DOCTORSMANAGEMENT®

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CHRONIC CARE MANAGEMENT

An Information & Resource Guide

WHY
CHRONIC CARE MANAGEMENT?

Per CMS, chronic care management (CCM) contributes to better outcomes and higher patient satisfaction. CCM codes can be billed for services furnished to patients with two or more chronic conditions at significant risk of death, **acute exacerbation or decompensation, or functional decline**.

CCM is the care coordination that is outside of the regular office visit 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 or decompensation, or functional decline. It can be delivered to people with many different types of health conditions.

Medicare began paying for CCM services separately under the Physician Fee Schedule (PFS) in 2015. Practitioners may now bill for CCM for a calendar month when at least 20 minutes of nonface-to-face clinical staff time, directed by a physician or other qualified healthcare professional, is spent on care coordination for a Medicare patient with multiple chronic conditions. This time may be spent on activities to manage and coordinate care for eligible Medicare and dual-eligible beneficiaries who have.

CMS encourages organizations to implement CCM for their patients to improve patient care, but also to support your practice in the following ways:

- **Improve care coordination.** Chronic care management can help improve care coordination and health outcomes, and you will receive payment specifically in support of your provision of care using this approach for a patient when you provide a minimum of 20 minutes of CCM services in a month.
- **Support patient compliance and help patients feel more connected.** Some healthcare professionals have reported that making CCM services available to their patients has helped improve their efficiency, patient satisfaction, and compliance, decreasing hospitalization and emergency department visits.
- **Sustain and grow your practice.** Ongoing care management outside the in-person visit has not always been separately billable in payment, making it difficult for practices to sustain service provision. Offering care management activities, CCM can provide you with additional resources to help your practice care for high-risk, high-needs patients.

REPORTING
CHRONIC CARE MANAGEMENT (CCM)

01

Confirming Eligibility

This is a Medicare-covered benefit, and may not be covered by commercial carriers as a primary benefit. Medicare deems a patient eligible if they have 2+ chronic conditions. Obviously, the providers must be enrolled and eligible and using EHR technology per CMS Interoperability specifications.

1. Appropriate staff and patients require 24/7 access to EHR/EMR
2. Practitioners must be accessible to discuss "urgent" needs 24/7
3. Secure messaging with patients (email is allowed if compliant)

02

Initiating Visit

Billed in conjunction with an E/M, however, the service must also be performed. G0506: Comprehensive assessment of and care planning for patients requiring chronic care management services

03

Documenting CCM Services

An entry for each episode or communication with the patient should be noted in the medical record. Please review the detailed expectations of the items that should be included for CCM elements to be met. Time is NOT the only criterion.

04

Reporting CCM Services

The appropriate coding and supervision requirements for CCM services

INITIATING CHRONIC CARE **MANAGEMENT VISIT G0506**

Before CCM services can start, an initial visit for new patients or patients the billing practitioner hasn't seen within one year is required.

During this visit, written or verbal consent for CCM services will need to be obtained to proceed with care on future dates of services.

According to CMS, the documentation of this encounter must also include that the patient has been advised/educated on the following:

- What CCM services are and their access and availability to CCM services
- Possible cost-sharing responsibilities (20% if no co-insurance)
- Ask if other provider offices are calling to check their overall health and well-being. Further, define that only one practitioner can furnish and bill CCM services during a calendar month, which is why you are asking.
- The patient always has a right to stop CCM services at any time (effective at the end of the calendar month)

Patients must provide informed consent only once unless they switch to a different CCM practitioner.

As part of the initiating visit, a Comprehensive Care Plan must be established for CCM and accessible by all staff 24/7. Furthermore, patients and their caregivers are required to have a way to contact health care practitioners in the practice to discuss "urgent needs" no matter the time of day or day of the week.

Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but isn't limited to:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers
- Requirements for periodic review
- When applicable, revision of the care plan

CCM **DOCUMENTATION**

1. Addressing the Management

Assess the patient's fundamental status in 3 areas: Medical | Functional | Psychosocial
Review medications and notate any changes or potential interactions. Query the patient regarding their own continued safety in self-management of medication. Although allowed by specialists, the rules for CCM are tailor-made for primary care and therefore identifying needs for preventive services and coordinating care for home/community-based clinical services should be mentioned to the patient. Remind the patient that CMS provides these resources and that more information can be provided.

2. Coordination of Care

The ultimate goal of CCM is monitoring the patient's chronic condition with the active goal of preventing exacerbation or furtherance of the disease process. For this reason, part of CCM is identifying other related encounters since the last patient interaction and creating appropriate document exchanges with these practitioners or organizations to ensure better patient management.

This might also include home/community-based care based on the patient's psychosocial and functional needs

3. Care Plan

Revise and monitor and as needed the patient care plan. While clinical staff would not be modifying the care plan, they could be identifying the need for further patient evaluation for physician/non-physician qualified provider review for care plan re-evaluation. These comments should be documented as part of the CCM service.

