinical Psychologist
  - Dentist
  - Podiatrist
- Their time counts toward monthly service
- Non clinical staff time does not count
  - Billers, coders, financial staff
  - Other administrative staff

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Scope of Service

Scope of Service

- Systematic assessment of health needs and receipt of preventive services
  - Assessment of medical, functional and psychosocial needs
  - Approach to ensure receipt of recommended preventive services
  - Medication reconciliation
  - Oversight of management of medication

Scope of Service 2

- Structured recording of
  - Demographics
  - Problems
  - Medications/medication allergies
  - Creation of structured clinical summary record, using certified electronic health records (EHR)

Comprehensive Care Plan

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom and medication management
- Planned interventions and identification of individuals responsible for each intervention
- Schedule periodic review and care plan revision
- Community/social services ordered
- Agency specialists/services (outside the practice) who will direct/coordinate

Managing Care Transitions

- Between health care providers/settings
  - Include referrals to other providers
  - Providing follow-up after emergency department visit
  - After discharge from hospitals, skilled nursing facilities (SNFs) or other health care facilities
- Important that other treating professionals know their time needed to aggregate CCM

Other Coordination Opportunities

- Coordination with home and community-based clinical service providers as appropriate
  - Communication to and from these providers
  - Methods are subject to HIPAA
- Enhance communication opportunities for patient and caregivers

Supervision

- Exception under “incident to” rule
  - Rather than direct supervision (physician must be in the clinic/office)
- Clinical staff under general supervision
  - Overall direction without physician presence

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CCM Billing

99490 = 20 minutes

- **99490** (global non-F2F service)
- Only one practitioner bills/allowed monthly
  - Reimburse approx. $40 - $50 monthly
  - POS = 11 (Office) 22 (Outpatient Practice)
    - No SNF or inpatient for Part B
  - 20 minutes or more; per 30 calendar days
  - Time aggregated/documented/collected from different clinicians by primary provider
  - NOS always 1 (no time maximum)
  - Deductible/Coinsurance apply

Complex CCMs Added

- **99487** (60 minutes/month)
- **99489** (additional 30 mins.)
  - 2017 added complex CCM CPT codes
  - ICD-10 Z71.89
- Complex/non-complex difference?
  - Moderate or high complexity medical decision making
  - At least 60 minutes of clinical staff care management to address medical, functional and psychological
- 60 minutes or less - at least 20 minutes monthly?
  - Bill CCM 99490 (20 minutes)

G0506 Add On Code

- **G0506** Comprehensive Assessment and Care Planning
- During initiating visit (AWV, IPPE & E/M), G0506 may be billed in addition
  - For beneficiaries requiring **extensive** face-to-face assessment and care planning (either face-to-face or non-face-to-face) by physician only
  - Not clinical staff
- Allows around $64

Other CPTs Not Covered

- "B" (bundled) – not separately covered
  - 99090/99091
  - Remote patient monitoring or analysis of patient-generated health data
  - As long as not only work performed, may count towards CCM

Date of Service

- When 20 or 60-minute threshold met, physician may **choose** that date of service
- No need to hold claim until month end
- Continue furnishing services during that month, even after time threshold met
- If patient passes away, bill date must be before date of death (if all criteria met)

Duplicate Monthly Services

- Medicare does not allow duplicate payment for similar services
- If paid in addition, must refund Medicare
- Not billed same month as
  - Transitional Care Management (TCM)
    - 99495 – 99496
  - End Stage Renal Disease (ESRD)
    - 90951 – 90970
  - Home Health Supervision (G0181)
  - Hospice Care Supervision (G0182)

SNF/Facility involvement

- Hospital Outpatient Prospective Payment Systems (OPPS)/Provider-Based (PBB)
- 99490 can **not** bill to Part B CMS-1500
  - Services provided to SNF inpatients or hospital inpatients in Part A covered stays
  - If facility paid under Part A for extensive care planning and care coordination
- If not inpatient entire month, may count

FQHC / RHC

- Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
  - CPT 99490 is ONLY payable in these settings
  - Complex CCM not payable
  - No add-on code separate payment
- Bill Part B per CR 9234 article
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9234.pdf

