Medicare Chronic Care Management Service Essentials

As part of an ongoing effort to enhance care coordination for Medicare beneficiaries, the Centers for Medicare & Medicaid Services (CMS) established a non-face-to-face chronic care management (CCM) service as a Medicare benefit effective Jan. 1, 2015. CMS finalized the use of CPT code 99490 for Medicare CCM, which may be billed as a complement to face-to-face services such as office visits. This document provides an overview of the CCM requirements, and practices may also refer to this CMS CCM Services Factsheet or check with their Medicare Administrative Contractor (MAC) for further information.

According to CMS, furnishing care management to beneficiaries with multiple chronic conditions requires multidisciplinary care that involves:

- Care management for chronic conditions including systematic assessment of the beneficiary’s medical, functional and psychosocial needs;
- Structured recording of demographics, problems, medications and medication allergies, as well as the creation of a structured clinical summary record;
- System-based approaches to ensure timely receipt of all recommended preventive care services;
- Medication reconciliation with review of adherence and potential interactions and oversight of beneficiary self-management of medications;
- Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues, which should be revised as necessary;
- Communication with other health professionals not employed in the same practice who are involved in the patient’s care;
- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities;
- Coordination with home and community-based clinical service providers; and
- Review of laboratory and other studies and adjustment of medical therapies, as needed.

Eligible patients
Patients eligible for CCM services include those with multiple chronic 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 does not specify which diagnoses are considered eligible chronic conditions.

CCM code description
Chronic care management services require at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, for a patient that meets the following required elements:

- Multiple (two or more) chronic conditions that are expected to last at least 12 months, or until the death of the patient;
- Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation or functional decline; and
• A comprehensive care plan that has been established, implemented, revised or monitored.

**Payment and beneficiary cost-sharing**

CMS finalized the following RVUs and payments for 2015. Specific payments vary based on Medicare geographic practice cost indices (GPCIs).

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Description</th>
<th>Physician Work RVUs</th>
<th>Non-Facility PE RVUs</th>
<th>Facility PE RVUs</th>
<th>Mal-Practice RVUs</th>
<th>Total Non-Facility RVUs</th>
<th>Average National Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99490</td>
<td>CCM</td>
<td>0.61</td>
<td>0.54</td>
<td>NA</td>
<td>0.05</td>
<td>1.19</td>
<td>$42.91*</td>
</tr>
</tbody>
</table>

*The final rule, released Oct. 31, set the conversion factor at $35.8013. On Dec. 30 CMS released an updated relative value file which set a new conversion factor of $35.7457 and included a revised CCM Malpractice RVU. These changes adjusted the average national CCM payment from $42.60 to $42.91.

As with most Medicare services (except those designated as preventive services), 20% beneficiary cost-sharing applies, which, based on the average national payment, equates to $8.52 coinsurance per calendar month. Beneficiaries may also be responsible for a deductible payment, if appropriate.

**Beneficiary Consent**

Before a practitioner can furnish or bill for CCM services, eligible beneficiaries must be informed about the availability of these services, how they are accessed and how their information will be shared with other providers involved in their care. Practices must obtain the beneficiary’s written agreement to furnish CCM services, including the beneficiary’s authorization for the electronic communication of his or her medical information with other treating providers as part of care coordination.

Additionally, as part of obtaining beneficiary consent a practice must:

- Identify the name of the provider who will be furnishing the CCM services and inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month;
- Inform the beneficiary that cost-sharing applies to CCM services even though they are not delivered face-to-face;
- Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of a calendar month) as well as the effect of a revocation of the agreement to receive CCM services;
- Provide a written or electronic copy of the comprehensive care plan to the beneficiary, which must be documented in the patient’s electronic medical record; and
- Document in the beneficiary’s medical record that all elements of the CCM service were explained and offered to the beneficiary, and note the beneficiary’s decision to accept or decline the service.

CMS suggests that practices may want to consider explaining that although cost-sharing applies for CCM services, they may help the beneficiary avoid the need for more costly face-to-face services that entail greater cost-sharing. CMS does not specify how frequently beneficiary consent must be obtained. Practices
may want to consider establishing a process for periodically obtaining this consent. For example, once a year or after there has been a break of more than a few months of furnishing CCM services.

**Billing**
At least 20 minutes of CCM services per calendar month are required in order to bill; CCM services of less than 20 minutes per month are not reportable. According to the 2015 CPT Manual, 99490 may only be reported by the physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month. The CPT manual also notes that practices should not report 99490 for any post-discharge care management services within 30 days of discharge if the practice is reporting transitional care management services, codes 99495 or 99496.

CMS notes that CCM services should not be treated as a per member, per month payment since CCM services may only be billed in months when at least 20 minutes of non-face-to-face care coordination services are furnished. The agency does not prohibit the use of recurring billing but advises practices to use caution to ensure billing does not occur in months when the CCM service requirements are not met.

