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Agenda

• Overview of Chronic Care Management (CCM) & Principal Care Management (PCM) Services
• Importance of Chronic Care Management
• Required elements of CCM & PCM documentation
• Billing Chronic Care Management codes (*2020 Updates!*)
• Resources
• Questions
Chronic Care Management Services

Overview

- Physician office covered service
- Focuses on patients with chronic disease
- Supports informed, activated patients
- Assigns a proactive healthcare team to your chronically ill patients

Hint
Ties in with PCMH Care Management and Support (CM)
Patient-Centered Medical Home
Care Management & Support (CM)

Care Management Competencies:

• Identify patients who may benefit from care management

• Collaborates with the patient and caregivers to develop a documented care plan that includes lifestyle goals and patient preferences
Benefits of receiving CCM services

- Team of health care professionals
- Personalized care plan
- Focused support between medical visits
- Better care transitions
- Increased self-management

Patient benefits
Benefits of providing CCM services

Provider benefits

- Billing for services you already provide
- Improves care coordination and transitions of care
- Supports patient/family adherence to care plans
- Increases patient-practice communication
The Importance of Chronic Care Management Services

An estimated 177 million Americans have one or more chronic health conditions; one in four adults have two or more chronic health conditions.

Most chronic diseases are caused by a short list of risk behaviors:

- Tobacco use and exposure to secondhand smoke
- Poor nutrition including diets low in fruits and vegetables and high in sodium and saturated fats.
- Lack of physical activity
- Excessive alcohol use

- Centers for Disease Control and Prevention (CDC)
### Maine Chronic Conditions 2017

<table>
<thead>
<tr>
<th>State</th>
<th>Beneficiaries 65 Years and Over</th>
<th>Beneficiaries 65 Years and Over</th>
<th>Beneficiaries 65 Years and Over</th>
<th>Beneficiaries 65 Years and Over</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Chronic Conditions</td>
<td>Number of Chronic Conditions</td>
<td>Number of Chronic Conditions</td>
<td>Number of Chronic Conditions</td>
</tr>
<tr>
<td></td>
<td>0 to 1</td>
<td>2 to 3</td>
<td>4 to 5</td>
<td>6+</td>
</tr>
<tr>
<td>Maine</td>
<td>Prevalence (%)</td>
<td>Prevalence (%)</td>
<td>Prevalence (%)</td>
<td>Prevalence (%)</td>
</tr>
<tr>
<td></td>
<td>35.9</td>
<td>30.1</td>
<td>19.2</td>
<td>14.8</td>
</tr>
</tbody>
</table>

64.1% of beneficiaries in Maine have 2 or more chronic conditions.

Find the statistics for your state here:

Figure 1: Prevalence of Chronic Conditions among Fee-for-Service Beneficiaries: 2017

- Hypertension: 57%
- Hyperlipidemia: 41%
- Arthritis: 33%
- Diabetes: 27%
- Ischemic Heart Disease: 27%
- Chronic Kidney Disease: 24%
- Depression: 18%
- Heart Failure: 14%
- COPD: 12%
- Alzheimer's Disease/Dementia: 11%
- Atrial Fibrillation: 8%
- Cancer: 8%
- Osteoporosis: 6%
- Asthma: 5%
- Stroke: 4%
- Drug Abuse/Substance Abuse: 3%
- Schizophrenia/Other Psychotic Disorders: 3%
- Alcohol Abuse: 3%
- Hepatitis (Chronic Viral B & C): 0.8%
- HIV/AIDS: 0.4%
- Autism Spectrum Disorders: 0.2%

CMS Chartbook 2017
Self-Reported Chronic and Other Health Conditions Among All Medicare Beneficiaries, 2016

Chronic Condition Examples include but are not limited to:

<table>
<thead>
<tr>
<th>Chronic Conditions</th>
<th>Chronic Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer's/ dementia</td>
<td>COPD</td>
</tr>
<tr>
<td>Arthritis (osteoarthritis, rheumatoid)</td>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>Asthma</td>
<td>Depression</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Autism disorders</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Cancer</td>
<td>Infectious disease; i.e., hepatitis, HIV</td>
</tr>
</tbody>
</table>

Consider Substance Use Disorders
Why is CCM important in rural areas?

