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

Chronic Care Management Services

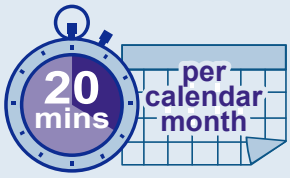
The Centers for Medicare & Medicaid Services (CMS) recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

Beginning January 1, 2015, Medicare pays separately under the Medicare Physician Fee Schedule (PFS) under American Medical Association Current Procedural Terminology (CPT) code 99490, for **non-face-to-face** care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. CPT 99490 is defined as follows:

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.

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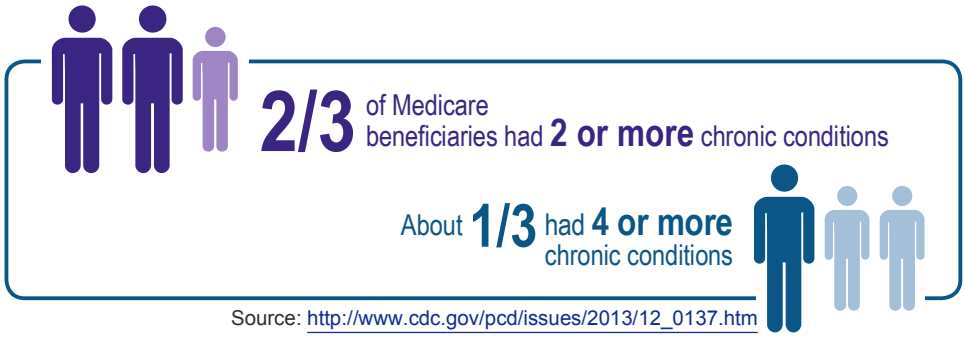
This fact sheet provides background on the newly payable chronic care management (CCM) service, identifies eligible providers and patients, and details the Medicare PFS billing requirements.

Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer's disease and related dementia;
- Arthritis (osteoarthritis and rheumatoid);
- Asthma;
- Atrial fibrillation;
- Autism spectrum disorders;
- Cancer;
- Chronic Obstructive Pulmonary Disease;
- Depression;
- Diabetes;
- Heart failure;
- Hypertension;
- Ischemic heart disease; and
- Osteoporosis.



Source: http://www.cdc.gov/pcd/issues/2013/12_0137.htm

Practitioner Eligibility

Physicians and the following non-physician practitioners may bill the new CCM service:

- Certified Nurse Midwives;
- Clinical Nurse Specialists;
- Nurse Practitioners; and
- Physician Assistants.

Only one practitioner may be paid for the CCM service for a given calendar month.

NOTE: Eligible practitioners must act within their State licensure, scope of practice, and Medicare statutory benefit. The CCM service may be billed most frequently by primary care physicians, although specialty physicians who meet all of the billing requirements may bill the service. The CCM service is not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, therefore these practitioners cannot furnish or bill the service. However, CMS expects referral to or consultation with such physicians and practitioners by the billing practitioner to coordinate and manage care.

Services provided directly by an appropriate physician or non-physician practitioner, or by clinical staff incident to the billing physician or non-physician practitioner, count toward the minimum amount of service time required to bill the CCM service (20 minutes per calendar month).

Non-clinical staff time cannot be counted. Consult the CPT definition of "clinical staff" and the Medicare PFS "incident to" rules to determine whether time by specific individuals may be counted towards the minimum time requirement. Practitioners may use individuals outside the practice to provide CCM services, subject to the Medicare PFS "incident to" rules and regulations and all other applicable Medicare rules.

Supervision

CMS provided an exception under Medicare's "incident to" rules that permits clinical staff to provide the CCM service incident to the services of the billing physician (or other appropriate practitioner) under the **general supervision** (rather than direct supervision) of a physician (or other appropriate practitioner).

Patient Eligibility

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 are eligible for the CCM service.

CMS **requires** the billing practitioner to furnish a comprehensive evaluation and management (E/M) visit, Annual Wellness Visit, or Initial Preventive Physical Examination (IPPE) to the patient prior to billing the CCM service, and to initiate the CCM service as part of this visit/exam.

