CHRONIC CARE MANAGEMENT TOOL KIT
What Practices Need to Do to Implement and Bill CCM Codes

Understanding CCM

Chronic care management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) significant chronic conditions. In addition to office visits and other face-to-face encounters separately billed, these services include communication with the patient and other treating health professionals for care coordination (both electronically and by phone), medication management, and 24-hour accessibility to patients and any care providers (physicians or other clinical staff). The creation and revision of electronic care plans is also a key component of CCM.

- The designated CCM clinician (MD, PA, NP) must establish, implement, revise, or monitor and manage an electronic care plan that addresses the physical, mental, cognitive, psychosocial, functional, and environmental needs of the patient, as well as maintain an inventory of resources and supports that the patient needs. Thus, the practice must use a certified EHR to bill CCM codes.
- Only one clinician can bill for any particular patient; therefore, it may be necessary to coordinate with the subspecialists who may be providing a significant amount of care and treatment to one or more of the patient's conditions. It will be important that the patient understands only one of their likely multiple physicians will be able to bill for CCM services.

These codes are generally intended for use by the clinician who provides the majority of the care coordination services, which most often would be the internal medicine physician providing primary care. However, certain specialists may be able to provide the services needed to qualify to bill the CCM codes, *but never in the same month as the primary care physician*. If the internal medicine physician providing primary care services personally performs the clinical staff activities, their time may be counted toward the required clinical staff time to meet the code requirements.

Definitions:

- *Eligible professional (EP)* – The CCM codes can only be billed by a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant.

- *Chronic condition* – CPT states that patients must have "two or more chronic continuous or episodic health conditions that are 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." CMS did not provide guidance as to what diagnoses would meet this definition.
- *Comprehensive Care Plan* – This is a person-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with particular focus on the chronic conditions being managed). A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements: problem list; expected outcome and prognosis; measurable treatment goals; symptom management; planned interventions and identification of the individuals response for each intervention; medication management; community/social services ordered; a description of how services of agencies and specialists outside the practice are directed/coordinated; and a schedule for periodic review and, when applicable, revision of the care plan. This plan should also include assurance of care appropriate for the patient's choices and values.
- *Clinical staff* – Licensed clinical staff members (including APRN, PA, RN, LSCSW, LPN, clinical pharmacists, and "medical technical assistants" or CMAs) who are directly employed by the clinician (or the clinician's practice) or a contracted third party *and* whose CCM services are generally supervised by the clinician, whether provided during or after hours. The "incident to" rules do not necessarily require that the clinician be on the premises while providing direct supervision.
- *Contact-based care* – To count the time towards the 20-minutes of non-face-to-face time, the care must be "contact initiated." This could be patient-doctor, patient-nurse, doctor-doctor, pharmacy-doctor, lab-doctor, or other contact regarding or by the patient via phone or electronic communication. General planning time or care coordination does not count unless it is initiated based on a contact and/or results in a patient or patient-related contact. For example, if the pharmacist calls the office because the patient reported a rash, then the time spent may be counted. If the office spends time running a report of all participants due for a flu shot or an A1C check, then that time should not count. When an eligible professional calls and speaks to the patient to coordinate care, then that time may be counted. In-person visits, including group visits, do not count toward CCM codes.
- *Certified CCM technology* – CCM codes must be provided by a certified EHR.

CPT and HCPCS Codes:

- CPT code 99490 – CCM services; first 20 minutes of clinical staff time, per calendar month; 20-39 minutes
- CPT code 99487 – Complex CCM services; first 60 minutes of clinical staff time, per calendar month; 60-89 minutes
- CPT code 99489 – Complex CCM services; each additional 30 minutes of clinical staff time, per calendar month
- HCPCS code G0506 – Comprehensive assessment of and care planning for CCM

Billing:

- The practice must have the patient's written or oral consent in order to furnish or bill CCM services (*see* Attachment 2).
- Only one clinician can furnish and bill CCM services during a calendar month. The clinician who is providing the primary care to the patient is the one who can bill for CCM. CCM may be billed most frequently by the internal medicine physician providing primary care services, but other specialists may be serving as the patient's primary care physician, either permanently (such as OBGYN for women) or temporarily (such as an oncologist).
- Copayments (coinsurance and deductibles) *do* apply, unless performed at the same time as the Annual Wellness Visit.
- Complex CCM and prolonged E/M services cannot be reported the same calendar month by the same physician or practitioner. If other E/M or procedural services are provided, those services should be billed as appropriate. Please note, however, that this time *cannot* be counted toward the required 20 minutes for CCM services. If time, such as from a phone call, leads to an office visit resulting in an E/M services, then that time should be included in the billed office visit, not the CCM service time.