Seniors who live in rural areas experience health disparities across a wide range of behavior and outcome measures.

- America’s Health Rankings Senior Report 2018

- Rural seniors are more physically inactive
- Fewer rural seniors report “very good” or “excellent” health

- Fewer rural seniors vaccinated for Flu
- More rural seniors report falling
- More rural seniors smoke
Operationalizing Chronic Care Management

Eligibility, Work Flow, Documentation and Billing
Services Summaries

Chronic Care Management (CCM)
- 2 or more chronic conditions (1 year)
- Verbal Consent
- Initiating visit
- Certified EHR use
- 24/7 on call service
- Comprehensive care management
- Care transitions
- Home services coordination
- Enhanced communication

Principal Care management (PCM)
- 1 complex chronic condition (3 months min)
- Verbal consent
- Usually managed by specialists
- Certified EHR use
- 24/7 on call service
- Comprehensive care management
- Care transitions
- Home services coordination
- Enhanced communication
Medicare’s CCM Patient Eligibility

Chronic Care Management

- Part B Medicare or dual eligible (Medicare & Medicaid)
- **2 or more chronic illnesses**
  - Illnesses expected to last at least **12 months**, with risk of
    - exacerbation
    - decompensation
    - functional decline
    - Death
- Patient consent documented
Medicare’s PCM Patient Eligibility

Principal Care management

- Part B Medicare or dual eligible (Medicare & Medicaid)
- **one serious chronic illnesses**
- Illness expected to last **3 to 12 months** with risk of
  - Hospitalization or has been the cause of a recent hospitalization
- Patient consent documented

*Maybe billed by PCPs or specialists*
A word about Medicare’s Annual Wellness Visits

<table>
<thead>
<tr>
<th>IPPE</th>
<th>Initial Preventive Physical Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provided within the 1st year of Medicare eligibility</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>AWV</th>
<th>Annual Wellness Visit, Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provided within the 2nd year of Medicare eligibility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AWV</th>
<th>Annual Wellness Visit, subsequent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provided annually thereafter</td>
</tr>
</tbody>
</table>

The perfect opportunity to identify patients for Chronic Care Management

RHC or FQHC use code G0468
Who Can Provide CCM Services?

All clinical staff as directed by and including physicians & non-physician practitioners

- Physician
- Nurse practitioner
- Physician’s Assistant
- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurses, Medical Assistants
How do you begin?  

Initiating Visit

Established patients
Seen within a year

- CCM may be initiated with consent, and creation of a care plan at any time

New patients or those not seen within a year

- An initiating visit (IPPE, AWV or office visit), consent & care plan are required

Hint

Consent may be verbal but must be documented in the medical record
Care Plan Documentation with patient engagement

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive & functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Community services plan
- Review date
- Care plan revision, when applicable

Hint: Ties in with PCMH CM 01 – CM 05
What actions count as CCM services?

- Patient/family communication
  - phone, email through portal
- Medical record and lab review
- Management of care transitions
  - discharge, ED visit follow-up, referrals
- Problem list & Care Plan Updates
  - medication reconciliation, disease status changes
- Specialty referrals & Coordinating Care
  - coordinating care with providers & community services

Hint: Tasks are performed by clinical staff including physicians
CCM Medical Record Documentation

Maintain a monthly Chronic Care Management summary of actions, including:

• Date of the action?
• Who performed the action?
• Time spent performing the action?

