

KENT MOORE

CHRONIC CARE MANAGEMENT AND OTHER NEW CPT CODES

At long last, physicians can be paid for some of the care coordination services that they provide.

Effective Jan. 1, 2015, Medicare began paying for chronic care management (CCM), recognizing the value that primary care brings to health care. This article provides you with information and tools that your practice needs to bill for these services. The requirements are numerous, but this new revenue could have a significant impact on your practice's bottom line. See "Other CPT changes of note" (page 11) to learn about additional code changes for 2015.

Patient eligibility

For Medicare payment purposes, the Centers for Medicare & Medicaid Services (CMS) has decided that CCM is for patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CMS has not specified or otherwise limited the eligible chronic conditions that meet this definition.

CMS expects that physicians will particularly focus on eligible patients with higher acuity and higher risk (e.g., patients with four or more chronic conditions) when

furnishing CCM services because the benefits are likely to be greater. (For a tool to assist with risk-stratified care management, see <http://bit.ly/1fWxfg6>.)

Practice standards

When CMS originally proposed to pay for CCM services, it stated its intent to develop standards that practices furnishing CCM services would have to meet. However, a funny thing happened as CMS worked to develop these standards. Namely, CMS found that many of the



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standards it thought were important either duplicated existing requirements or, worse, imposed conflicting requirements on providers that would furnish CCM services. Therefore, CMS decided not to propose an additional set of standards but to emphasize that certain requirements are inherent in the scope of CCM services (discussed below) and must be met to bill for those services.

Scope of services

Eight elements define the current scope of CCM services:

1. Access to care management services 24 hours a day, 7 days a week. This means providing patients with a means to make timely contact with health care providers in the practice to address urgent chronic care needs regardless of the time of day or day of the week.

2. Continuity of care. The patient must be able to get successive routine appointments with a designated provider or care team member.

3. Care management for chronic conditions. This includes the following:

- Systematic assessment of a patient's medical, functional, and psychosocial needs,
- System-based approaches to ensure timely receipt of all recommended preventive care services,
- Medication reconciliation with review of adherence and potential interactions,
- Oversight of patient self-management of medications.

4. Creation of a patient-centered care plan document to ensure that care is provided in a way that is congruent with patient choices and values. A plan of care is based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues. (A care plan form created for this purpose by *Family Practice Management's* medical editor, Kenneth G. Adler, MD, MMM, can be downloaded with the online version of this article. The form can serve as the basis for an EHR template, in which case several sections of the form can be imported.)

5. Management of care transitions between and among health care providers and settings. This includes the following:

- Referrals to other clinicians,
- Follow-up after a patient visit to an emergency department,
- Follow-up after a patient discharge from a hospital, skilled nursing facility, or other health care facility.

Communicating relevant patient information through electronic exchange of a summary care record is required upon these transitions. CMS is not requiring providers to use a specific tool or service to communicate clinical summaries electronically, but faxing is not allowed. Providers must format their clinical summaries according to, at a minimum, the standard that is acceptable for the Medicare & Medicaid Electronic Health Record (EHR) Incentive Program as of Dec. 31 of the calendar year preceding each payment year.

6. Coordination with home- and community-based clinical service providers. This is to ensure appropriate support of a patient's psychosocial needs and functional deficits.

7. Enhanced opportunities for a patient and any relevant caregiver to communicate with the provider regarding the beneficiary's care. This includes communicating through not only telephone access but also the use of secure messaging, Internet, or other asynchronous, non-face-to-face consultation methods.

8. Electronic capture and sharing of care plan information. This information must be available on a 24/7 basis to all providers within the practice who are furnishing CCM services and whose time counts toward the time requirement for billing the CCM code. It must also be shared electronically (other than by facsimile) as appropriate with other providers who are furnishing care to the beneficiary.

CMS requires practices to provide the patient a written or electronic copy of the care plan and to document in the EHR that this was done. Additionally, to ensure all practices have adequate technological capabilities (structured recording of demographics, problems, medications, medication allergies, and

■ The new chronic care management (CCM) benefit is for patients with two or more chronic conditions.

■ The scope of CCM comprises eight elements, including those related to access, use of a care plan, care coordination, and others.

■ Information must be captured and shared electronically using certified electronic health record technology.

AGREEMENT TO RECEIVE MEDICARE CHRONIC CARE MANAGEMENT SERVICES

As of Jan. 1, 2015, Medicare covers chronic care management services provided by physician practices per calendar month. I understand that my primary care physician, named below, is willing to provide such services to me, including the following:

- Access to my care team 24-hours-a-day, 7-days-a-week, including telephone access and other non-face-to-face means of communication (e.g., email),
- The ability to get successive, routine appointments with my designated primary care physician or member of my care team,
- Care management of my chronic conditions, including timely scheduling of all recommended preventive care services, medication reconciliation, and oversight of my medication management,
- Creation of a comprehensive plan of care for all my health issues that is specific to me and congruent with my choices and values,
- Management of my care as I move between and among health care providers and settings, including the following:
 - Referrals to other health care providers,
 - Follow-up after I visit an emergency department,
 - Follow-up after I am discharged from the hospital or other facility (e.g., skilled nursing facility),
- Coordination with home- and community-based providers of clinical services.

