FREQUENTLY ASKED QUESTIONS: MEDICARE’S CHRONIC CARE MANAGEMENT (CCM) SERVICES

Patient eligibility

Q: Who is eligible to receive CCM services under Medicare?
A: According to the Centers for Medicare & Medicaid Services (CMS), CCM is for “patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.”

Q: Does CMS have a specified list of chronic conditions that meet this definition?
A: No, CMS has not specified or otherwise limited the eligible chronic conditions that meet this definition.

Q: Will CCM codes be available to “dual eligible” patients (i.e., Medicare beneficiaries who are also eligible for Medicaid)?
A: Yes.

Q: Must a patient have received a Medicare annual wellness visit (AWV) in the past 12 months for a provider to be able to bill separately for CCM services?
A: No. While CMS proposed to make this a requirement at one point, it now simply recommends, but does not require, a provider to furnish an AWV or initial preventive physical examination (IPPE, also known as a “Welcome to Medicare” visit) to a patient before billing for CCM services furnished to that same patient.

Scope of services

Q: How does CMS define the scope of CCM services?
A: CMS has established eight elements that it uses to define the current scope of CCM services:

1. Access to care management services 24-hours-a-day, 7-days-a-week, which means providing patients with a means to make timely contact with health care providers in the practice to address the patient’s urgent chronic care needs regardless of the time of day or day of the week.

2. Continuity of care with a designated provider or member of the care team with whom the patient is able to get successive routine appointments.

3. Care management for chronic conditions including:
   - Systematic assessment of patient’s medical, functional, and psychosocial needs,
   - System-based approaches to ensure timely receipt of all recommended preventive care services,
   - Medication reconciliation with review of adherence and potential interactions,
   - Oversight of patient self-management of medications.

4. Creation of a patient-centered care plan document to assure that care is provided in a way that is congruent with patient choices and values. A plan of care is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues.

5. Management of care transitions between and among health care providers and settings, including the following:
   - Referrals to other clinicians,
   - Follow-up after a patient visit to an emergency department,
   - Follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities.

6. Coordination with home and community based clinical service providers as appropriate to support a patient’s psychosocial needs and functional deficits.

7. Enhanced opportunities for a patient and any relevant caregiver to communicate with the provider regarding the patient’s care through not only telephone access but also the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

8. Use of certified electronic health record (EHR) or other health information technology or health information exchange platform that includes an electronic care plan accessible to all providers within the practice, including those who are furnishing care outside of normal business hours, and can be shared electronically with care team members outside of the practice.

Q: What does CMS expect the plan of care to include?
A: The plan of care should typically include, but is not limited to, the following elements:
   - Problem list,
   - Expected outcome and prognosis,
   - Measurable treatment goals,
   - Symptom management,
   - Planned interventions,
   - Medication management,
   - Community/social services ordered,
   - How the services of agencies and specialists not connected to the practice will be directed/coordinated,
   - The individuals responsible for each intervention,
   - Requirements for periodic review and, when applicable, revision of the care plan.
Additionally, CMS expects the provider to reflect a full list of problems, medications, and medication allergies in the EHR to inform the care plan, care coordination, and ongoing clinical care.

Q: Do I have to provide the patient with a copy of the care plan?
A: Yes. CMS requires you to provide the patient with a written or electronic copy of the care plan and to document in the EHR that the care plan was provided to the patient.

Q: What does CMS expect with respect to management of care transitions?
A: The practice must be able to communicate relevant patient information through electronic exchange of a summary care record with other health care providers regarding these transitions. The practice must also have qualified personnel who are available to deliver transitional care services to a patient in a timely way so as to reduce the need for repeat visits to emergency departments and readmissions to hospitals and skilled nursing facilities.

Q: Are patients required to use secure messaging, Internet, or other asynchronous, non-face-to-face consultation methods?
A: No. While CMS expects practices to provide these communication options, it does not require the practice to ensure that every patient and caregiver makes use of these options.