**Who can bill CCM services**
CMS expects CCM services to be most frequently billed by primary care physicians, though specialists who meet the requirements may also bill for these services. CMS believes that nurse practitioners, physician assistants, clinical nurse specialists and certified nurse midwives are the only non-physician qualified health care professionals that may furnish the full range of these services under their Medicare benefit, but only to the extent permitted by applicable limits on their state scope of practice. While clinical psychologists are not permitted to bill for CCM services, practitioners furnishing the service may refer patients to mental health professionals as part of chronic care management when necessary.

According to the 2015 CPT manual, only the time of clinical staff of the reporting professional may be counted. Additionally, the manual instructs practices to:

"only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient. Note: do not count any clinical staff time on a day when the physician or qualified healthcare professional reports a E/M service (office or other outpatient services 99301, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, domiciliary rest home services 99324, 99325, 99326, 99327, 99328, 99335, 99336, 99337, home services 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350)."

**Incident to CCM guidance**
CMS expects that many CCM services will be furnished “incident to” a physician’s services. If provided in compliance with applicable state law, time spent by a clinical staff person furnishing aspects of CCM during which there is no direct (i.e. on-site) physician supervision would be eligible to be counted toward the time requirement to bill the service. This use of general (rather than direct) supervision is permitted during and outside of normal business hours.

CMS amended the incident to regulations in 2014 to require that personnel performing incident to services meet any applicable state law or state requirements to provide the services, including licensure. CMS believed this change provides a clear basis to deny claims and help ensure it has recourse to recover Medicare dollars when services are not furnished in compliance with state laws. As with other incident to services, they are paid at the applicable rate of the physician or practitioner billing for the service.
EHR requirement
In order to meet the core technology capabilities (structured recording of demographics, problems, medications and medication allergies and the creation of a structured clinical summary), CCM services must be furnished using, at a minimum, the edition(s) of certification criteria acceptable for the EHR Incentive Programs as of Dec. 31st of the calendar year preceding each CCM payment year. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care. Practitioners must also use this technology to fulfill the CCM scope of service requirements whenever the requirements reference a health or medical record. For 2015 CCM services, practitioners can use EHR technology certified to either the 2011 or 2014 edition(s) of certification criteria.

Electronic care plan requirement
Practices must create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental assessment, or reassessment, of the beneficiary. The practice must electronically capture care plan information and make it available 24 hours a day, 7 days a week to all of a practice’s clinicians involved in furnishing the CCM services (i.e., those whose time is counted towards the practice billing for the CCM code). Billing practitioners must be able to share care plan information electronically (other than by facsimile) as appropriate with other practitioners furnishing care to the beneficiary. CMS does not mandate the use of a specific electronic tool or service to furnish the care plan element of the CCM service, only that the method must be electronic and cannot include facsimile transmission.

24/7 access and continuity of care
Eligible practitioners, or care team members they supervise, furnishing CCM services must be accessible 24 hours a day, 7 days a week to patients and other healthcare professionals involved in the patient’s care. This 24/7 access to care management services includes providing the beneficiary with a means to make timely contact with healthcare providers in the practice to address his or her urgent chronic care needs. Practices may satisfy the 24/7 care plan access requirement in a number of ways, including remote access to an EHR, web-based access to a care management application or web-based access to a health information exchange service that captures and maintains care plan information.

Continuity of care is another required scope of service element for CCM services. Specifically, CMS requires continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments. Practices should provide enhanced opportunities for beneficiary and practitioners to communicate about the beneficiary’s care through not only telephone access, but also through the use of secure messaging, internet or other non-face-to-face consultation methods.

Documentation
Practices should carefully establish processes to ensure detailed documentation for CCM services, which is especially important given the non-face-to-face nature of the service. Documentation in the electronic medical record must include details regarding:

- Beneficiary consent, including the date of the signed agreement and the beneficiary’s decision to accept the service (See the “Beneficiary Consent” section for more details);
- Detailed accounting of the time (at least 20 minutes per calendar month) furnishing non-face-to-face services, including the performing clinical staff and details on what the time was spent doing;
• Provision of a written or electronic copy of the comprehensive care plan to the beneficiary; and
• Communication to and from home and community-based providers regarding the patient’s psychosocial needs and functional deficits.

Practices should reach out to their EHR vendor to discuss options for how to best document CCM time in the EHR. Additionally, if using incident to billing, it is important to note that standard incident to documentation requirements apply.

Frequently Asked Questions

Q: CCM services appear to be preventive, which do not have cost-sharing in Medicare. Why is CMS requiring the 20% coinsurance, resulting in an approximate $8.50 per month payment for beneficiaries?
A: Beneficiary cost-sharing is only waived for preventive services that have been assigned an “A” or “B” rating by the United States Preventive Services Task Force (USPSTF). At this time, CCM has not earned such a rating and therefore is required to have beneficiary cost-sharing. If in the future the USPSTF assigns an “A” or “B” rating to this service, beneficiary cost-sharing would be waived.

