Providing and Billing Medicare for Chronic Care Management

2015 Medicare Physician Fee Schedule Final Rule

November 2014

The financial and human cost of chronic disease – like cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions, and mental illness – is staggering. Consider the following statistics from the Centers for Disease Control and Prevention:

- **Today, 133 million Americans – one-third of the total population – suffer from at least one chronic disease.**
- **70% of all deaths result from chronic diseases.**
- **85% of all healthcare dollars go to treatment of chronic diseases.**
- **More than two-thirds of Medicare dollars are spent on patients with five or more chronic diseases.**

The Problem with the Solution

Research studies have demonstrated time and again that care management reduces total costs of care for chronic disease patients while improving their overall health. Despite these impressive results, patients receiving care management services remain the exception, not the rule.

Historically, payers have taken the position that payment for non-face-to-face care management services (e.g., medication reconciliation, coordination among providers, arrangements for social services, remote patient monitoring) is bundled into the payment for face-to-face evaluation and management (E&M) services. But these payments do not cover the significant staffing and technology investments required for chronic care management, and thus providers do not furnish these services.

As a result, chronic disease patients are too often left to manage for themselves between episodes of care. That pattern of sporadic care translates into higher complication rates which, in turn, means more suffering and costly care.

New Opportunities

Since 2011, states can apply for federal funds to pay providers to furnish specified "health home" services for Medicaid recipients with certain chronic diseases. These services include comprehensive care coordination and health promotion. To date, 14 states have approved programs. Providers in these states are now furnishing and getting paid for these care coordination services for high-cost, high-risk Medicaid beneficiaries.

Download the State-by-State Health Home State Plan Amendment Matrix

In 2013, the Centers for Medicare & Medicaid Services (CMS) acknowledged the additional work involved in managing a patient following a hospital discharge was not covered by existing reimbursement. CMS, therefore, created a new payment for transitional care management, or TCM. A physician who furnishes specified services for a Medicare beneficiary over a 30-day post-discharge period receives payment roughly equal to the highest payment for a new patient office visit.

Download PYA's Transitional Care Management White Paper

New Medicare Payment for CCM

With the publication of the 2015 Medicare Physician Fee Schedule Final Rule, it is now certain that Medicare will pay for chronic care management, or CCM, beginning January 1, 2015. As detailed below, CCM payments will reimburse providers for furnishing specified non-face-to-face services to qualified beneficiaries over a calendar month.

Download the 2015 Medicare Physician Fee Schedule Final Rule

In the Final Rule, CMS has adopted CPT[1] 99490 for Medicare CCM services, which is defined in the CPT Professional Codebook as follows:

> "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."

CMS developed the requirements for providing and billing for CCM over a three-year period. To fully understand those requirements, one must review the three different proposed and three different final rules CMS published during that period. We have analyzed those rules carefully, and condensed them down to three core requirements a provider must meet to bill for CCM:

1. **Secure the eligible beneficiary's written consent.**
2. **Have five specified capabilites needed to perform CCM.**
3. **Provide 20+ minutes of non-face-to-face care management services per calendar month.**

You will find a complete discussion of each core requirement in the tables below. The tables also provide an explanation of potential revenue; address which providers can bill for CCM; outline which Medicare beneficiaries are eligible for the service; and offer next steps for providers interested in furnishing CCM.

[1] Current Procedural Terminology (CPT) a registered trademark of the American Medical Association.

Potential Revenue

What is the reimbursement for CCM?

For the first quarter of 2015, the national average reimbursement will be $40.39 per beneficiary per calendar month. This amount is subject to change thereafter based on Congressional action on the Sustainable Growth Rate (SGR) formula.

Does CCM qualify as a preventive service exempt from beneficiary cost sharing?

No. CMS determined it does not have the statutory authority to exempt CCM from cost sharing requirements. A beneficiary will be responsible for any co-payments or deductible amounts.

What is the potential revenue associated with providing CCM?

