Chronic Care Management

A Guide for RHCs & FQHCs

The Centers for Medicare & Medicaid Services (CMS) recognize Chronic Care Management (CCM) Services as a key element of providing patient with chronic conditions with vital services to maintain their health and wellness.

As part of CCM, Medicare will reimburse for services that you already perform, including:

Patient-Practice Communication
Phone, email, portal

Medical Record and Lab Review

Disease and Care Plan Updates

Medication Management
Medication Changes

Community- Based Services
Connecting patients with needed services

Referrals
Specialty or Home Health

1 Identify Patients Eligible for CCM

Determine Patient Eligibility

Patient has Medicare Part B, Medicare Advantage Plan, or is Dual Eligible with two or more chronic conditions, expected to last at least 12 months with risk of:

- exacerbation
- decompensation
- functional decline
- death

Did you know?
Other insurers pay for CCM services, too.

For CMS chronic care management guide:
www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Chronic Conditions

Chronic conditions include but are not limited to:

- Alzheimer's/dementia
- Arthritis
- Asthma
- Atrial Fibrillation
- Cancer
- COPD
- Cardiovascular Disease
- Depression
- Diabetes
- Hypertension
- Autism
- Infectious Disease
  - Hepatitis
  - HIV

Providers

Who can provide CCM services?

- All clinical staff as directed by physicians and non-physician practitioners
- Physicians
- Nurse Practitioners, Physician Assistants
- Certified Nurse Midwives
- Clinical Nurse Specialists

Certified Life or Health coaches may be considered clinical staff.

2 Initiate Services

- **Established patients**
  CCM may be initiated at any time with patient consent and creation of a comprehensive care plan for any patient seen within the past year.
- **New patients or those not seen within the past year**
  An initiating visit, such as a Welcome to Medicare (IPPE), Annual Wellness Visit (AWV) or office visit is necessary. A care plan is created and patient consent is obtained.

Consent is verbal and documente d in the medical record.

3 Document CCM

Documenting CCM services:

- Create a new encounter each month for tracking the summary of actions for CCM.
- Entries include: date of action, who performed the action and time spent.
- Maintain a current Problem List, reconcile medications, and update the health history in your electronic health record (EHR).
- Update the Care Plan as needed.

Check for CCM templates in your EHR.

An effective way to identify Medicare patients eligible for CCM is at their Annual Wellness Visit

4 Billing CCM Services

- Bill at the end of each month
- May be billed by only one provider per beneficiary per month
- May not be billed with Transitional Care Management (TCM), Home Health or Hospice Supervision, End-Stage Renal Disease service, or Prolonged E&M services

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

5 Coding

RHC/FQHC Medicare Code:

- G0511 - Payable alone or with other services

RHC/FQHC Commercial Payor Codes:

- 99490 – CCM services, 20 minutes
- 99487 – Complex CCM services, 60 minutes
- + 99489 – each additional 30 minutes

G0511 may also be used for Behavioral Health Management.

In 2019, code G0511 pays $67.03.

Still unsure of how to implement CCM Services?
Contact Healthcentric Advisors for personalized support:
neqpp.org/ask-question/support-team

© 1995-Present Healthcentric Advisors - All Rights Reserved.