Q: Is there any relation to CCM service and the Medicare annual wellness visit (AWV) or initial preventative physical examination (IPPE)?
A: CMS recommends that a practitioner furnish an AWV or IPPE prior to furnishing CCM services. CMS states in their CCM fact sheet that the billing practitioner is required to furnish either an AWV, IPPE or comprehensive evaluation and management visit to the patient prior to billing the CCM service, and to initiate the CCM service as part of one of those exams/visits.

Q: Does a clinician have to be a direct employee of the practitioner billing for the CCM service to furnish parts of that service?
A: No. In the 2015 final Medicare physician fee schedule, CMS removed a previously-finalized requirement that clinical staff must be a direct employee of the practitioner or practice billing for CCM services. Provided the clinical staff are under the general supervision of a practitioner and all other requirements of the incident to regulations at §410.26 are met, CMS does not stipulate the nature of the employment or contractual relationship between the clinical staff and the practitioner or practice billing for CCM services.

Q: Are Medicare Advantage (MA) plans required to cover CCM services?
A: MA plans must provide or pay for medically necessary Part B covered items and services, which includes the CCM service. However, MA plans may impose cost-sharing for a particular item or service that is above or below the original Medicare cost-sharing for that service, provided the overall cost-sharing under the plan is actuarially equivalent to that under original Medicare and the plan cost-sharing structure does not discriminate against sicker beneficiaries. MA plans may require enrollees to pay higher cost-sharing amounts for services furnished out-of-network. Additionally, some MA plans may choose to provide more robust coverage of non-face-to-face care coordination of services.

Q: Does Medicare cover other non-face-to-face care management codes?
A: At this time, 99490 is the only chronic care management service covered by Medicare Part B. CMS indicated it will monitor use of this code and, in the future, may evaluate whether to cover additional types of non-face-to-face chronic care management. MA plans may independently choose to cover additional CCM services.
Please note: this Medicare chronic care management beneficiary consent form template is provided for information only. It is up to each practice to modify it to meet its specific needs.

Template for Medicare Chronic Care Management Service Consent Form

As part of an ongoing effort to enhance care coordination for Medicare beneficiaries, {INSERT PRACTICE NAME HERE} is pleased to offer a new chronic care management service which will help us better coordinate your care. Chronic care management consists of non-face-to-face care services which our office will furnish to assist in coordination of your care among your different care providers and to help you better manage your chronic conditions. This service would be a complement to face-to-face services you receive, such as office visits.

As part of this service {INSERT CLINICIAN NAME HERE} at {INSERT PRACTICE NAME HERE} will work with a team of healthcare providers at our practice to provide care management for your chronic conditions, such as to:

- Create a comprehensive care plan, which will be made available to you either in a written or electronic format and may be periodically revised.
- Coordinate and communicate with other health professionals outside of our practice who are also involved in your care. (Please note, this communication will be done in accordance with all state and federal privacy and security laws.)
- Help you manage care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals or other health care facilities.
- Have {INSERT CLINICIAN NAME HERE}, or a member of {HIS or HER} care team, accessible 24 hours a day, 7 days a week to help you with any urgent chronic care needs and to coordinate with other healthcare professionals involved in your care.
- Review and track your key health information such problems, laboratory results, medications and medication allergies as well as help you know when to receive recommended preventive care services.

By signing this consent form, you agree to:

- Allow {INSERT PRACTICE NAME HERE} to bill Medicare for chronic care management services on your behalf no more frequently than once a month. This service may be billed even if you do not come into the office that month. ({INSERT PRACTICE NAME HERE} will not bill Medicare for chronic care management during months in which less than 20 minutes of non-face-to-face chronic care management is provided.)
- Pay a copayment of {INSERT APPLICABLE COPAYMENT HERE} during months in which this service is provided. Deductibles may also apply. Although there is a fee for this service, it may help you avoid the need for more costly face-to-face services that entail greater cost-sharing. Please note that only one healthcare provider can be paid for these services during a calendar month. If another provider has offered to furnish this service, please let us know.
- Authorize the electronic communication of your medical information with other treating providers as part of these care coordination efforts.

You have the right to stop receiving CCM services at any time (effective at the end of a calendar month) and can do so by notifying us of your decision, at which point we will have you sign a CCM termination form.

I permit {INSERT CLINICIAN NAME HERE} at {INSERT PRACTICE NAME HERE} to bill Medicare for chronic care management services provided to me and understand I will be responsible for applicable co-payments and deductibles.

_______________________________________   ____________________
Patient signature      Date