National Hospice and Palliative Care Organization

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Palliative Care Resource Series

CHRONIC CARE MANAGEMENT

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INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) established a separate payment under the Medicare Physician Fee Schedule for "non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions." The separate payment, which began January 1, 2015, has been established because CMS recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending. The American Medical Association Current Procedural Terminology (CPT) code to be used is 99490. CPT 99490 is defined as follows: 99490 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, and
- Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline, and
- Comprehensive care plan established, implemented, revised, or monitored.

No face-to-face services are required, and the CCM services may be provided by the physician, NPP or clinical staff. Incident-to- supervision criteria have been waived for CCM and 24/7 access is required. The organization or practice must use an EHR certified by ONC.

CHRONIC CARE MANAGEMENT (CCM)

- CPT® 99490 is billed when at least 20 minutes of clinical staff time is spent in care management activities in a calendar month.
- Only one physician/NPP may bill for CCM.
- Covers a calendar month.
  - **Medicare allowable:** ~$45/month
- Patients must have
  - 2 or more chronic conditions
  - Expected to last at least 12 months,
  - That place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

CARE MANAGEMENT ACTIVITIES

- Communication/engagement w/patient, family, guardian, surrogate decision makers, and/or other professionals regarding aspects of care
- Communication with HHAs, other community services
- Patient/caregiver education to support self-management, independent living, ADLs
- Assessment, support of treatment regimen &/or medication management

PRACTICE/ORGANIZATION CAPABILITIES

- 24/7 access to physician/NPP/Clinical staff to address urgent needs
- Continuity of care via designated team member w/whom patient can schedule successive appointments
- Timely access, management for f/up after an ED visit or facility d/c
- Utilize an EHR so care providers have timely access to clinical information
- Use standardized methodology to identify patients requiring CCM

CCM: 99490 REQUIRED ELEMENTS

- Multiple (2+) 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 or decompensation, or functional decline.
- Comprehensive care plan established implemented, revised or monitored.
- 20 minutes or more of CCM services, in a calendar month, must be provided and documented.
- Cannot bill CCM in the same month as TCM, Care Plan Oversight.

CCM: Additional CMS Requirements

Explain cost-sharing to the patient and obtain their consent prior to providing the service
"Practitioners should explain that a likely benefit of agreeing to receive CCM services is that although cost-sharing applies to these services, CCM services may help them avoid the need for more costly face to face services that entail greater cost-sharing." CMS 1612-FC

Elements of the comprehensive care plan

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions
- Medication management
- Community/social services ordered
- How services of agencies/specialists unconnected with the practice will be coordinated
- Identify who is responsible for each intervention
- Requirements for periodic review and, when applicable, revision of the care plan

Facilitate communication of relevant clinical information via electronic exchange of summary care record

- No facsimile use
- Could be secure messaging
- HIPAA applies

Have qualified personnel available to deliver transitional care services to the patient in a timely way to reduce the need for repeat ED visits, and readmission to hospitals, SNFs, or other health care facilities

Obtain patient's written agreement to have the services provided
- Including authorization for electronic communication of the patient's clinical info w/other treating providers as part of care coordination.

Document that all elements of CCM service were explained and offered, and note the beneficiary's decision to accept or decline the service

Provide the patient a written or electronic copy of the care plan
- Document in the EMR that the care plan was provided to the beneficiary.

Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of a calendar month) and the effect of revocation

Inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.
- Similar to TCM

Certified EHR technology for core elements of CCM, including structured recording of:
- Demographics
- Problem list
- Medications
- Medication allergies
- Structured clinical summary

CHRONIC CARE MANAGEMENT AND PALLIATIVE CARE

Most of these requirements are part of a palliative care program's essential capabilities.
- Most physician practices will feel overwhelmed
- CCM is an asset for commercial/Medicare ACOs

Potential issues
- Certified EHR technology
- Not stepping on a patient's primary care physician's toes
  - But, see sub-bullet above
  - Easily overcome vis-à-vis communication

Resources and Links

- Chronic Care Management Fact Sheet, published by CMS
- CY 2014 Medicare PFS Final Rule (CMS-1600-FC) pages 74414-74427
- CY 2015 Medicare PFS Final Rule (CMS-1612-FC) pages 67715-67730

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