The following analysis assumes a family medicine physician with an average size patient panel, an average percentage of Medicare beneficiaries in that panel, and the average number of Medicare beneficiaries with two or more chronic diseases:

Description	Average	Formula
Annual Number of Unique Patients[1]	3,279	A
Percent of Patients Covered by Medicare[1]	21.85%	B
Annual Number of Unique Medicare Patients	716	C = A*B, Rounded
Percent with 2+ Chronic Conditions[2]	68.60%	D
Annual Number of Unique CCM Patients	491	E = D*C, Rounded
CCM Monthly Payment[3]	$40.39	F
Esimated Annual Gross Revenue for Family Medicine Physician	**$237,978**	**G = (F*12)*E**

[1] Per the MGMA *Cost Survey for Single Specialty Practices: 2013 Report Based on 2012 Data* specific to the specialty of family medicine. Includes Medicare A/B and Medicare Advantage.

[2] CMS.gov - *County Level Multiple Chronic Conditions (MCC) Table: 2012 Prevelance, National Average*

[3] Reimbursement amount from the *CY 2015 Physician Fee Service Final Rule;* assumes 100% of unique patients are covered by Medicare A/B. Medicare Advantage reimbursement will vary.

Of course, the incremental economic benefit a provider may realize depends on costs incurred in providing the service. The following detailed discussion of CCM requirements should assist a provider in estimating those costs.

Will Medicare Advantage (MA) plans reimburse for CCM? Commercial payers?

An MA plan must offer its enrollees at least traditional Medicare benefits, which now will include CCM. Presumably, an MA plan will pay for CCM in the same manner as it now pays for other physician services. Whether commercial payers will pay for CCM remains to be seen, although the fact CMS is paying for this service makes it more likely.

Are there other financial benefits associated with developing a CCM program?

In addition to the potential for more than $200,000 in new incremental revenue per physician (or other qualified practitioner), CCM offers providers a bridge over the chasm between fee-for-service and value-based reimbursement. By developing and implementing a CCM program, a provider will grow skill sets and internal processes critical to population health management, all the while receiving fee-for-service payment to support those activities.

Eligible Providers	
Which practitioners are eligible to bill Medicare for CCM?	Physicians (regardless of specialty), advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse midwives (or the provider to which such individual has reassigned his/her billing rights) are eligible to bill Medicare for CCM. Other non-physician practitioners and limited-license practitioners (*e.g.*, clinical psychologists, social workers) are not eligible.
Can more than one provider bill for CCM for the same beneficiary?	No. CMS will pay only one claim for CCM per beneficiary per calendar month.
Must a practice be recognized as a patient-centered medical home (PCMH) to provide CCM?	At one point, CMS proposed PCMH recognition as a condition to provide CCM, but the Final Rule does not include this requirement. That said, the transformation to PCMH should position a practice to successfully provide CCM. Also, many commercial payers offer financial incentives for PCMH-recognized practices. There are at least four accreditation organizations that have established specific standards and are offering formal recognition for PCMH practices: National Committee on Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAHC), Joint Commission, and URAC (formerly known as the Utilization Review Accreditation Commission).
Are there services a provider must furnish to a beneficiary prior to billing for CCM for that beneficiary?	While CMS strongly recommends that a provider furnish an annual wellness visit (HCPCS G0438, G0439) or an initial preventive physical exam (G0402) to the beneficiary, there are no prerequisite services required to bill for CCM.
Are there services for which a provider cannot bill during the same calendar month as CCM?	Yes, there are four: transitional care management (CPT 99495 and 99496), home healthcare supervision (HCPCS G0181), hospice care supervision (HCPCS G0182), and certain end-stage renal disease (ESRD) services (CPT 90951-90970). If the provider furnishing CCM performs any other services for the beneficiary (such as an office visit or an immunization), the provider should bill for that service in addition to CCM. However, provider(s) not providing CCM to a beneficiary may provide and bill for the four services listed above.
Is CCM recognized as a rural health clinic (RHC) service and/or a federally qualified health center (FQHC) service?	For now, CMS has not recognized CCM as an RHC or FQHC service; thus, these providers will not be reimbursed at their all-inclusive rate for CCM services. An RHC or FQHC may have the opportunity to bill for CCM on the Medicare Physician Fee Schedule, provided it satisfies the applicable requirements to bill for non-RHC/non-FQHC services.

