noridian
Healthcare Solutions

Chronic Care Management (CCM) Services

Presented by Noridian Part B Medicare
Provider Outreach and Education
September 2017

DISCLAIMER

This information release is the property of Noridian Healthcare Solutions, LLC (Noridian). It may be freely distributed in its entirety but may not be modified, sold for profit or used in commercial documents.

The information is provided “as is” without any expressed or implied warranty. While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal advice.

All models, methodologies and guidelines are undergoing continuous improvement and modification by Noridian and the Centers for Medicare & Medicaid Services (CMS). The most current edition of the information contained in this release can be found on the Noridian website at http://www.med.noridianmedicare.com and the CMS website at http://www.cms.gov

The identification of an organization or product in this information does not imply any form of endorsement.

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
SNF	Skilled Nursing Facility

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

Agenda

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

noridian

Healthcare Solutions

CCM Overview & 2017 Updates/Changes

CCM Overview

- CMS recognized CCM contributes to better health and care while focused on patient
  - Started January 1, 2015; updated 2017
- 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)
- Need patient permission before starting
  - Responsible for coinsurance / unmet deductible

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

Why CCM Important?

- Patient benefits:
  - Dedicated team for better health
  - Receive a comprehensive plan
  - Provides support in-between visits
- Provider benefits:
  - Care coordination improvement
  - Patient compliance and connection
  - Grow the practice

F2F Beneficiary Visit 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

Beneficiary Consent – Shared Info

- Prior patient consent - 2017 verbal accepted
  - If patient was seen in last year
  - 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 own format
- Provide POC copy to patient or caregiver

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

noridian
Healthcare Solutions

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 U.S.

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

noridian
Healthcare Solutions

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:
  - 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)
  - Advance Registered Nurse Practitioner (ARNP)
- Physician Assistant (PA)
- Specialists (Neurology, Oncology, Urology, Cardiology, etc.)

Clinical Staff Eligible

- Eligible to contribute time only to monthly CCM, if “incident to”, state licensure met
  - Other Physicians
  - Licensed Clinical Social Workers (LCSW)
  - Medical Assistants (MA)
  - Registered Nurses (RN)
  - Pharmacists
  - Technicians
  - Therapists (PT, OT)

Clinical Staff Eligible 2

- Pharmacists employed by physician/ASC may count (e.g. medication management)
  - Cannot bill direct for services
  - Must be contracted/employed by physician
- 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, update and modify plans
  - LPN/RN may document services toward CCM
- Any clinician (e.g. RN, CMA, etc.) may count their "time" toward 20/60 minutes
  - Other than clerks or other non-medical staff
- Incident To "general supervision" rules:
  - Performed under physician overall direction
  - Physical presence is not required

Provider-Based Billing (PBB)

- Special Edition (SE) 1516
  - PBB outpatient department may bill under the hospital Outpatient Prospective Payment System (OPPS) at facility rate
- PBB status that complies with provision
  - Relationship between PBB entity, remote location of hospital, satellite facility, provider department and the main provider

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 U.S.

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

noridian
Healthcare Solutions

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 and assessments
- 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

Helpful Tips

- Provider 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
  - Monthly fee = coinsurance / unmet deductible

What Patients Read

CCM Connected Care Website:

- https://www.cms.gov/About-CMS/Agency-Information/_OMH/equity-initiatives/ccm/patient-resources.html

Chronic care management services include:

- At least 20 minutes a month of non F2F CCM services
- Personalized assistance from a dedicated health care professional who work with you to create a care plan
- Coordination of care between your pharmacy, specialists, testing centers, hospitals and more
- Timely access to a health care professional
- Expert assistance with meeting your health goals

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

noridian
Healthcare Solutions

CCM Billing/Documentation

Overview

- Only one practitioner bills/allowed monthly
  - POS = 11 (Office) 22 (Outpatient Practice)
    - No SNF or inpatient for Part B
  - **99490** (20 minutes or more)
  - Time aggregated/documented/collected from different clinicians by primary provider
    - Per 30 calendar days
  - NOS always 1 (no time maximum)
  - Deductible/Coinsurance apply

Complex CCMs Added

- **99487** (60 minutes/month)
- **99489** (additional 30 mins.)
  - 2017 added complex CCM
  - No particular diagnosis needed-use chronic dx
- Complex/non-complex difference?
  - Moderate/high complex medical decision making
  - At least 60 minutes of clinical staff
  - Addresses medical, functional and psychological
- Less than 60 minutes/month?
  - Bill 99490 (if at least 20 minutes/month)

Actual Time Spent?