Patient Consent

Obtaining advance patient consent for CCM services ensures the patient is engaged and aware of applicable cost sharing. It may also help prevent duplicative physician and practitioner billing. A physician or practitioner must obtain patient consent *before* furnishing or billing CCM. Consent may be verbal or written but must be documented in the medical record, and includes informing them about the following:

- The availability of CCM services and applicable cost sharing
- That only one physician or practitioner can furnish and be paid for CCM services during a calendar month
- The right to stop CCM services at any time (effective at the end of the calendar month)

Informed patient consent need only be obtained once prior to furnishing CCM, or if the patient chooses to change the practitioner who will furnish and bill CCM.

Documentation:

- Document patient consent, if they declined to participate, or indicated participation elsewhere (and if so, with whom). Oral consent is acceptable until the next time the patient comes to the office, when they should sign the written consent (but it is not required). Documentation in the medical record should also include that the required information was explained.
- Document 20 minutes of non-face-to-face clinical staff time. Each practice will need to develop its own consistent system of documentation based on its unique physical, staffing, and EHR configuration. Consideration should include documentation of care provided by both internal and external (such as for call coverage) individuals, who and how care will be documented in the record, and how to

3

document time spent doing different aspects of care and care coordination. It is possible that there will not be a CCM code billed for every patient every month since some months may not generate the required 20 minutes of care coordination.

- If after hours care is provided by a clinician who is not part of the practice, such as for call coverage, that individual must have access to the electronic care plan (other than by fax). The care plan may be accessed via a secure portal, a hospital platform, a web-based care management application, a health information exchange, or an EHR to EHR interface.

- Services can be provided "incident to" the designated clinician if the CCM services are provided by licensed clinical staff employed by the clinician or practice who are under the general, not necessarily the direct, supervision of the designated clinician. The normal "incident to" documentation requirements apply, including that the furnishing of CCM services "incident to" is subject to applicable state law, licensure, and scope of practice.

- Contracted clinicians, such as covering clinicians or locum tenens, count so long as they provide the information in a timely manner, which can be done by electronic means including fax.

For more information, please see module 13 from ACP's Coding for Clinicians series, "Chronic and Transitional Care Management."

How to Implement CCM Codes

Step 1: Identify eligible patients.

- Use your EHR to search for patients that have two or more chronic conditions. Run reports sorted by physician. Each physician can then review their report and cross off anyone they do not think is a good fit for the CCM program.
- The patient must have two or more chronic conditions that have the following required elements:
  - Multiple (two or more) chronic conditions that are expected to last at least 12 months or until death; and
  - Those conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- Initially, you may wish to focus on a small number of specific diagnoses, such as diabetes, COPD, CVD, and/or A-fib. Create a log of participating CCM patients (*see* Attachment 1).

Step 2: Designate personnel for each identified patient – primary clinician, nurse, and/or other staff helping with enrollment, consents, and scheduling.

- Patient should be able to access "successive routine appointments" with the designated clinician.
- Other licensed clinical staff can provide services "incident to" the primary clinician, so long as the primary physician or provider is giving general supervision.

Step 3: Design a CCM process and schedule.

- Set up appointment codes for new visits and nurse assessment calls as needed.
- Create a CCM note in the EHR for the team to use to document their interactions, including time spent on non-face-to-face care coordination with the patients (usually this is in the Case Management section of the record).
- As enrollment increases, consider designating timeframes for clinician visits and nurse calls (new and subsequent).
- Assign CCM nurse(s) and staff to assist with enrollment, consents, scheduling, and other related CCM activities.
- Consider a dedicated phone line that would be answered by designated CCM staff and forwarded to an on-call clinician after hours.
- Run monthly reports that cross-reference patients enrolled in CCM who have had at least 20 minutes of discussion regarding CCM services. This will allow case managers to cross-check with case logs for any missed notes or interactions.

Step 4: Inform the patient.

- Invite patients to participate using an invitation letter and written consent to participate (*see* Attachment 2).