Eligible Beneficiaries

Who is an eligible beneficiary?	A beneficiary is eligible to receive CCM if he or she has been diagnosed with 2 or more chronic conditions expected to persist at least 12 months (or until death) that place the individual at significant risk of death, acute exacerbation/ decompensation, or functional decline. CMS has not provided a definition or definitive list of "chronic conditions" for purposes of CCM. Nor has the agency offered guidance on how to determine or document the specified acuity level.
Is there a list of chronic conditions on which a provider can rely?	CMS maintains a Chronic Condition Warehouse (CCW) to provide researchers with beneficiary, claims, and assessment data linked by beneficiary across the continuum of care. The CCW includes information on 22 specified chronic conditions.[2] However, the CCW list is not an exclusive list of chronic conditions; CMS may recognize other conditions for purposes of providing CCM.

Requirement No. 1: Beneficiary's Written Consent

How does a provider obtain a beneficiary's consent to receive CCM?	A provider cannot bill for CCM unless and until the provider secures the beneficiary's written consent. Specifically, the beneficiary must acknowledge in writing that the provider has explained the following: (1) the nature of CCM; (2) how CCM may be accessed; (3) that only one provider at a time can furnish CCM for the beneficiary; (4) the beneficiary's health information will be shared with other providers for care coordination purposes; (5) the beneficiary may stop CCM at any time by revoking consent, effective at end of then-current calendar month; and (6) the beneficiary will be responsible for any associated copayment or deductible.
What should a provider do with the consent form once it is signed?	A copy of the signed consent form must be maintained in the beneficiary's medical record. See discussion below regarding the required use of a certified electronic health record (EHR) in providing CCM.
What happens if a beneficiary revokes his or her consent?	Once a beneficiary revokes his or her consent to receive CCM from a specific provider, that provider cannot bill for CCM after the then-current calendar month. The provider may bill for CCM for the month in which the revocation is made, if the provider has furnished 20+ minutes of non-face-to-face care management services for the beneficiary.
How does a beneficiary revoke consent?	CMS does not specify the manner in which a beneficiary must revoke consent. Presumably, if a beneficiary gives written consent to a second provider to furnish CCM, that will revoke the consent given to the first provider. However, this can create confusion (and billing issues) if the first provider is unaware of the consent given to the second provider.

[2] The CCW includes data on the following chronic conditions: Acquired Hypothyroidism; Acute Myocardial Infarction; Alzheimer's Disease Related Disorders, or Senile Dementia; Anemia; Asthma; Atrial Fibrillation; Benign Prostatic Hyperplasia; Cancer (Colorectal, Endometrial, Breast, Lung, and Prostate); Cataract; Chronic Kidney Disease; Chronic Obstructive Pulmonary Disease; Depression; Diabetes; Glaucoma; Heart Failure; Hip/Pelvic Fracture; Hyperlipidemia; Hypertension; Ischemic Heart Disease; Osteoporosis; Rheumatoid Arthritis/Osteoarthritis; and Stroke/Transient Ischemic Attack.

Can a provider require a beneficiary to revoke consent in a certain manner?	In an effort to avoid confusion, a provider should specify on the CCM consent form the manner in which the beneficiary should revoke consent (*e.g.*, in writing delivered to the provider). Such an attempt to limit the manner of revocation, however, may or may not be recognized by CMS; CMS may deny payment based on the beneficiary's revocation in a manner other than specified on the provider's consent form.

