Chronic Care Management

i3ACS

Objectives of Chronic Care Management

- What is Chronic Care Management?
- Why should I bill this?
- Where and When can I use this Care code in my practice?
- Who can provide CCM services?
- How do I bill this code set?

WHAT?

Chronic Care Management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple significant chronic conditions.

Chronic care management services are services provided to patients who have medical **and/or** psychosocial needs requiring establishing, implementing and monitoring a care plan.

Chronic Care Management engages patients with chronic conditions with a goal to better self manage their care and understand their health care benefits.

Chronic Care Management requires more focused management of patient needs and extensive care coordination among all the patient's care providers

WHY?

Fifty percent of all adult Americans have a chronic condition.

One in four Americans have two or more chronic conditions.

Chronic disease is a leading cause of death.

The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) ***as a critical component of primary care*** *that contributes to better health and care for individuals*.

Why again?

- **Additional benefits of Chronic Care Management**
  - Care Coordination
  - Quality of Life
  - Access to Care
  - Patient Satisfaction
  - An overall savings in healthcare costs
  - Providers are actively engaged in their patient's healthcare goals

Where and When to use CCM codes?

- Beneficiaries with two or more chronic conditions expected to last at least 12months.
- Chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

WHO?

- **Who can provide the service?**
  - Physicians
  - Certified Nurse Midwives
  - Clinical Nurse Specialists
  - Nurse Practitioners
  - Physician Assistants

Who qualifies for CCM?

- Adult patients who require 3 or more prescription drugs
- need for the coordination of a number of specialties and services
- inability to perform activities of daily living and/or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver; psychiatric and other medical comorbidities

How.....to get started?

- **Identify** your patients
  Designate a staff member
  Develop a CCM process/schedule
  Inform the patient; invite them to participate
  Create the comprehensive care plan
  Provide the patient with the comprehensive care plan
  Track time
  Process for termination

Additional requirements

- Verbal consent from the patient Development of a comprehensive care plan
- The patient must have a designated physician/NPP as their clinician, and have 24/7 access to address urgent needs
- The practice must use a certified electronic health record, although faxing is allowed to share the care plan
- Use a standardized method to identify patients who are eligible for the service Manage care transitions
- Give a copy of the plan to the patient

How to inform the patient.

The patient must consent and understand the process of CCM and is made aware of the cost share aspect. (coinsurance may apply)

Consent may be verbal or written but must be documented in the medical record, and is only required once.

Include an explanation that only one practitioner can furnish the service and be paid during a calendar month

Include in the documentation that the patient was informed they have the right to stop CCM services at any time

Plan of care

A plan of care for health problems is based on a physical, mental, cognitive, social, functional, and environmental evaluation.

It is intended to provide a simple and concise overview of the patient, and his/her medical condition(s) and be a useful resource for patients, caregivers, healthcare professionals, and others, as necessary

Care planning

Provide access to physicians or other qualified health care professionals or clinical staff, to address any urgent needs.

Ensure continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.

Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care by telephone or any other asynchronous non face to face methods (email, secure messaging…)

Check list?

- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive assessment
- Functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and healthcare professionals and others, as necessary
- Summary of advance directives

Documentation Requirements

- Management of chronic conditions
  - Management of referrals to other providers
  - Management of prescriptions
  - Ongoing review of patient status
  - **Time spent**
  - Patient goals

Coding and billing for CCM

- **99490** – 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 that 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.

Add-on coding

- **99439** – 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; **each additional 20 minutes** of clinical staff time directed by a physician
or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Coding and billing for CCM 30 minutes

- **99491** – 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- • comprehensive care plan established, implemented, revised, or monitored; first **30 minutes** provided personally by a physician or other qualified health care professional, per calendar month.

Add-on coding

- **+ 99437** – 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; **each additional 30 minutes** by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Complex Chronic Care Management

- **99487** – Complex 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
-
  • comprehensive care plan established, implemented, revised, or monitored
-
  • moderate or high complexity medical decision making; first **60 minutes** of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Add-on coding

- **+ 99489** – Complex 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making;
each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

CCM codes at a glance

- CPT code 99490 - non-complex CCM is a 20-minute timed service provided by clinical staff to coordinate care across providers and support patient accountability.
- CPT code 99439 - each additional 20 minutes of clinical staff time spent providing non-complex CCM directed by a physician or other qualified health care professional (billed in conjunction with CPT code99490)
- CPT code - 99487 complex CCM is a 60-minute timed service provided by clinical staff to substantially revise or establish comprehensive care plan that involves moderate- to high-complexity medical decision making.
- CPT code 99489 is each additional 30 minutes of clinical staff time spent providing complex CCM directed by a physician or other qualified health care professional (report in conjunction with CPT code 99487; cannot be billed with CPT code 99490)
- CPT code 99491 - CCM services provided personally by a physician or other qualified health care professional for at least 30 minutes.

Billing CCM to Medicare

- Bill your RHC claim using HCPCS code G0511 (99490) for CCM or general BHI services or G0512 (99491) for psychiatric CoCM services, alone or with other payable A/B MAC (A) services

Care planning code

- **G0506** – Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
  Report when extensive assessment and care planning outside of the usual effort described by the billed E/M code is performed by the billing provider.

Remote Patient Monitoring

- Remote patient monitoring (RPM) is the use of physiologic readings data from a
  device to monitor and manage a patients care remotely.
  Types of devices that can be used, depending on the patient's condition(s)
  • Blood glucose monitors
  • Blood pressure monitors
  • Scales
  • Pulse oximeters are the most common
  • Device must qualify as a medical device und Food, Drug, and Cosmetic Act
  • Data must be collected and transmitted electronically as opposed to self reported by the patient

CPT coding for remote patient monitoring

- **99453** – Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
- **99454** – Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission,
  each 30 days

Remote monitoring

- **99091** – Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a **minimum of 30 minutes of time, each 30 days**

Physiologic Monitoring

- **99457** – Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
  + 99458 – Remote physiologic monitoring treatment management services,
  clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **each additional 20 minutes**
- (List separately in addition to code for primary procedure)

References and Resources

- AAPC
- CMS. Gov. education and Outreach
- Medicare Learning Network
- OPTUM Encoder Pro
- Coding Intel
- AAFP

Questions??

- Thanks for your attendance