Audio Title: Chronic Care Management Services
Audio Date: 10/13/2015
Run Time: 12 minutes
ICN: 909188P

Welcome to Medicare Learning Network® Podcasts at the Centers for Medicare and Medicaid Services, or "CMS." These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information that health care professionals can trust.

Are you a physician or other qualified health care professional who bills for chronic care management services? Then this podcast is for you. Based on the "Chronic Care Management Services" Fact Sheet, it provides important information on the newly payable chronic care management, or C-C-M, service, identifies eligible providers and patients, and details the Medicare Physician Fee Schedule, or P-F-S, billing requirements.

Let's start off with the background of C-C-M. Beginning January 1, 2015, Medicare pays separately under P-F-S under American Medical Association Current Procedural Terminology, or C-P-T, code nine nine four nine zero (99490), for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions.

C-P-T code nine nine four nine zero (99490) is defined as chronic care services of at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following three required elements:

- One (1) - multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;

- Two (2) - chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; and

Three (3) - a comprehensive care plan is established, implemented, revised, or monitored.

Page two (2) of the "Chronic Care Management Services" Fact Sheet contains examples of chronic conditions. Some examples include arthritis, asthma, diabetes, and hypertension. Two-thirds of Medicare beneficiaries had two or more chronic conditions. About one-third had four or more chronic conditions.

Next, let's discuss practitioner eligibility. Physicians and the following non-physician practitioners may bill the new C-C-M service:

- Certified Nurse Midwives;
- Clinical Nurse Specialists;
- Nurse Practitioners; and
- Physician Assistants.

Note: Only one practitioner may be paid for the C-C-M service for a given calendar month.

Eligible practitioners must act within their State licensure, scope of practice, and Medicare statutory benefit. Primary care physicians may bill the C-C-M service most frequently, although specialty physicians who meet all of the billing requirements may bill the service. The C-C-M service is not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists; therefore, these practitioners cannot furnish or bill the service. However, CMS expects referral to, or consultation with, such physicians and practitioners by the billing practitioner to coordinate and manage care.

Services provided directly by an appropriate physician or non-physician practitioner or by clinical staff incident to the billing physician or non-physician practitioner, count toward the minimum amount of service time required to bill the C-C-M service, which is 20 minutes per calendar month.

You may not count non-clinical staff time. Consult the C-P-T definition of "clinical staff" and the Medicare P-F-S "incident to" rules to determine whether you may count time by specific individuals towards the minimum time requirement. You may use individuals outside the practice to provide C-C-M services, subject to the Medicare P-F-S "incident to" rules and regulations and all other applicable Medicare rules.

CMS provided an exception under Medicare's "incident to" rules that allows clinical staff to provide the C-C-M service incident to the services of the billing physician, or other appropriate practitioner, under the **general supervision**, rather than direct supervision, of a physician, or other appropriate practitioner. Please note, CMS requires the billing practitioner to furnish an Annual Wellness Visit, Initial Preventive Physical Examination, or comprehensive evaluation and management visit to the patient prior to billing the C-C-M service, and to initiate the C-C-M service as part of this exam/visit.

Now, we will discuss patient eligibility. Patients with multiple (two or more) chronic conditions expecting 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 eligible for the C-C-M service. /decomposition, or functional decline are eligible for the C-C-M service.

You must inform eligible patients of the availability of and obtain consent for the C-C-M service before furnishing or billing the service. Some of the patient agreement provisions require the **use of certified Electronic Health Record, or E-H-R, technology.** For a complete listing of the patient Agreement and Related E-H-R Requirements, see Table one (1) on page seven (7) of the "Chronic Care Management Services" Fact Sheet.

Patient consent forms include the following four requirements:

- First, inform the patient of the availability of the C-C-M service and obtain written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers;

- Second, explain and offer the C-C-M service to the patient. In the patient's medical record, document this discussion and note the patient's decision to accept or decline the service;

- Third, explain how to revoke the service; and

Fourth, inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.