Q: Is 24/7 access to care management defined as a phone call? Would 24/7 access for “urgent chronic care needs” by a patient portal be acceptable under the guidelines?
A: Regarding 24/7 access to care management, CMS states, “To accomplish this, the patient must be provided with a means to make timely contact with health care providers in the practice to address the patient’s urgent chronic care needs regardless of the time of day or day of the week.” Elsewhere, CMS states that the scope of CCM services includes “Enhanced opportunities for the beneficiary and any relevant caregiver to communicate with the practitioner regarding the beneficiary’s care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.” Based on this information, 24/7 access is not necessarily defined as a phone call.

Q: If I am reading this right, we are not being asked to be available for “urgent acute care needs” but “urgent” issues regarding their chronic care conditions. Does Medicare define how quickly the provider must respond to the patient’s urgent care needs?
A: As noted, CMS states, “To accomplish this, the patient must be provided with a means to make timely contact with health care providers in the practice to address the patient’s urgent chronic care needs regardless of the time of day or day of the week.” (Emphasis added) Thus, this access is related to “urgent chronic care needs.” Medicare does not define “timely” in this context.

Q: Does my EHR have to be certified?
A: Yes. You must use an EHR that meets the National Coordinator for Health Information Technology’s certification criteria for the prior year. For 2015, providers furnishing CCM services are allowed to use an EHR certified to either the 2011 or 2014 certification criteria.

Q: Does doing prior authorizations for medications and tests over the phone or ordering them electronically satisfy the Chronic Care Management (CCM) scope of service?
A: The CCM scope of service includes “medication reconciliation with review of adherence and potential interactions” as well as “oversight of patient self-management of medications.” It is debatable whether time spent on the phone doing prior authorization for medications and tests or time sending in such prior authorization electronically would count for this purpose. At this point, it is probably safer not to count time spent on prior authorizations as CCM time, although CMS has not explicitly addressed the question.

Q: Can only the physician create the care plan, or can the physician delegate it to other clinical staff? Also, can a mid-level provider, such as a nurse practitioner or physician assistant, acknowledge/sign the care plan?
A: In the final rule on the 2015 Medicare physician fee schedule, in its discussion of the scope of the CCM service, CMS states, “In consultation with the patient, any caregiver, and other key practitioners treating the patient, the practitioner furnishing CCM services must create a patient-centered care plan document to assure that care is provided in a way that is congruent with patient choices and values.” I interpret this to mean that the physician or non-physician practitioner who is nominally furnishing CCM services and, presumably, under whose provider number the services will be billed is responsible for creating the care plan. Also, CMS uses the word “practitioner” rather than “physician,” so I believe that a mid-level provider, such as a nurse practitioner or physician assistant, could acknowledge/sign the care plan if he or she created it.

Coding and billing

Q: What code should I use to report CCM services?
A: You should use code 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.”
Q: Must you complete a patient-centered care plan before doing any charges?
A: The scope of service for CCM includes creation of a patient-centered care plan. CMS also requires that you provide a copy of that care plan to the patient. I believe CMS expects both of those things to be done before you report 99490 the first time.

Q: When billing 99490, do we use the diagnosis codes for the two chronic care conditions we are using?
A: CMS has not specified what diagnosis codes should be reported with code 99490. Absent guidance to the contrary, it seems reasonable to report at least the two primary chronic care conditions for which you are providing 99490.

Q: How many work relative value units (RVUs) are assigned to the CCM code?
A: The 2015 Medicare physician fee schedule assigns 0.61 work RVUs to code 99490.

Q: If my staff spends 10 minutes or more, can I round up and bill the service?
A: No. The 20 minutes is a minimum threshold.

Q: Is there an option to charge more if you spend a lot more than 20 minutes?
A: There is no current mechanism to charge Medicare more if you spend longer than 20 minutes. CPT has complex chronic care management codes that would facilitate that, and the AAFP encouraged CMS to use those codes for just this reason. However, for 2015, CMS is only recognizing and paying 99490, which is open-ended in terms of the time involved.

Q: If two staff are providing CCM services simultaneously to a patient (e.g., in a team meeting related to the patient’s care), can I count the time of both staff toward the 20 minutes?
A: No. You can count the time of only one clinical staff member for a particular segment of time. So, in your example, you would count 10 minutes, not 20 minutes.