Payment Information

- Payment for CCM service
  - Separate under Medicare fee schedule
- Medicare Physician Fee Schedule (PFS)
- JF
  - https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/mpfs
- JE
  - https://med.noridianmedicare.com/web/jeb/fees-news/fee-schedules/mpfs

Documentation

- Clinical record includes:
  - Comprehensive care plan established, implemented, revised (when necessary) or significantly monitored
  - Care plan for each chronic condition with measurable goals
  - Signed and dated
- Beneficiary's prior permission documented
  - Beneficiary may terminate at any time
- Care plan needed every CCM month

Time "Counts" Example

- Time counts:
  - Pharmacist call POC office when patient reports a rash
  - Office calls the patient to coordinate care
- Time does **not** count:
  - Office runs a report on all patients due for a influenza vaccine or A1C check
  - In person visits (including group) separately billed (screenings, E/M, preventive, etc.)

If CCM Elements Not Met

- Cannot bill partial CCM
- Do not bill patient
- Advance Beneficiary Notice of Noncoverage (ABN) **not** appropriate

Talk to your Patients about CCM!

- CMS encourages our valued providers to reach out to those rural/underserved beneficiaries too!
- 2 out of 3 Medicare beneficiaries experience multiple chronic conditions
  - Eligible for CCM
- *Connected Care Campaign* national launch – only 1 Noridian state
  - Washington (Seattle) and Clallam County

Helpful Tips

- Health Care Professional Toolkit
  - How to get started and engage staff
  - Testimonials from other offices
  - http://go.cms.gov/ccm
- Patients can read more on Medicare.gov
  - https://www.medicare.gov/coverage/chronic-care-management-services.html

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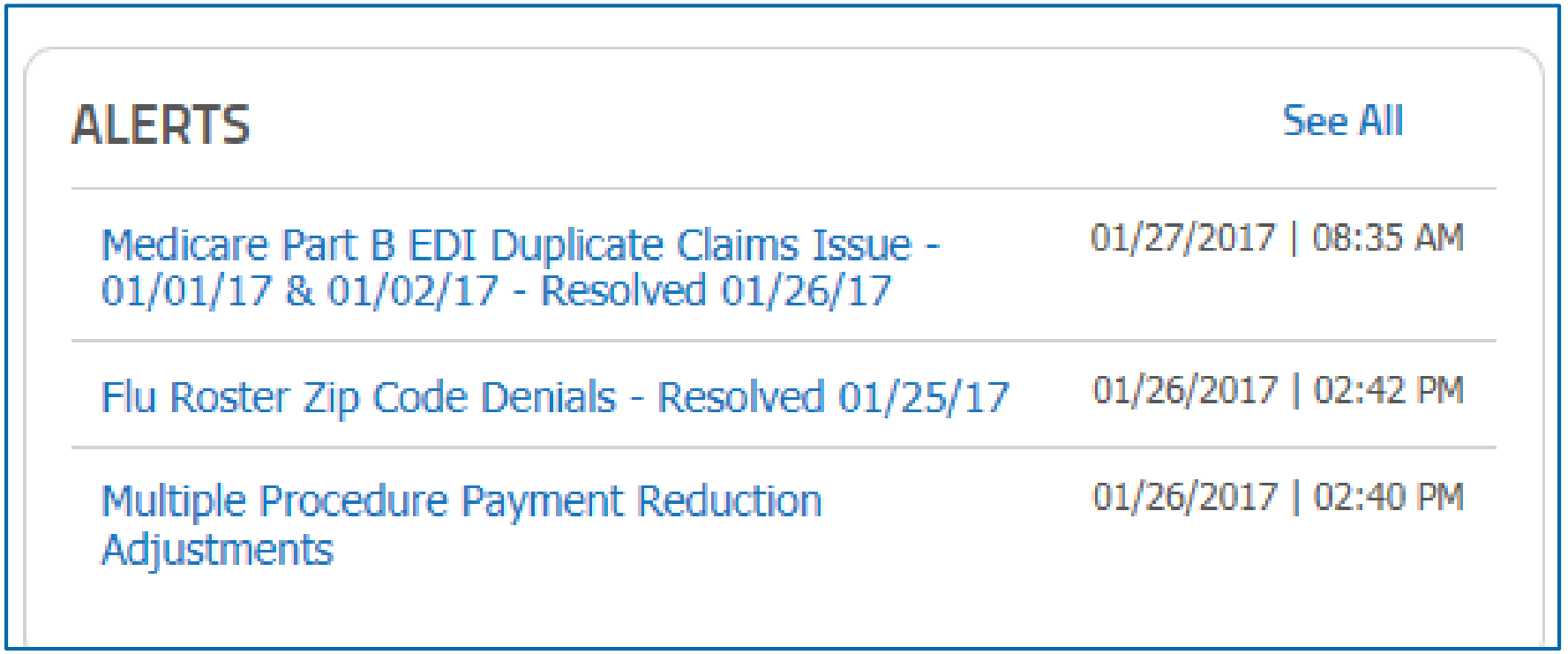
Noteworthy & Resources