CCM **REPORTING**

CPT Code	Provider	Description
+G0506	MD, DO, NP, PA	Comprehensive assessment of and care planning by the physician or other qualified health care practitioner for patients requiring CCM services (Add-on code, list separately in addition to primary service)
99490	Clinical Staff	Chronic care management services 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; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99439	Clinical Staff	Chronic care management services, **each additional 20 minutes** of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99491	MD, DO, NP, PA	Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of physician or other qualified healthcare professional time, 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

YOUR LOGO

Chronic Care Management Patient Agreement

Client Information and Consent

Name			
DOB		**Phone**	
Address			
City		**Zip**	
State		**Email**	

PLEASE REVIEW THE FOLLOWING:		**Yes**	**No**
1.	Medicare is offering a new benefit for beneficiaries with multiple chronic conditions, by assignment I agree and consent to these services	◯	◯
2.	You consent to receiving CCM services at **ORGANIZATION NAME,** and you certify that these services were explained to you	◯	◯
3.	You acknowledge that only one practitioner can furnish and be paid for CCM services during a calendar month.	◯	◯
4.	You understand that CCM services are subject to Medicare Co-Insurance, and so you may be billed for a portion of the CCM services	◯	◯
5.	You understand you have the right to terminate CCM services by revoking this agreement effective at the end of the then-current month	◯	◯

You may revoke this agreement verbally by notifying our office by telephone at (XXX) XXX-XXXX or by mailing your written revocation form to Mailing Address, City, State Zip

Your provider will then give you written confirmation, including the effective date of revocation.

◯ **I agree and consent to this service**

Beneficiary/Responsible Party Signature: _____

Print Name: _____ Date: _____

YOUR LOGO

CCM PATIENT JOURNAL

MONTH: ______

Patient: ______ DOB: ______ MRN: ______

Managing Provider: ______

Phone # ______ Preferred Contact Method: ◯ Audio Call ◯ Video Call ◯ Messaging

Date: ______

Time Spent: ______

MD Action Needed: ◯ Yes ◯ No

Provided By: ______

Service Details:

Interaction Type:

◯ Phone/Audio Only ◯ Text Messaging

◯ Work related to patient care ◯ Video Interaction

Date: ______

Time Spent: ______

MD Action Needed: ◯ Yes ◯ No

Provided By: ______

Service Details:

Interaction Type:

◯ Phone/Audio Only ◯ Text Messaging

◯ Work related to patient care ◯ Video Interaction

Date: ______

Time Spent: ______

MD Action Needed: ◯ Yes ◯ No

Provided By: ______

Service Details:

Interaction Type:

◯ Phone/Audio Only ◯ Text Messaging

◯ Work related to patient care ◯ Video Interaction

Date: ______

Time Spent: ______

MD Action Needed: ◯ Yes ◯ No

Provided By: ______

Service Details:

Interaction Type:

◯ Phone/Audio Only ◯ Text Messaging

◯ Work related to patient care ◯ Video Interaction

◯ CCM Services billed on: ______ By: ______

Provider Comments:

These interactions have been reviewed by: ______

NATIONAL ALLIANCE OF MEDICAL AUDITING SPECIALISTS

CHRONIC CARE MANAGEMENT

Chronic Care Management (CCM) services are reimbursed in addition to E/M reimbursement, to those providers who care for patients with multiple chronic conditions.

Patient Eligibility
Medicare Part B patients with two or more chronic conditions expected to last at least 12 months (or until the patient's death) that place the patient at significant risk of death, acute exacerbation and/or decompensation, or functional decline.

Patient Consent
Obtain patient consent for CCM. Use a consent form and/or include verbal consent in the documentation of the Initiating Visit. Consent must indicate the patient was educated on CCM services and applicable cost sharing, only one provider may render and bill for CCM services each month, and that the patient has the right to terminate CCM services at any time.

Provider Eligibility
Only one provider/organization is paid per month for CCM. Eligible providers include: Physicians, Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, Certified Nurse Midwives, Rural Health Clinics, Federally Qualified Health Centers, and Hospitals, including Critical Access Hospitals.

Physician Specialty
CMS expectation is CCM would be used by the acting primary care practitioners, which may even include a specialist.
Note: CCM is not billable by clinical psychologists, podiatrists, or dentist.

Supervision
Monthly service work can be performed by Clinical Staff. General supervision is requires, which requires physician oversight, but does not require their physical presence while the services is furnished.

Other Requirements

24/7 Access to Care
Comprehensive Care Mangement
Create & Maintain Care Plan
Care Transition Management
Coordinate Home-Community Care
Enhanced Communication
Electronic Capture of Patient Progress and Use

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Initiating Visit

New patients as well as those patients not seen within one year of the first CCM service, require a CCM Care Plan that may be billed with G0506. This visit is an add-on service and may be separately billed with an E/M service, Medicare Annual Wellness Visit (AWV) or Initial Preventive Physical Exam (IPPE) provided the visit is face-to-face visit with the provider who will bill for CCM.