- 99490:
  - Assumes at least 15 minutes of work
- 99487/99489:
  - Complex CCM services of less than 60 minutes, in a calendar month, **not** reported separately
  - Do not report 99489 less than 30 minutes additional to complex 99487
- Total minutes or start/stop time accepted
- Per CMS CCM Fact Sheet – Dec. 2016

Initiating Visit Add On Code

- **+G0506** Comprehensive Assessment and Care Planning (add-on code)
- If needing extra F2F time during initiating visit (AWV, IPPE or E/M)
  - Report once with CCM initiation
- For beneficiaries requiring extensive face-to-face assessment & care planning by physician only
  - Never clinical staff

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 (G0181) & Hospice Care (G0182)
  - Care Plan Oversight (CPO)
- Additional restrictions for participation in CMS sponsored model or demonstration programs
  - E.g., Comprehensive Primary Care (CPC) initiative

SNF/Facility involvement

- CCM can not bill to Part B CMS-1500
  - For some Hospital Outpatient Prospective Payment Systems (OPPS)/Provider-Based (PBB)
- Facility-setting patients may overlap with care management activities included Part A UB-04 payment
  - SNF/Hospital inpatient - Part A covered stays
- Part A allows facility for extensive care planning/care coordination
  - May significantly overlap with Part B CCM
  - If not inpatient entire month, may count towards Part B CCM

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

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

noridian
Healthcare Solutions

CERT Errors
Comprehensive Error Rate Testing

Documentation Needs

- 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

Comprehensive Error Rate Testing (CERT) Post Pay Review

- CERT Errors Identified for Insufficient CCM Documentation
  - Recent CERT reviews revealed errors regarding insufficient CCM documentation
- Visit Noridian's CCM webpage under E/M
- Last updated August 2017

CERT CCM Errors

- Insufficient Documentation:
  - Certified Electronic Health Record required to standardize formatting in medical record of core clinical information
    - Demographics, problems, medications, etc.
  - At least 20 or 60 minutes of CCM monthly
  - Time spent on CCM in beneficiary's chart

CERT CCM Errors 2

- Notes to establish need for CCM and supports beneficiary has 2 or more chronic conditions expected to last at least 12 months
  - Medical record to support CCM services
- Patient verbal/written consent documented
- Patient/caregiver provided copy of care plan

noridian
Healthcare Solutions

Noteworthy & Resources

Beneficiary Misc. Questions

- **Can a provider waive the coinsurance?** No. This would be an Anti-Kickback Statute violation on a routine basis. Only in cases of financial hardship may a provider waive any amounts. Any amount deducted from the patient's bill should also be deducted from the amount billed to Medicare.
- **Can CMS change the Part B cost-sharing requirement for the beneficiary?** Neither CMS or Noridian Medicare can change the cost requirements as these rules are legislated by Congress.

Demonstrations/Initiatives

- **Can I bill CCM services if I am participating in Medicare's Multi-Payer Advanced Primary Care Practice Demonstration (MAPCPD) or the Comprehensive Primary Care Initiative (CPCI)?**
- If providers participate in either MAPCPD or CPCI, you may not bill Medicare for CCM services furnished to any patient attributed to participating in one of these initiatives. However, you may bill Medicare for CCM services furnished to eligible patients who are not attributed to your practice as part of these initiatives.

Patient Phone Calls/Messages

- **Do telephone calls include calls to patients?**
- CCM includes activities that are not typically or ordinarily furnished face-to-face with the beneficiary and others; such as telephone communication, review of medical records, test results and coordination and exchange of health information with other practitioners and providers.

Patient Phone Calls/Messages 2

- **If we leave three (3) voicemail messages without reaching the patient, does that count for CCM? How about the clinical staff time in researching the patient's information, leaving messages and documentation of the attempt before the patient is reached (e.g. 9-10 mins.)?**
- No. It could only count toward CCM if the provider eventually reached the patient. The time spent by the staff researching and leaving messages would **not** be covered towards the 20 minutes.