Hint
Check for CCM templates in your EHR
CCM Medical Record Documentation

Using a Certified Electronic Health Record, maintain a current

- Problem List
- Medication reconciliation
- Health History

Hint

Ties in with PCMH – Knowing and Managing your Patients (KM)
Chronic Care Management Billing Information

- Create an encounter each month for tracking the summary of actions for CCM documentation
- Bill at the end of each calendar month
- Bill before end of month if CCM services are completed
- Patient’s request to discontinue CCM services would be effective at the end of the calendar month
Coding Summary

RHC or FQHC use only G0511 when billing Medicare

**Medicare only**

- + G0506 – Comprehensive CCM assessment & plan (Medicare code, add to initiating visit)

**All payor codes**

- 99491 – CCM by Physician or NPP, 30+ minutes
- 99490 – CCM by clinical staff, 20 – 59 minutes
- + G2058 - additional 20 minutes (may bill x 2)
- 99487 – Complex CCM services, 60 - 89 minutes
- + 99489 – each additional 30 minutes

Medicare only

All payor codes

NEW
Coding Summary

- **Physician** (MD, DO, NP, PA, CNS, CNM)
  - + G0506 – Complex CCM Assessment/ add to initiating visit or 99491 (Medicare only, non-RHC code)
  - 99491 – 30 minutes of CCM by physician

- **Clinical Staff** under supervision
  - 99490 – 20 minutes of CCM
  - + G2058 – additional 20 minutes of CCM (may be billed x 2) new Medicare for 2020!
  - 99487 – 60 minutes of Complex CCM (moderate to high medical decision-making)
    - + 99489 – each additional 30 mins CCM
Principal Care Management (PCM) New for 2020!

• **G2064** - Comprehensive care management for a single high-risk disease, **at least 30 minutes of physician or other qualified health care professional time** per calendar month

• **G2065** - Comprehensive care management for a single high-risk disease, **at least 30 minutes of clinical staff time** directed by a physician or other qualified health care professional, per calendar month

**Both services contain the following elements:**

• one complex chronic condition lasting at least 3 months, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization

• the condition requires development or revision of disease-specific care plan

• the condition requires frequent adjustments in the medication regimen, and/or care plan

• is unusually complex due to comorbidities

*May be billed with CCM done by a different provider*

*Not finalized for use in RHC or FQHC 2020*
CCM services furnished on or after January 1, 2018

**G0511**

Add the general care management HCPCS code, **G0511** to an RHC or FQHC claim, either alone or with other payable services.

Payment is set annually at the average of the national non-facility PFS payment rate for CPT codes 99490 (20 minutes or more of CCM services), 99487 (60 minutes or more of complex CCM services), and 99484 (20 minutes or more of general behavioral health Integration services).

**2020 payment (HCPCS code G0511) – $66.77**

**Co-insurance $13.35 a month**
Medicare Coding Summary for RHC/ FQHC

Psychiatric Collaborative Care management (CoCM), 60 minutes or more of clinical staff time per calendar month

**G0512**

Add to an RHC or FQHC claim, either alone or with other payable services. Includes behavioral health care management, consultation with psychiatrist

*2020 payment (HCPCS code G0512) – $141.83*
Remote Physiologic Monitoring codes

- 99457 – Remote physiologic monitoring treatment management services, first 20 minutes of clinician or staff time within the month
  - + 99458 – each additional 20 minutes

Is this billable in RHC & FQHC?  NO

Response: RHCs are paid an all-inclusive rate (AIR) when a medically necessary, face-to-face visit is furnished by an RHC practitioner. FQHCs are paid the lesser of their charges or the FQHC PPS rate when a medically necessary, face-to-face visit is furnished by an FQHC practitioner. Both the RHC AIR and the FQHC PPS rate include all services and supplies furnished incident to the visit. Services such as RPM are not separately billable because they are already included in the RHC AIR or FQHC PPS payment. ~ CMS FFS Final Rule for CY2020

May this be counted in CCM time? Need this questions answered by CMS.
CCM services may not be billed in conjunction with:

- Home health supervision (G0181)
- Hospice supervision (G0182)
- ESRD services (90951 – 90970)
- Prolonged E&M services
- Another provider’s CCM

New for 2020! May be billed with TCM – transitional care management (99495/ 99496)
Resources

CMS Chartbook 2017

CMS Connected Care

CMS Connected Care Toolkit

Chronic Care Management in RHCs and FQHCs
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

Centers for Disease Control and Prevention (CDC) – Chronic Disease
https://www.cdc.gov/chronicdisease/index.htm
Contact Information

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Questions?