

## AMERICAN GERIATRICS SOCIETY

### Chronic Care Management (CCM) Services FAQs:

Developed for AGS by Denise A. Merlino, CPC, MBA, CNMT of Merlino Healthcare Consulting Corp.

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**Q. Can all physicians including specialists bill the CCM services, or are they just for primary care physicians?**

**A.** Yes, any physician or qualified health care professional meeting the reporting requirements is able to bill for CCM. Physicians treating patients with at least two or more chronic conditions could be eligible to bill the codes. Only one physician per month may report these services.

**Q. For a Medicare patient, since Medicare is only paying for the single CPT code 99490, if a patient meets the elements of 99487 or a combination of 99487 and 99489, can I bill the 99490 rather than the higher complexity code?**

**A.** Yes, similar to how Medicare is not recognizing the consultation codes and they instruct providers to use other E&M codes in their place, we would see no difference for these codes, therefore CPT would defer to the payer policies and allow billing the less intense code when Medicare is not recognizing the higher complexity services.

**Q. Are there only certain diagnoses that CCM codes can be reported with?**

**A.** There is not a defined list of diagnosis codes that meet the requirements of CCM. What is required is that the chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline and that management requires a care plan. There has been no guidance as to whether claims will require two or more diagnoses. The American Geriatrics Society and the American Academy of Neurology give examples of patients with two or more of the following conditions that may be appropriate for the use of chronic care management services:

- neurocognitive disorders including Alzheimer's disease, Dementia and Parkinson's disease
- stroke with late effects that place the patient at risk for falls, fractures and aspiration pneumonia
- congestive heart failure
- COPD
- poorly controlled diabetes mellitus

\*Please note this is not an all-inclusive list.

**Q. Can an E/M visit be billed at the same time as the CCM code?**

**A.** Yes, but any clinical staff time on a day when the physician reports an E/M service may not be counted toward the care management service code. E/M services may be reported separately by the same physician (or other qualified health care professionals) during the same calendar month.

**Q. Will the patient have cost sharing each month, when the CCM service is reported?**

**A.** Yes, the patient must indicate to the physician he/she wants chronic care management services, and is responsible for the **cost share**. It is the responsibility of the health care provider to notify the patient and document consent for the service. Medicare has not yet indicated if signed consent is required yearly, each month or for a series of months. We believe yearly is reasonable unless a payer specifies differently.

**Q. Can CCM services be reported if the patient / caregiver has not given consent?**

**A.** No, a requirement of the service is knowledge and recognition by the patient that the physician will perform care management services on the patient's behalf. In the event of an audit, documentation of patient consent is crucial.

**Q. Is a new consent form required for each calendar month the service is provided? Or is it preferred the potential length of care be established with the care plan?**

**A.** Absent Medicare guidance, we believe a reasonable assumption is that the consent would apply for the period of time established for the care plan. We hope to obtain further guidance from CMS as to whether once annually is reasonable or request CMS define in future guidance a time period that would be sufficient and reduce the administrative burden.

**Q. What is the difference between chronic care management and *complex* chronic care management services?**

**A.** *Complex* chronic care management services include the same criteria as the chronic care management service, with an additional requirement of the establishment or substantial revision of a comprehensive care plan, medical decision-making of moderate to high complexity, and at least 60 minutes of clinical staff time. For 2015, CMS has indicated the agency will *not* reimburse for complex chronic care management services 99487 and 99489. These services may not be billed to the patient or Medicare. (Private insurers may have differing coverage/payment policies.)

**Q.** Must all of the required elements be met in order to report chronic and/or complex chronic care management services?

**A.** Yes, all of the required elements as provided by CPT must be met in order to report the service.

**Q.** Can CCM services be reported if the total time spent on care management for a patient is less than 20 minutes in a calendar month?

**A.** No, a requirement of chronic care management services code 99490 is at least 20 minutes of clinical staff time directed by a physician or physician time, if the physician performs the clinical staff function. This code deviates from the standard time based coding CPT nomenclature, which allows the reporting of a service once the mid-point of time is reached.