Q: If we don’t do 20 minutes of CCM in a month, but our work over two or three months adds up to 20 minutes, can we bill at that time for a month?
A: No. Code 99490 is for 20 minutes “per calendar month.” You cannot add time up over multiple months to report 99490.

Q: How must my staff and I document this service?
A: CMS has not specified any documentation requirements for this service. Family Practice Management offers a tool for tracking time spent on CCM services.

Q: What do we use for a date of service?
A: CMS has not addressed this particular question. Code 99490 is intended to encompass a calendar month’s worth of work. Box 24 on the CMS-1500 claim form does permit a “from” and “to” date, so I would consider putting the first day of the month as the “from” date and the last day of the month as the “to” date for 99490 as a line item. (I presume electronic claims would also support this approach.) Because code 99490 does encompass the entire calendar month, I would refrain from billing it until the last day of the month, in much the same way that CMS expects providers to wait until the end of the 30-day period to report transitional care management (TCM) codes.

Q: Can I bill CCM in the same month in which I see and treat a patient?
A: I am not aware of anything that would prohibit you from reporting 99490 in the same calendar month during which you saw the patient and reported an appropriate evaluation and management code for that encounter. The only codes of which I am aware that CMS has stated you cannot bill in addition to CCM services for a patient during the same time period are TCM services (99495 or 99496), home health care supervision (G0181), hospice care supervision (G0182), or certain end-stage renal disease services (90951-90970).

Q: How much does Medicare allow for this service?
A: The Medicare allowance will vary geographically. However, the geographically unadjusted amount is approximately $42 per month.

Q: Are CCM services subject to Medicare’s deductible and coinsurance?
A: Yes.

Q: 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)?
A: If you participate in either MAPCPD or CPCI, you may not bill Medicare for CCM services furnished to any patient attributed to your practice for purposes of 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.

Q: Can CCM services related to medication management be delivered by a clinical pharmacist embedded in the clinic? If yes, would billing still be under the supervising physician or mid-level provider, or can the clinical pharmacist bill directly for the CCM service?
A: CMS has acknowledged that the services of pharmacists may be billed “incident to” those of a physician or other qualified health care professional, such as a nurse practitioner or physician assistant, as long as all of the “incident to” requirements are otherwise met. Thus, a clinical pharmacist could be counted among the clinical staff able to provide CCM services “incident to” the services of the physician or mid-level provider under whose provider number the services will otherwise be billed to Medicare. I do not believe that Medicare recognizes clinical pharmacists as providers for purposes of billing Medicare directly under Medicare Part B or the physician fee schedule.
Q: Can the case manager of a Medicare Shared Savings Program accountable care organization (MSSP ACO) who works under the physician’s direction be counted for doing work outside of the office?
A: If the MSSP ACO case manager is a clinical staff person and the work that he or she does otherwise meets Medicare’s “incident to” rules relative to the physician who will be reporting 99490 (understanding that, for CCM, CMS allows “incident to” services to be provided under general, rather than direct, supervision), then his or her time may be counted toward the 20 minutes necessary to report code 99490, where appropriate.

Q: Can Medicare shared savings plans (i.e., Medicare accountable care organizations) bill for this service?
A: CMS has not excluded these plans from billing this service.

Q: May I bill Medicare for CCM and transitional care management (TCM) services provided to the same beneficiary during the same time period?
A: No. You cannot bill CCM services for a patient during the same 30-day period in which you are otherwise billing Medicare for TCM services (99495 or 99496), home health care supervision (G0181), hospice care supervision (G0182), or certain end-stage renal disease services (90951-90970).

Q: Can I bill CCM services for patients in a facility setting?
A: No. CMS believes the resources required to provide care management services to patients residing in facility settings significantly overlap with care management activities by facility staff that are included in the associated facility payment.

Q: How is “facility” defined?
A: In the final rule on the 2014 Medicare physician fee schedule, CMS stated, “The resources required to provide care management services to patients residing in facility settings significantly overlap with care management activities by facility staff that is included in the associated facility payment.” CMS did not define “facility” beyond that. I interpret facility in this context to be any health care entity (e.g., hospital, skilled nursing facility, etc.) that receives a facility payment from Medicare.