Requirement No. 2: Five Specified Capabilities

What are the five capabilities CMS requires a provider to have to bill for CCM?	The five capabilities include: (1) Use a certified EHR for specified purposes; (2) Maintain an electronic care plan; (3) Ensure beneficiary access to care; (4) Facilitate transitions of care; and (5) Coordinate care. When a provider submits a claim for CCM, the provider is, in effect, attesting to the fact the provider has each of these capabilities for providing CCM. Each of these capabilities is discussed in the following sections.
For what purposes must a provider use a certified EHR in furnishing CCM (1st capability)?	A provider is not required to be a meaningful user of a certified EHR technology, but is required to use "CCM certified technology" (*i.e.*, for 2015, an EHR that satisfies either the 2011 or 2014 edition of the certification criteria for the EHR Incentive Programs) to meet the following core technology capabilities: • Structured recording of demographics, problems, medications, and medication allergies, all consistent with 45 CFR 170.314(a)(3)-(7) • Creation of summary care record consistent with 45 CFR 170.314(e)(2) The provider must be able to transmit the summary care record electronically for purposes of care coordination. CMS does not specify acceptable methods of transmission, but does state that facsimile transmission is not acceptable. Additionally, a provider must use CCM certified technology to fulfill any CCM requirement that references a health or medical record. Specifically, the following must be documented in the beneficiary's record using CCM certified technology: • Beneficiary consent • Provision of care plan to beneficiary • Communication to and from home and community-based providers regarding beneficiary's psychosocial needs and functional deficits (care coordination)
What is the requirement for an electronic care plan (2nd capability)?	The provider must maintain a regularly updated electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment of the beneficiary's needs. The plan should include an inventory of resources and supports; address all health issues (not just chronic conditions); and be congruent with the beneficiary's choices and values. While required to bill for CCM, the preparation of the care plan is not part of the reimbursable service. **Instead, these activities may be billed separately as an evaluation and management service, provided the applicable requirements are satisfied.**

What items are typically included in a care plan?	CMS has identified the following as items typically included in a care plan (although the agency does not specifically require a care plan to include each): • Problem list; expected outcome and prognosis; measurable treatment goals • Symptom management and planned interventions (including all recommended preventive care services) • Community/social services to be accessed • Plan for care coordination with other providers • Medication management (including list of current medications and allergies; reconciliation with review of adherence and potential interactions; oversight of patient self-management) • Responsible individual for each intervention • Requirements for periodic review/revision
Does the care plan have to be created, maintained, and updated using a certified EHR?	CMS requires a provider to "use some form of electronic technology tool or services in fulfilling the care plan element," but acknowledges that "certified EHR technology is limited in its ability to support electronic care planning at this time." Accordingly, providers "must have flexibility to use a wide range of tools and services beyond EHR technology now available in the market to support electronic care planning."
Who must have access to electronic care plan?	CMS imposes three requirements with respect to electronic access to the beneficiary's care plan: 1. The care plan must be electronically accessible on a 24/7 basis to all care team members furnishing CCM services billed by the provider. • *E.g.*, remote access to EHR, web-based access to care management application, web-based access to an electronic health information exchange (HIE) (facsimile is not sufficient) 2. The provider "must electronically share care plan information as appropriate with other providers" caring for the beneficiary. • *E.g.*, secure messaging, participation in HIE (facsimile not sufficient) 3. The provider must make available a paper or electronic copy of the care plan to the beneficiary. • Must be documented in CCM certified technology
What is required with respect to beneficiary access to care (3rd capability)?	A provider furnishing CCM must: 1. Provide a means for the beneficiary to access a member of the care team on a 24/7 basis to address acute/urgent needs in a timely manner (who constitutes a member of the care team is discussed below). 2. Ensure the beneficiary is able to get successive routine appointments with a designated practitioner or member of care team. 3. Provide enhanced opportunities for beneficiary-provider (or caregiver-provider) communication by telephone and asynchronous consultation methods (*e.g.*, secure messaging, internet), although the beneficiary is not required to use these methods.

What is required with respect to transitions of care (4th capability)?	A provider must have the capability to do the following: 1. Follow-up with the beneficiary after an ER visit. 2. Provide post-discharge transitional care management (TCM) services as necessary (although the provider cannot bill for TCM and CCM during the same month). 3. Coordinate referrals to other clinicians. 4. Share information electronically with other clinicians as appropriate (see prior discussion of summary care record and electronic care plan).
What is required with respect to coordination of care (5th capability)?	The provider must have the capability to coordinate with home and community-based clinical service providers to meet beneficiary's psychosocial needs and functional deficits (including providers of home health and hospice, outpatient therapies, durable medical equipment, transportation services, and nutrition services). The provider's communication with these service providers must be documented in CCM certified technology.