General Reminders

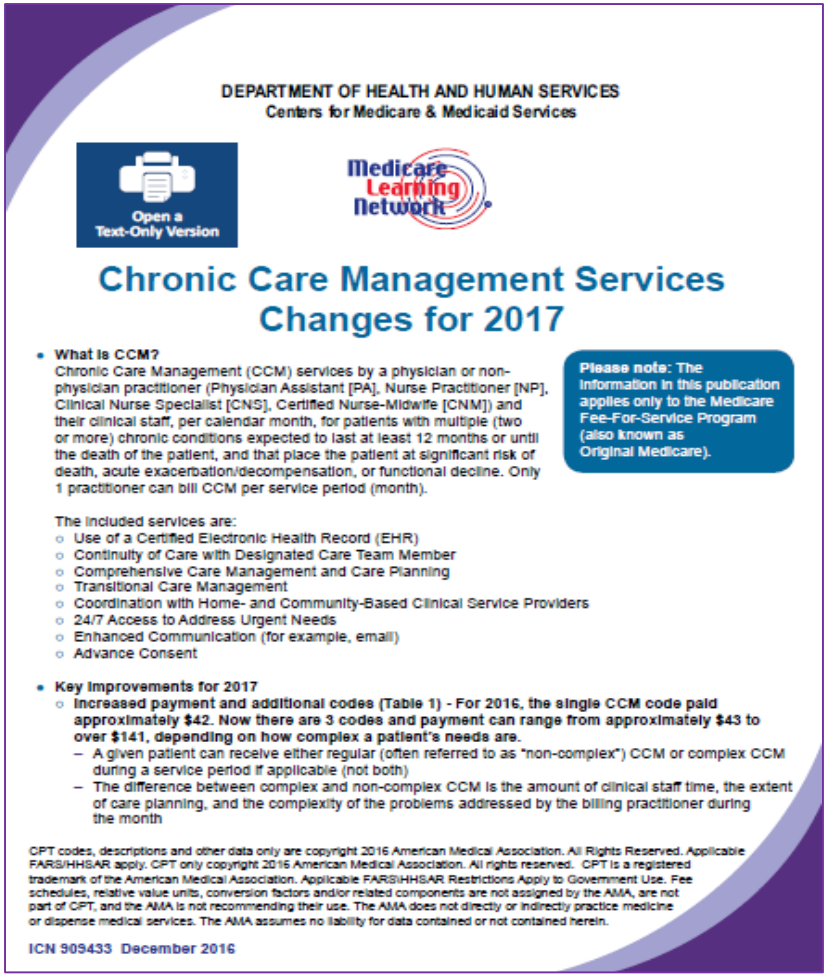
1. Checking for Enrollment Revalidation?
   - Noridian emails POC couple months before
2. Utilizing new Noridian Medicare Portal (NMP)? New feature-Reopenings!
3. Reading articles for 2017 Payment MACRA programs (MIPS/APM)?
   - Combined Quality Incentive Programs
   - PQRS, VM and EHR Reporting

Production Alerts – Home Page



CMS "CCM Changes" Fact Sheet

- December 2016
- 4 pages with updates
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf



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Chronic Care Management Services Changes for 2017

- **What is CCM?**
  Chronic Care Management (CCM) services by a physician or non-physician practitioner (Physician Assistant [PA], Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Certified Nurse-Midwife [CNM]) and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions 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. Only 1 practitioner can bill CCM per service period (month).