Q: Can you bill CCM for patients in an assisted living facility?
A: CMS has stated in the final rule that physicians cannot bill CCM services for patients in a facility setting. CMS said, “The resources required to provide care management services to patients residing in facility settings significantly overlaps with care management activities by facility staff that is included in the associated facility payment.” CMS did not define “facility” beyond that. I interpret “facility” in this context to be any health care entity (e.g., hospital, skilled nursing facility, etc.) that receives a facility payment from Medicare. If an assisted living facility is receiving Medicare facility payments for a given patient residing in that facility, I do not believe that you can report CCM for that patient.

Q: Can you bill CCM for Medicare Advantage patients?
A: You will need to check with the Medicare Advantage plans in your area regarding whether or not they will pay for 99490 in 2015. My understanding is that, in general, patients in Medicare Advantage plans are entitled to the same benefits enjoyed by patients covered under traditional Medicare. However, I have heard from some family physicians that some Medicare Advantage plans do not plan to cover and pay 99490.

Q: Is billing for CCM services limited to primary care physicians?
A: No. While CMS expects the chronic care management code to be billed most frequently by primary care physicians, specialists who meet the requirements may also bill for these services. Nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse midwives can also furnish the full range of these services under their Medicare benefit, to the extent permitted by applicable limits on their state scope of practice.

Getting patient agreement

Q: What do I need from the patient before I bill the service?
A: CMS requires you to:

- Inform the patient about the availability of CCM services from the provider and obtain his or her written agreement to have the services furnished, including authorization for electronic communication of the patient’s medical information with other treating providers as part of care coordination.
- 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 to accept or decline these services.
- Inform the patient of the right to stop CCM services at any time (effective at the end of a calendar month) and the effect of a revocation of the agreement on CCM services.
- Inform the patient that only one provider can furnish and be paid for these services during a calendar month.

Q: How often do I need to get the patient’s agreement?
A: CMS requires a written agreement before initiating the service.

Q: Is there a standard written agreement for this purpose?
A: CMS has not provided a standard form for this purpose.

You may want to use the one provided by Family Practice Management.
services. You do not need to inform the beneficiary each time a bill for CCM services is submitted.

Q: Can a patient revoke his or her agreement?

A: Yes, the patient can revoke the agreement for CCM services at any time. However, if the revocation occurs during a current chronic care management calendar month, the revocation is not effective until the end of that month. The patient can notify the provider of revocation verbally or in writing. The date of revocation must be recorded in the patient’s medical record, and the practice must give the patient written confirmation that it will not be providing CCM services beyond the current calendar month.

Miscellaneous

Q: Medicare’s “incident to” rules generally require the physician to be present in the office suite and immediately available to provide assistance and direction throughout the service when ancillary staff are involved in the provision of a service billed under the physician’s provider ID. Will that apply to CCM services, too?

A: No. For purposes of providing CCM services, CMS has created an exception to the requirement that “incident to” services must be furnished under direct supervision. Specifically, CMS is requiring only general, rather than direct, supervision when CCM services are furnished incident to a provider’s services. This means that the supervising physician must be available by telephone only. All other requirements related to “incident to” services would still apply to CCM services.

Q: Are federally qualified health centers (FQHCs) and rural health clinics (RHCs) excluded from billing this service?

A: This is not yet known. The American Academy of Family Physicians has strongly urged CMS to include a mechanism for RHCs and FQHCs to bill for CCM services, especially since CMS allows RHCs and FQHCs to bill the TCM service.

Source: Kent Moore, senior strategist for physician payment, American Academy of Family Physicians. These FAQs are drawn from CMS’s discussion of CCM services in the final rule on the 2014 Medicare physician fee schedule as published in the Federal Register on Dec. 10, 2013, and in the proposed rule on the 2015 Medicare physician fee schedule as published in the Federal Register on July 11, 2014, as well as the final rule on the 2015 Medicare physician fee schedule as published in the Federal Register on Nov. 13, 2014.

See the related article at http://www.aafp.org/fpm/2015/0100/p7.html.