Required Activities of the G0506:	
Obtain Patient Consent	Medication Management
Current Problem List	Environmental Evaluation
Expected Outcome and Prognosis	Caregiver Assessment
Measurable Treatment Goals	Interaction and Coordination of Care
Cognitive and Functional Assessment	Requirements for Periodic Review
Planned Interventions for Care Plan	Revised Care Plan, as Needed
Symptom Management Through Care Plan	

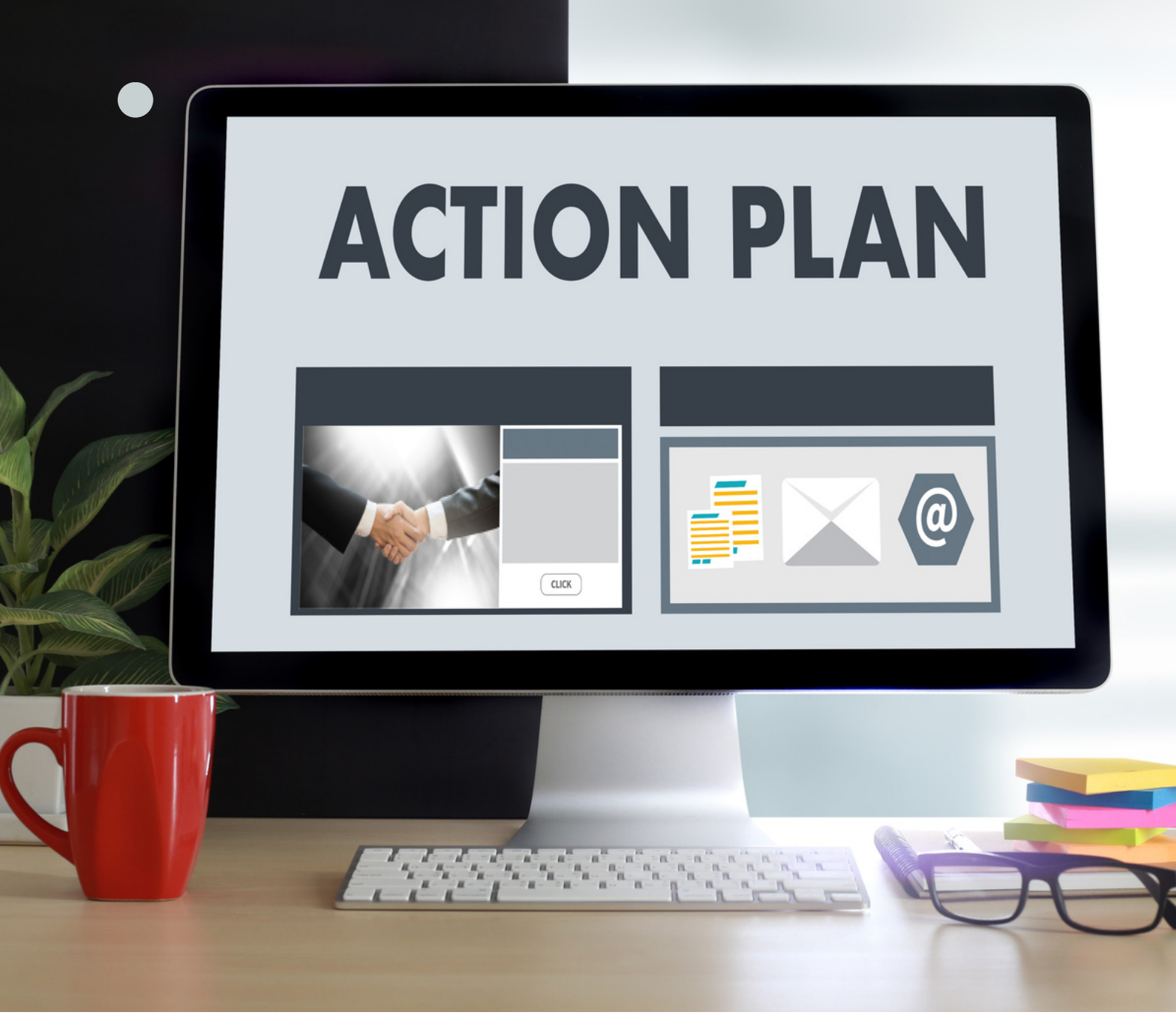
Monthly CCM Service Requirements

The purpose of CCM is to minimize the potential of hospitalization and further exacerbation of the chronic problems. The monthly services support this initiative by following the patient throughout the month to assist in meeting the Care Plan objectives..

CPT CODE	Time	Provider Type
99490	20 minutes	Clinical Staff
(+) 99439	Each additional 20 minutes	Clinical Staff
99491	30 minutes	Physician or Non-physician Qualified Provider
(+) 99437	Each additional 30 minutes	Physician or Non-physician Qualified Provider

Approved CCM Activities:

Face-to-Face	Non-Face-to-Face
Providing Records to Other Care Providers	Telephone Communication
Managing Care Transitions	Review of Medical Records and Test Results
Coordinating Home and Community-Based Services	Self-Management Education and Support
Coordination of Care with Other Unique Providers	Coordination of Care with Other Unique Providers



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RESOURCES:
LINKS & INFORMATION

CMS CCM Toolkit:
https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/connected-hcptoolkit.pdf

CMS CCM MLN:
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

Coding Resource Lookup:
Optum Encoder Pro