



Chronic Care Management Services Changes for 2017

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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

- **What is CCM?**

Chronic Care Management (CCM) services by a physician or non-physician practitioner (Physician Assistant [PA], Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Certified Nurse-Midwife [CNM]) and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only 1 practitioner can bill CCM per service period (month).

The included services are:

- ✓ Use of a Certified Electronic Health Record (EHR)
- ✓ Continuity of Care with Designated Care Team Member
- ✓ Comprehensive Care Management and Care Planning
- ✓ Transitional Care Management
- ✓ Coordination with Home- and Community-Based Clinical Service Providers
- ✓ 24/7 Access to Address Urgent Needs
- ✓ Enhanced Communication (for example, email)
- ✓ Advance Consent

- **Key Improvements for 2017**

- **Increased payment and additional codes (Table 1) - For 2016, the single CCM code paid approximately \$42. Now there are 3 codes and payment can range from approximately \$43 to over \$141, depending on how complex a patient's needs are.**
 - A given patient can receive either regular (often referred to as "non-complex") CCM or complex CCM during a service period if applicable (not both)
 - The difference between complex and non-complex CCM is the amount of clinical staff time, the extent of care planning, and the complexity of the problems addressed by the billing practitioner during the month

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- **Reduced requirements associated with initiating care, and increased payment when extensive initiation work is necessary (Table 1)**
 - Initiating visit only required for new patients or those not seen within a year prior to the commencement of CCM (previously all patients required an initiation visit)
 - Increased payment for CCM-related work by the billing practitioner during initiating visits (Add-On Code G0506 can be billed in addition to the initiating visit service code when the billing practitioner personally performs extensive assessment and CCM care planning beyond the usual effort for the initiating visit code)
- **Significantly reduced administrative burden (reduced payment rules for billing the services, Table 2)**
 - Improved alignment with CPT coding language for administrative simplicity, focus on timely sharing and availability of health information rather than use of specific electronic technology, simplified patient consent, reduced documentation rules
- **General supervision in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)**, however only CPT 99490 is payable in these settings (complex CCM is not payable) and there is no add-on code/separate payment for initiating visits

TABLE 1. SUMMARY OF 2017 CCM CODING CHANGES

BILLING CODE	PAYMENT (NON-FACILITY RATE)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
CCM (CPT 99490)	\$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised, or monitored	Ongoing oversight, direction, and management Assumes 15 minutes of work
Complex CCM (CPT 99487)	\$94	60 minutes	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 26 minutes of work
Complex CCM Add-On (CPT 99489, use with 99487)	\$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 13 minutes of work
CCM Initiating Visit*	\$44-\$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	\$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

*(Annual Wellness Visit [AWV], Initial Preventive Physical Examination [IPPE], Transitional Care Management [TCM], or Other Qualifying Face-to-Face Evaluation and Management [E/M])

TABLE 2. SUMMARY OF CCM SERVICES CHANGES FOR 2017

CCM Requirement	Changes for 2017
Initiating Visit	<ul style="list-style-type: none"> • Now only required for new patients or patients not seen within 1 year prior to commencement of CCM • Extra payment for extensive initiating services by the CCM practitioner (G0506)
Certified EHR and other electronic technology requirements	<ul style="list-style-type: none"> • Certified EHR still required to standardize formatting in the medical record of core clinical information (demographics, problems, medications, medication allergies), but certified technology no longer required for other CCM documentation or transitional care management documents • No specific technology requirements for sharing care plan information electronically within and outside the practice, and fax can count, as long as care plan information is available timely (meaning promptly at an opportune, suitable, favorable, useful time) • Individuals providing CCM after hours no longer required to have access to the electronic care plan, as long as they have timely information • Remove standards for formatting and exchanging/transmitting continuity of care document(s) • Continue to encourage and support the use of certified technology and increased inter-operability, but code-level conditions of Medicare Physician Fee Schedule (PFS) payment may not be the best means of accomplishing this. Practitioners are likely to transition to advanced electronic technologies due to incentives of the Quality Payment Program, independent of CCM rules.
Continuous Relationship with Designated Care Team Member	<ul style="list-style-type: none"> • Improved alignment with CPT language for administrative simplicity
Comprehensive Care Management and Care Planning	<ul style="list-style-type: none"> • Improved alignment with CPT language for administrative simplicity and appropriate caregiver inclusion • No longer specify format of the care plan copy that must be given to the patient (or caregiver if appropriate) • Electronic technology use standards relaxed (see above)
Transitional Care Management	<ul style="list-style-type: none"> • Improved alignment with CPT language for administrative simplicity • Clinical summaries used in managing transitions renamed “continuity of care document(s)” • Electronic technology use standards relaxed (see above)
24/7 Access to Address Urgent Needs	<ul style="list-style-type: none"> • Improved alignment with CPT language • Clarifying the required access is for urgent needs
Advance Consent	<ul style="list-style-type: none"> • Verbal instead of written consent is allowed (but must still be documented in the medical record, and the same information must be explained to the patient for transparency)

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