**Q.** Can care management time within the emergency department be reported using the CCM codes?

**A.** Yes, time within the ED is reportable using 99487, 99489, 99490, but time while the patient is in-patient or admitted as observation is not.

**Q.** CPT states that the care management office / practice must provide 24/7 access to physicians or clinical staff including providing patients / caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week. Does resident coverage meet this requirement?

**A.** Yes, any licensed practitioner counts when calculating the clinical staff time required to meet the elements of the CCM codes. This includes a resident, nurse, nurse practitioner, physician assistant, licensed medical aide.

**Q.** Can CCM services be reported by more than one physician within a calendar month?

**A.** No, only one physician or other qualified health care professional can report a CCM service in a calendar month.

**Q.** If more than 20 minutes are spent on care management within a given calendar month by the healthcare provider, can multiple units of 99490 be reported?

**A.** No. One unit of the CCM code should be reported, however it is important to document the time spent on care management services in the medical record.

**Q. What date of service should be used when reporting CCM services?**

**A.** Medicare did not specify a specific date of service to bill as they did with the Transitional Care Management services. In general, when the code elements are met, the provider should choose that date as the date of service. We would not see any reason to hold the claim unless CMS or third party payers provide further guidance. Consecutive month billing need not use dates 30 or more days apart, but the months must be different.

**Q. Can other care management services be reported in addition to the CCM?**

**A.** No, additional care management services may not be reported separately during the month for which chronic care management services are reported. This includes care plan oversight services, prolonged services without patient contact, anticoagulant management, medical team conferences, education and training, telephone services, on-line medical evaluation, preparation of special reports, analysis of data, transitional care management services, and medication therapy management services. These services may have higher payments than CCM in some cases (e.g. care plan oversight), so it is useful to be aware of this when deciding what services to report.

**Q. Can CCM services be provided for patients in the hospital in-patient setting?**

**A.** No. The introductory language in the 2015 CPT book states, “Care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, *to a patient residing at home or in a domiciliary, rest home, or assisted living facility.*”

**Q. For audit purposes, how should the required 20 minutes of time be documented?**

**A.** At this time specific requirements have not been established, however it is in the health care professionals’ best interest to document the clock start and stop time of the services.

**Q. Is an Electronic Medical Record (EMR) required and must the billing provider meet the requirements for a Certified EHR technology (CEHRT) or have successfully attained meaningful use?**

**A.** The EHR record must meet, at a minimum, the edition(s) of certification criteria that is acceptable for purposes of the EHR Incentive Programs as of December 31<sup>st</sup> of the calendar year preceding each PFS payment year (hereinafter “CCM certified technology”) to meet the final core technology capabilities (structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary).

Therefore, to bill Medicare for CCM payment in CY 2015, CMS allows practitioners to use EHR technology certified to either the 2011 or 2014 edition(s) of certification criteria. This requirement will fulfill the CCM scope of service requirements whenever the Medicare requirements reference a health

or medical record for payment for CCM services. Basically the provider must maintain the record with a Certified EHR technology (CEHRT) for the year prior to the year in which CCM services are reported.

The reporting provider does not have to attain meaningful use. CMS stated that many of the Meaningful Use measures are not relevant for the provision of CCM and therefore CMS will only require practitioners to adopt the certified technology that is relevant to the scope of CCM services.

**Q. Is 24x7 EMR access required for covering providers?**

**A.** No, covering providers do not need access, but the reporting practice must have 24x7 access and be able to communicate by other than fax alone. CMS stated they are not requiring that practitioners use a specific electronic technology to meet the requirement to share care plan information electronically with other practitioners and providers who are not billing for CCM. For instance, practitioners may meet this sharing requirement through the use of secure messaging or participation in a health information exchange with those practitioners and providers, although they may not use facsimile transmission. We have asked CMS to clarify that EHRs that communicate via fax are acceptable, as this was not clear in the final rule.