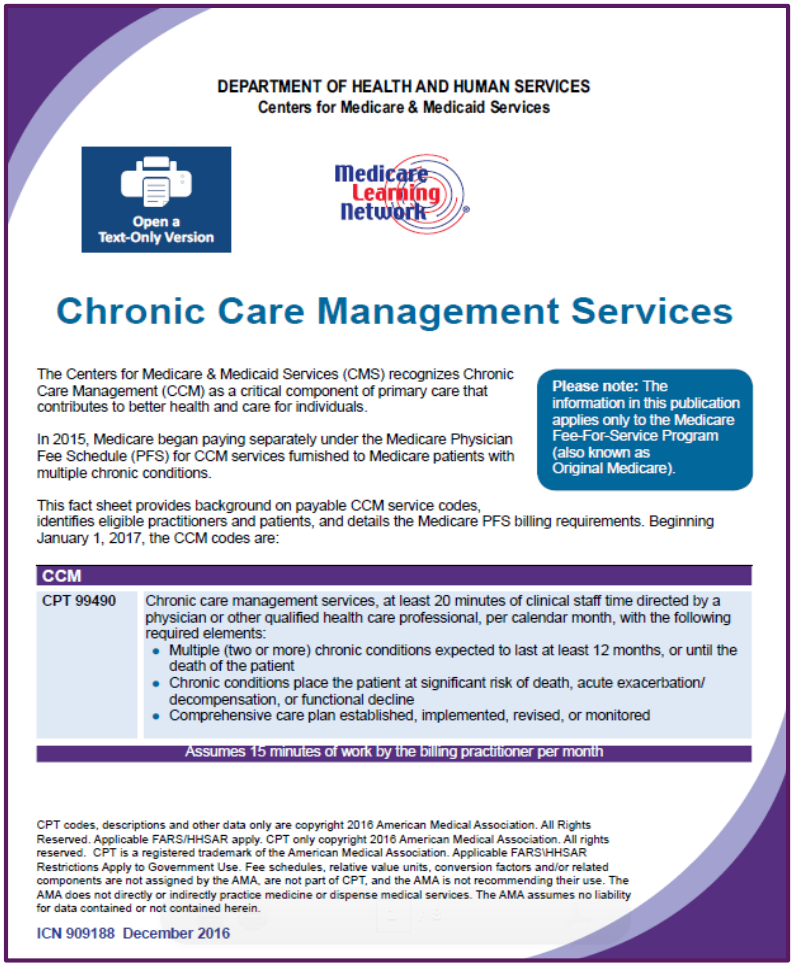
  Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

  The included services are:
  - Use of a Certified Electronic Health Record (EHR)
  - Continuity of Care with Designated Care Team Member
  - Comprehensive Care Management and Care Planning
  - Transitional Care Management
  - Coordination with Home- and Community-Based Clinical Service Providers
  - 24/7 Access to Address Urgent Needs
  - Enhanced Communication (for example, email)
  - Advance Consent

- **Key Improvements for 2017**
  - **Increased payment and additional codes (Table 1) - For 2016, the single CCM code paid approximately $42. Now there are 3 codes and payment can range from approximately $43 to over $141, depending on how complex a patient's needs are.**
    - A given patient can receive either regular (often referred to as "non-complex") CCM or complex CCM during a service period if applicable (not both)
    - The difference between complex and non-complex CCM is the amount of clinical staff time, the extent of care planning, and the complexity of the problems addressed by the billing practitioner during the month

ICN 905433 December 2016

CMS "CCM Services" Booklet



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Chronic Care Management Services

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.

In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This fact sheet provides background on payable CCM service codes, identifies eligible practitioners and patients, and details the Medicare PFS billing requirements. Beginning January 1, 2017, the CCM codes are:

CCM	
CPT 99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, 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

Assumes 15 minutes of work by the billing practitioner per month

ICN 909188 December 2016

- December 2016
- 8 pages with updates
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

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- PDF presentation emailed again with CEU
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Thank you!