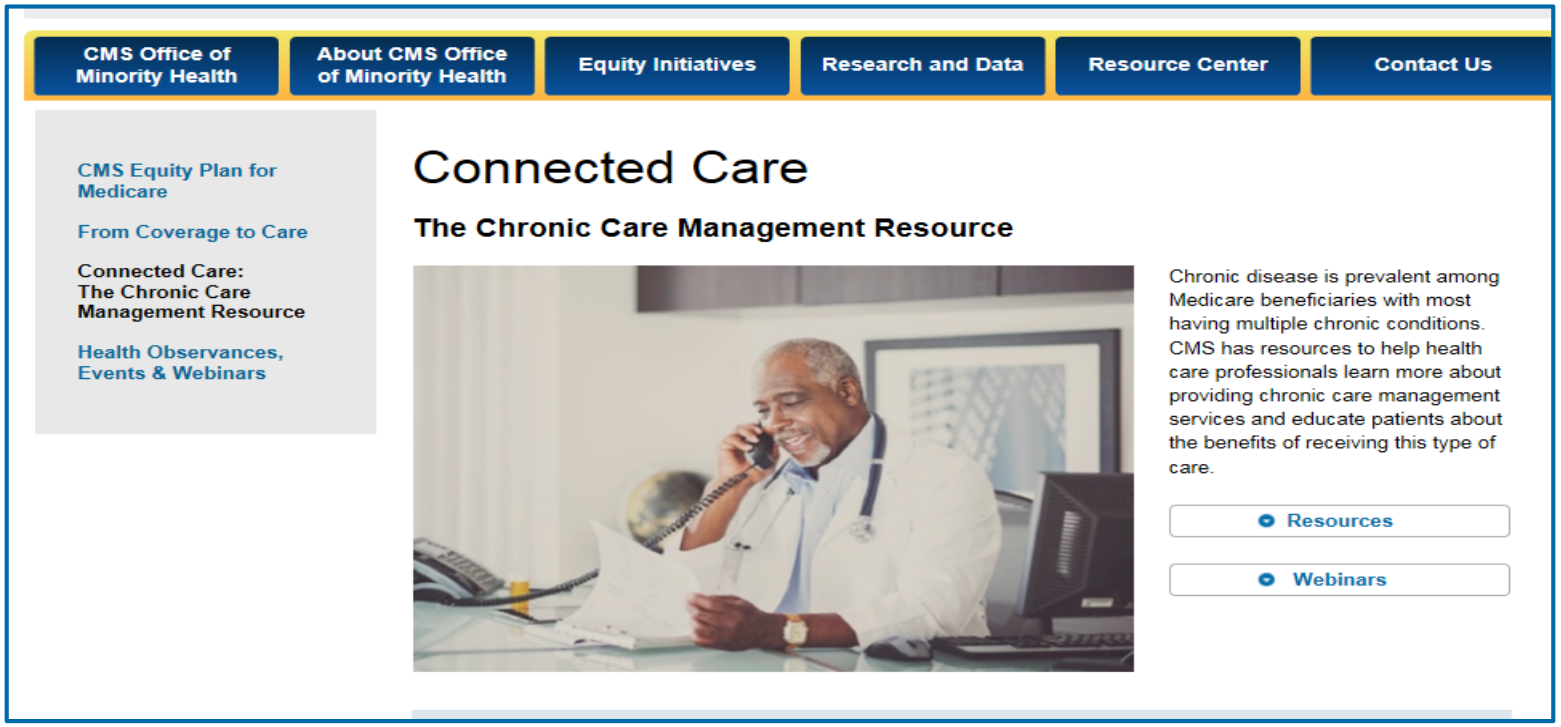
Production Alerts – Home Page

Noridian Medicare & CCM

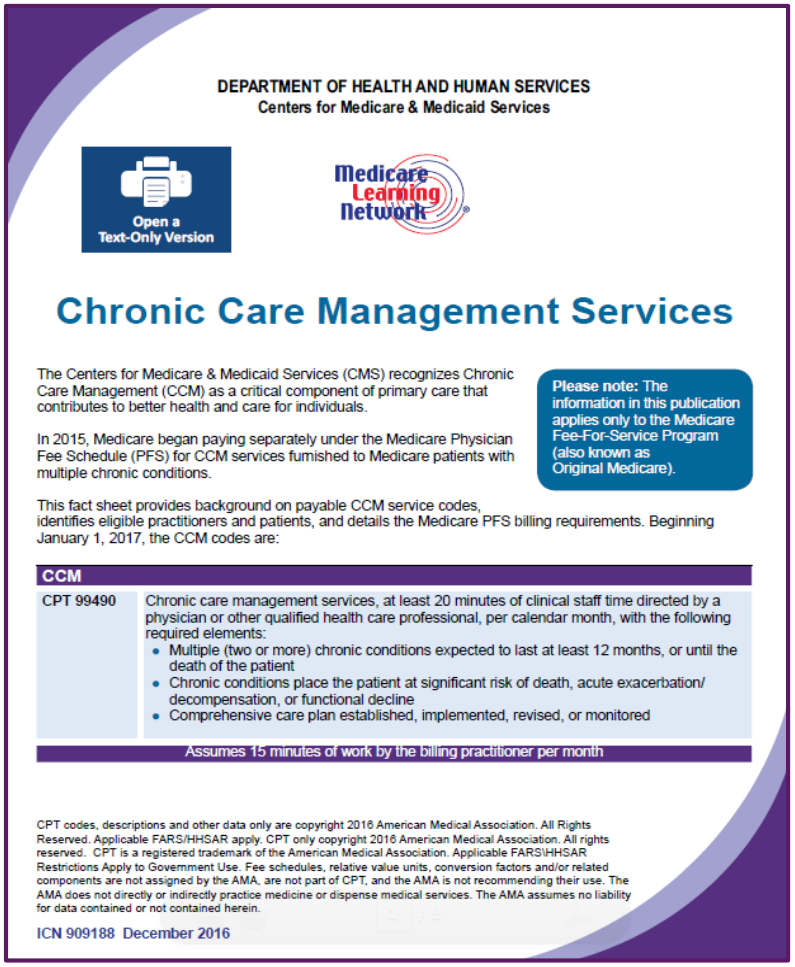
- Other valuable resources for CCM
  - Dedicated webpage - Browse by Topic
- **Moved under E/M – September 2017**
  - 3-part CCM series recordings
  - Webinars provided quarterly to all states
  - Involve state medical, specialty associations and QIOs to promote CCM
  - List serv provider emails frequently promoting Chronic Care Management (CCM)