Patient Agreement Requirements

A practitioner must inform eligible patients of the availability of and obtain consent for the CCM service before furnishing or billing the service. Some of the patient agreement provisions require the **use of certified Electronic Health Record (EHR) technology**. For a complete listing of the Patient Agreement and Related EHR Requirements, see Table 1.

Patient consent requirements include:

- Inform the patient of the availability of the CCM service and obtain written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers.
- Explain and offer the CCM service to the patient. In the patient's medical record, document this discussion and note the patient's decision to accept or decline the service.
- Explain how to revoke the service.
- Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.

This agreement process should include a discussion with the patient, and caregiver when applicable, about:

- What the CCM service is;
- How to access the elements of the service;
- How the patient's information will be shared among practitioners and providers;
- How cost-sharing (co-insurance and deductibles) applies to these services; and
- How to revoke the service.

Although patient cost-sharing applies to the CCM service, CCM may help avoid the need for more costly face-to-face services in the future by proactively managing patient health, rather than only treating disease and illness.

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

CCM Scope of Service Elements - Highlights

The CCM service is extensive, including structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. Some of the CCM Scope of Service elements require the use of a certified EHR or other electronic technology. **For a complete listing of the CCM Scope of Service elements and electronic technology requirements that must be met in order to bill the service, see Table 1.**

Structured Data Recording	Record the patient's demographics, problems, medications, and medication allergies and create structured clinical summary records using certified EHR technology.
Care Plan	Create a patient-centered 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). Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record. Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service. Share the care plan electronically outside the practice as appropriate.

Comprehensive Care Plan

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 responsible for each intervention;
- Medication management;
- Community/social services ordered;
- A description of how services of agencies and specialists outside the practice will be directed/coordinated; and
- Schedule for periodic review and, when applicable, revision of the care plan.

Access to Care

- Ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services, providing the patient with a means to make timely contact with health care practitioners in the practice who have access to the patient's electronic care plan to address his or her urgent chronic care needs.
- Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care. Do this through telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Manage Care

- Care management services such as:
  - Systematic assessment of the 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; and
  - Oversight of patient self-management of medications.
- Manage care transitions between and among health care providers and settings, including referrals to other providers, including:
  - Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.
- Coordinate care with home and community based clinical service providers.

EHR and Other Electronic Technology Requirements

CMS requires the use of certified EHR technology to satisfy some of the CCM scope of service elements. In furnishing these aspects of the CCM service, CMS requires the use of a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year **(referred to as "CCM certified technology")**. For more information, visit http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms on the CMS website.

For CCM payment in calendar year (CY) 2015, practitioners may use EHR technology certified to either the 2011 or 2014 edition(s) of certification criteria.

At this time, CMS does not require the use of certified EHR technology for some of the services involving the care plan and clinical summaries, allowing for broader electronic capabilities. These are described in Table 1, CCM Scope of Service and Billing Requirements.

Table 1. CCM Scope of Service and Billing Requirements

CCM Scope of Service Element/Billing Requirement	Certified EHR or Other Electronic Technology Requirement
Initiation during an AWV, IPPE, or comprehensive E/M visit (billed separately).	None
Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.	Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology.
Access to care management services 24/7 (providing the beneficiary with a means to make timely contact with health care practitioners in the practice who have access to the patient's electronic care plan to address his or her urgent chronic care needs regardless of the time of day or day of the week).	None
Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.	None
Care management for chronic conditions including systematic assessment of the beneficiary'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; and oversight of beneficiary self-management of medications.	None
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. Share the care plan as appropriate with other practitioners and providers.	Must at least electronically capture care plan information; make this information available on a 24/7 basis to all practitioners within the practice whose time counts towards the time requirement for the practice to bill the CCM code; and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers.

Table 1. CCM Scope of Service and Billing Requirements (cont.)