- o <u>Review the patient consent requirements in this toolkit</u>
  - o Explain how it works and that they can decline, transfer, or terminate at any time for any reason
  - o Provide information on how to terminate or transfer
  - o Explain authorization of electronic communication of medical information with other clinicians (as allowed by federal, state, and local rules and regulations)
  - o Provide the designated physician's name as well as the CCM nurse
  - o Explain the monthly scheduled nurse assessment visit, which should be treated like a regular visit, and explain that this visit may occur by phone
  - o Explain how and when the bill(s) will be generated and what the patient's obligations are for payment of coinsurance and deductibles
- Review participation agreement with patients and validate their understanding (in person or via phone).
- Record in the electronic chart that CCM was explained and written, or oral consent obtained to accept or decline services. This documentation should include from whom (name of clinician), describe the right to receive electronic care plan, and note the right to stop CCM services at any time for any reason

Step 5: Create and document a Comprehensive Care Plan.

- Care management for chronic conditions should include:
  - o A systematic assessment of the patient's medical, functional, and psychosocial needs;
  - o System-based approaches to ensure timely receipt of all recommended preventive care services;
  - o Medication reconciliation with review of adherence and potential interactions; and
  - o Oversight of beneficiary self-management of medications.
- Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports.
- As appropriate and permitted, share the Comprehensive Care Plan with other clinicians and providers.

Step 6: Provide the patient with the written or electronic copy of the Comprehensive Care Plan

- Using the patient portal is a low cost way to deliver the care plan, so encourage all participating patients (or their designated caregiver) to join and become familiar with use of the portal.

Step 7: Document the time spent (*see* "Documentation" on page 2)

- Set up a system that can keep track of time spent on non-face-to-face services provided, including:
  - o phone calls and email with the patient;
  - o time spent coordinating care (by phone or other electronic communication) with other clinicians, facilities, community resources, and caregivers; and
  - o time spent on prescription management/medication reconciliation.

6

Step 8: Termination from program (*see* Attachment 3)

- Document death, transfer of patient to another clinician, or termination from the CCM plan for any reason (e.g., non-payment of copays or patient wants another physician to be in charge of their CCM, such as the oncologist, cardiologist, rheumatologist, or another specialist that may apply to the more intensive chronic condition).

ATTACHMENT 3

Sample Welcome Letter and Visit Checklist

Dear Patient,

Congratulations on taking a step toward managing your health by participating in the
[name of practice   ] Chronic Care Management (CCM) program. CCM is a model of care designed to improve the coordination of your health care with an emphasis on your overall well-being.

We believe that to achieve this goal, there must be a **partnership** between the patient and their medical provider. By being actively involved in the decisions regarding your health, health care, and lifestyle, we can develop a stronger relationship with you.

BEFORE YOUR NEXT CCM NURSE ASSESSMENT CALL, PLEASE USE THIS HANDY CHECKLIST
- ☐ Make a list of any questions you have about your health, including questions about dietary recommendations and lifestyle.
- ☐ Inform the CCM nurse of any other health care providers that you have visited in the last month and the reason why you visited them. This includes urgent care or the ER.
- ☐ Have a list of all of your prescribed medications ready, including over-the counter, herbal, and dietary supplements. Inform the CCM nurse of any refills that you require.
- ☐ Inform the CCM nurse of any new problems that may have developed in the last month.
- ☐ Confirm the date of your next CCM nurse assessment call as well as the date of your next office visit with us.
- ☐ As a reminder, please use the dedicated phone number that was provided to you during your first CCM nurse assessment call so you can call us after hours if necessary. This provides you with 24/7 access to your physician or to the covering physician partner.
- ☐ Register for our patient portal. This is a good way to communicate with your doctor and CCM nurse, as well as to view your care plan.
- ☐ If you want to designate a caregiver to have access to your record, please ask our office for the necessary forms.

With continued partnership in the CCM program, we hope to optimize your health, increase your quality of life, and prevent hospitalization.

We look forward to continuing to serve you.

Sincerely,

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Sample Chronic Care Management End of Service Form

As of [insert last day of current calendar month], I have decided to terminate participation in the Chronic Care Management program. I understand that this termination will be effective at the end of the calendar month. I also understand that any services provided in the future regarding any of my conditions will have to be in-person and that I will no longer be charged for the Chronic Care Management services.

_____   _____
Patient Signature   Date