Requirement No. 3: 20+ Minutes of Non-Face-to-Face Care Management Services

What types of services constitute non-face-to-face care management services?	In the context of CCM, CMS identifies the following types of services performed on a beneficiary's behalf as counting toward the 20-minute requirement: (1) performing medication reconciliation and overseeing the beneficiary's self-management of medications; (2) ensuring receipt of all recommended preventive services; and (3) monitoring the beneficiary's condition (physical, mental, social). This list, however, is not exclusive; other types of services may count toward the 20-minute requirement. In the context of TCM, for example, CMS identified the following additional services as non-face-to-face care management services: provide education and address questions from patient, family, guardian, and/or caregiver; identify and arrange for needed community resources; and communicate with home health agencies and other community service providers utilized by the beneficiary.
Who may perform non-face-to-face care management services?	These services may be furnished by licensed clinical staff subject to proper supervision. Licensed clinical staff, in this context, includes APRNs, PAs, RNs, LSCSWs, LPNs, and what CMS refers to as "medical technical assistants" (CNAs and certified medical assistants).

What level of supervision is required for clinical staff providing non-face-to-face management services?	Initially, CMS proposed to require direct supervision of clinical staff (*i.e.*, physician or other practitioner present in the same suite of offices and immediately available to provide assistance while non-face-to-face care management services were being provided), with a limited exception for services furnished outside normal business hours. However, the Final Rule requires only general supervision (*i.e.*, physician or other practitioner available by telephone to provide assistance as required). The physician or other practitioner does not have to be the same person under whose name CCM is billed. Thus, a provider could contract with a third party to provide non-face-to-face care management services (including after-hours availability to address the beneficiary's urgent care needs), provided the third party has electronic access to the beneficiary's care plan. This "subscription service" approach would allow a smaller provider that could not otherwise afford necessary staffing to provide CCM.
What documentation is required?	CMS does not list explicit documentation requirements for non-face-to-face care management services. In the event of an audit, a provider would be well-served to have the following documentation available in the beneficiary's record: • Date and amount of time spent providing non-face- to face services (preferably start/stop time) • Clinical staff furnishing services (with credentials) • Brief description of services
What time counts toward the 20-minute minimum requirement?	Time spent providing services on different days or by different clinical staff members in the same month may be aggregated to total 20 minutes. However, if two staff members are furnishing services at the same time, only the time spent by one individual may be counted. Time of less than 20 minutes during a calendar month cannot be rounded up to meet this requirement; nor may time be carried over from a prior month.
Can remote monitoring be included in the 20 minutes?	According to CMS, "[p]ractitioners who engage in remote monitoring of patient physiological data of eligible beneficiaries may count the time they spend reviewing the reported data towards the monthly minimum time for billing the CCM code, but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device."

So What's Next?

Who can help your organization design and implement a CCM program?	PYA has the experience and know-how to assist your organization in developing an effective and efficient chronic care management program. We pride ourselves on our ability to transition complicated rules and regulations into practical, straightforward strategies.
Who are the members of PYA's team?	Our integrated delivery team includes experienced clinicians, certified case managers, regulatory specialists, data analysts, process improvement experts, and IT gurus.
What specific services does PYA provide?	Our CCM-related services include: • Gap analysis (current capabilities and resources vs. CCM requirements) • Business plan development and ROI analysis • Staffing plans • Staff training • Identification and stratification of eligible beneficiaries • Development and implementation of beneficiary enrollment process • Work flow design • Electronic care plan development • Documentation tools • Internal/patient communication strategies • Selection of supportive technology • Strategies to achieve PCMH recognition • Coding and billing processes • Compliance reviews

PYA can help you devise a winning strategy for providing and billing Medicare for CCM. To learn more, please contact one of the following:

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