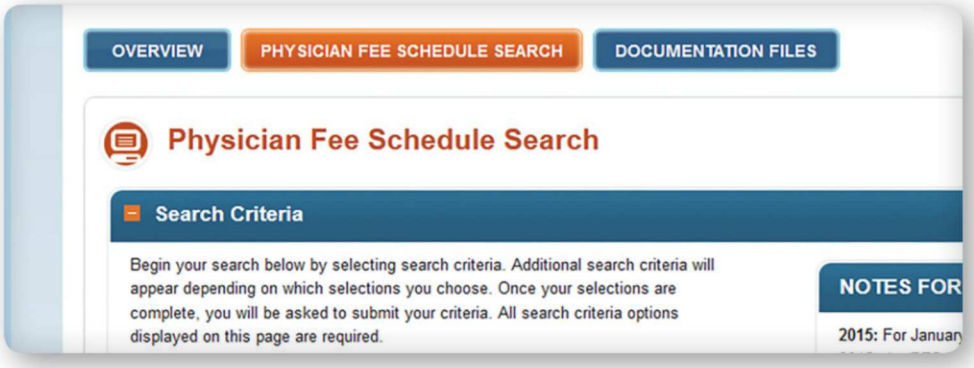
CCM Scope of Service Element/Billing Requirement	Certified EHR or Other Electronic Technology Requirement
Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.	Document provision of the care plan as required to the beneficiary in the EHR using CCM certified technology.
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.	Format clinical summaries according to CCM certified technology. Not required to use a specific tool or service to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by fax).
Coordination with home and community based clinical service providers.	Communication to and from home and community based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record using CCM certified technology.
Enhanced opportunities for the beneficiary and any 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.	None
Beneficiary consent—Inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers. Document in the beneficiary's medical record that all of the CCM services were explained and offered, and note the beneficiary's decision to accept or decline these services.	Document the beneficiary's written consent and authorization in the EHR using CCM certified technology.
Beneficiary consent—Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of the calendar month) and the effect of a revocation of the agreement on CCM services.	None
Beneficiary consent—Inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.	None

Other Billing Requirements

CPT code 99490 **cannot be billed during the same service period as** CPT codes 99495–99496 (transitional care management), Healthcare Common Procedure Coding System (HCPCS) codes G0181/G0182 (home health care supervision/hospice care supervision), or CPT codes 90951–90970 (certain End-Stage Renal Disease services). Also consult CPT instructions for additional codes that cannot be billed during the same service period as CPT code 99490. There may be additional restrictions on billing for practitioners participating in a CMS sponsored model or demonstration program.

Payment

CMS pays for the new CCM service separately under the Medicare PFS. To find payment information for a specific geographic location, access the Medicare PFS Look-Up tool at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup on the CMS website.



CCM and Other CMS Advanced Primary Care Initiatives

The CCM service provides payment of care coordination and care management for a beneficiary with multiple chronic conditions within the Medicare Fee-For-Service Program. Medicare will not make duplicative payments for the same or similar services for beneficiaries with chronic conditions already paid for under the various CMS advanced primary care demonstration and other initiatives, such as the Multi-payer Advanced Primary Care Practice (MAPCP) or the Comprehensive Primary Care (CPC) Initiatives. For more information on potentially duplicative billing, consult the CMS staff responsible for these separate initiatives. As CMS implements new models or demonstrations that include payments for care management services, or as changes take place that affect existing models or demonstrations, it will address potential overlaps with the CCM service and seek to implement appropriate payment policies.

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Resources

For a summary of all available products on the Medicare Learning Network® (MLN), refer to the "Medicare Learning Network® Catalog of Products" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right.

Table 2 provides resources for additional information on CCM services.

Table 2. CCM Resources

Resource	Website
CCM Frequently Asked Questions (FAQs)	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS
Chronic Conditions	http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions
Chronic Conditions Data Warehouse	https://www.ccwdata.org/web/guest
Final Rules in the Federal Register (policies governing CCM services)	▸ CY 2014 Medicare PFS Final Rule (CMS-1600-FC) pages 74414-74427: http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28696.pdf ▸ CY 2015 Medicare PFS Final Rule (CMS-1612-FC) pages 67715-67730: http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf ▸ CY 2015 Medicare PFS Final Rule; Correction Amendment (CMS-1612-F2), page 14853: http://www.gpo.gov/fdsys/pkg/FR-2015-03-20/pdf/2015-06427.pdf
Medicare Administrative Contractor (MAC) Contact Information	http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
"MLN Guided Pathways: Basic Medicare Resources for Health Care Professionals, Suppliers, and Providers" booklet	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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