The agreement process should include a discussion with the patient, and caregiver when applicable, about the following five elements:

- One (1) - what the C-C-M service is;
- Two (2) - how to access the elements of the service;
- Three (3) - how the patient's information will be shared among practitioners and providers;
- Four (4) - how cost-sharing (co-insurance and deductibles) applies to these services; and
- Five (5) - how to revoke the service.

Informed patient consent need only be obtained once prior to furnishing the C-C-M service, or if the patient chooses to change the practitioner who will furnish and bill the service.

Although patient cost-sharing applies to the C-C-M service, C-C-M may help avoid the need for more costly face-to-face services in the future by proactively managing patient health, rather than only treating disease and illness.

Next, let's discuss the highlights of the C-C-M Scope of Service elements. The C-C-M service is extensive, including structured recording of patient health information, an electronic care plan addressing all health issues (see Comprehensive Care Plan elements identified on page 5 of the "Chronic Care Management Services" Fact Sheet), access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. Some of the C-C-M Scope of Service elements require the use of a certified E-H-R or other electronic technology. **For a complete listing of the C-C-M Scope of Service elements and electronic technology requirements that must be met in order to bill services, see Table one (1) on page seven (7) of the "Chronic Care Management Services" Fact Sheet.**

Now, we will discuss E-H-R and other electronic technology requirements. CMS requires the use of certified E-H-R technology to satisfy some of the C-C-M scope of service elements. In furnishing these aspects of the C-C-M service, CMS requires the use of a version of certified E-H-R that is acceptable under the E-H-R Incentive Programs as of December 31st of the calendar year preceding each Medicare P-F-S payment year. This is **referred to as "C-C-M certified technology**." For more information, see page six (6) of the "Chronic Care Management Services" Fact Sheet.

At this time, CMS does not require the use of certified E-H-R technology for some of the services involving the care plan and clinical summaries, allowing for broader electronic capabilities. These are described in Table one (1) on page seven (7) of the "Chronic Care Management Services" Fact Sheet.

Next, let's discuss other billing requirements. C-P-T code nine nine four nine zero (99490) **cannot be billed during the same calendar month** as C-P-T codes nine nine four nine five (99495) through nine nine four nine six (99496) (transitional care management), Healthcare Common Procedure Coding System, or HCPCS codes G zero one eight one /G zero one eight two (G0181/G0182) (home health care supervision/hospice care supervision), or C-P-T codes nine zero nine five one (90951) through nine zero nine seven zero (90970) (certain End-Stage Renal Disease services). Also, consult C-P-T instructions for additional codes that cannot be billed during the same service period as C-P-T code nine nine four nine zero (99490). There may be additional restrictions on billing for practitioners participating in a CMS sponsored model or

demonstration program.

CMS pays for the new C-C-M service separately under the Medicare P-F-S. See page nine (9) of the "Chronic Care Management Services" Fact Sheet for payment information for specific geographic locations.

Last, we will discuss C-C-M and other CMS advanced primary care initiatives. The C-C-M service provides payment of care coordination and care management for a beneficiary with multiple chronic conditions within the Medicare Fee-for-Service Program. Medicare will not make duplicate payments for the same or similar services for beneficiaries with chronic conditions already paid for under the various CMS advanced primary care demonstration and other initiatives. For example, the Multi-payer Advanced Primary Care Practice or the Comprehensive Primary Care Initiatives. For more information on potential duplicate billing, consult the CMS staff responsible for these separate initiatives. As CMS implements new models or demonstrations that include payments for care management services, or as changes take place that affect existing models or demonstrations, it will address potential overlaps with the C-C-M service and seek to implement appropriate payment policies.

There are additional resources to help you with your chronic care management services. These resources can be found on page ten (10) of the "Chronic Care Management Services" Fact Sheet.

More questions? To learn more about chronic care management services contact your Medicare Administrative Contractor or visit our website at www.cms.gov to download the Fact Sheet. At the top of the page in the search bar type "Chronic Care Management Services" Fact Sheet.

Be on the lookout for future Medicare Learning Network® podcasts on subjects of interest to you.