CMS “Connected Care”

- https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/ chronic-care-management.html



CMS "CCM Services" Booklet



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Open a Text-Only Version

Medicare Learning Network

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

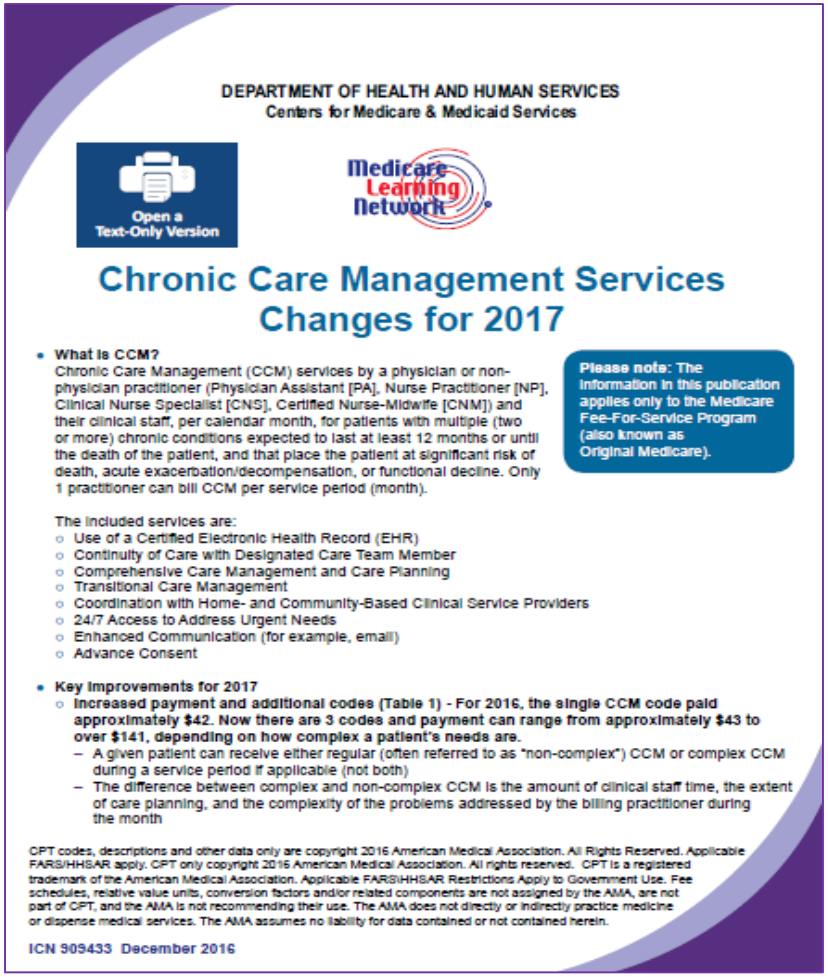
Assumes 15 minutes of work by the billing practitioner per month

ICN 909188 December 2016

- December 2016
  - Current Sep. 2017
- 8 pages
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

CCM 2017 Fact Sheet

- CMS MLN “CCM Changes” Fact Sheet
- December 2016
  - Current Sep 2017
- 4 pages
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Open a Text-Only Version

Medicare Learning Network

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

noridian
Healthcare Solutions

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Thank you!

Continuing Education Unit (CEU)

- Take short polling survey
  - Pops up **after** closing out of webinar
- CEU emailed 3 days after presentation
  - Earn **CEUs** today
  - No password/index number needed for AAPC
- PDF presentation emailed again with CEU
- Q/A posted 30 business days