I understand that as part of these services I will receive a copy of my comprehensive plan of care.

I also understand that I can revoke this agreement at any time (effective at the end of a calendar month) and can choose, instead, to receive these services from another health care professional after the calendar month in which I revoke this agreement. Medicare will only pay one physician or health care professional to furnish me chronic care management services within a given calendar month.

I understand these chronic care management services are subject to the usual Medicare deductible and coinsurance applied to physician services.

I hereby indicate by signature on this agreement that _____ is designated as my primary care physician for purposes of providing Medicare chronic care management services to me and billing for them.

My signature also authorizes my primary care physician to electronically communicate my medical information with other treating providers as part of the care coordination involved in chronic care management services.

This designation is effective as of the date below and remains in effect until revoked by me.

Patient name (please print): _____

Patient or guardian signature: _____

Date: _____

CCM payment for Medicare participating physicians is \$42 per patient per month.

the creation of a structured clinical summary), they must use EHR technology that meets the certification criteria for the Medicare & Medicaid EHR Incentive Program as of Dec. 31 of the calendar year preceding each payment year. For 2015, the CMS policy will allow providers to use EHR technology that meets either the 2011 or 2014 edition of the certification criteria.

can furnish and be paid for these services during a calendar month.

CMS expects that this discussion with the patient, and caregiver when applicable, will include the following:

- What CCM services are,
- How these services are accessed,
- How the patient's information will be shared among other providers in the care team,
- How cost sharing applies to these services even when they are not delivered face-to-face in the practice.

CCM services will be subject to the usual cost sharing (i.e., deductible and coinsurance) for Medicare patients. When discussing cost sharing with the patient, you should explain that a likely benefit of receiving CCM services is avoiding the need for more costly face-to-face services (e.g., emergency department visits or hospital admissions). It may be worth pointing out how the deductible and coinsurance for a hospital admission compare with the \$8 to \$9 coinsurance that patients must pay for a month's worth of CCM.

Because of the cost sharing and because CCM services will typically be non-face-to-face services, CMS believes it is prudent to require written agreement prior to initiating CCM. The informed agreement process need only occur once at the outset of furnishing the service, and need only be repeated if the patient opts to change providers. A practice

■ Practices must collect a signed patient agreement before billing CCM.

■ The CCM benefit is subject to the Medicare deductible and coinsurance.

Getting patient agreement

Before billing CCM services, CMS requires you to do the following:

- Inform the patient of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers as part of care coordination,
- Document in the patient's medical record that all of the CCM services were explained and offered to the patient, and note the patient's decision to accept or decline these services,
- Inform the patient of the right to stop CCM services at any time (effective at the end of the calendar month) and what effect a revocation of the agreement would have on CCM services,
- Inform the patient that only one provider

MEDICARE CHRONIC CARE MANAGEMENT SERVICES LOG

Patient name: _____

Medicare number: _____ Calendar month: _____

Date of activity	Description of activity	Time spent (minutes)	Name of team member

OTHER CPT CHANGES OF NOTE

The addition of a new chronic care management code is not the only change in CPT 2015. Others are summarized in Appendix B of the manual. You are encouraged to review that appendix and the sections of CPT that you use most often to identify other changes that may be relevant to your practice. Here is a quick summary of the changes most likely to affect family physicians:

Vaccines

There is a new code for influenza vaccine: 90630, "Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use." Concurrently, CPT has revised code 90654 by adding "trivalent (IIV3)" to the descriptor, which will help distinguish it from 90630. The new descriptor for 90654 reads, "Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use."

Similarly, there is a new code for Human Papillomavirus vaccine: 90651, "Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (HPV), 3 dose schedule, for intramuscular use."

Both code 90651 and code 90630 have a lightning bolt symbol next to them in CPT 2015, indicating that Food and Drug Administration approval is pending.

Joint injections

CPT 2015 revises the existing joint injection codes (20600, 20605, and 20610) and adds three new codes (20604, 20606, and 20611) to distinguish joint injections without and with ultrasound guidance. The new and revised codes read as follows:

20600 Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); without ultrasound guidance,

20604 with ultrasound guidance, with permanent recording and reporting,

20605 Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow, ankle, olecranon bursa); without ultrasound guidance,

20606 with ultrasound guidance, with permanent recording and reporting,

20610 Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); without ultrasound guidance,

20611 with ultrasound guidance, with permanent recording and reporting.

Note that the new codes "with ultrasound guidance" also reference "with permanent recording and reporting." If you are using ultrasound but not generating a permanent recording and reporting, you should not use these codes. Also note that if you are using some other form of imaging guidance (e.g., fluoroscopy), that remains separately reportable, as it was in 2014.

Fluoride application

There is a new code for application of topical fluoride varnish: 99188, "Application of topical fluoride varnish by a physician or other qualified health care professional." Family physicians and other primary care physicians sometimes find themselves in the position of providing primary, preventive dental services to their patients, especially children. This new code will allow physicians to report one such service. (To learn more, see "Offering Oral Health Services in Your Office," *FPM*, <http://www.aafp.org/fpm/2014/0700/p21.html>.)

does not need to inform a patient before submitting each bill for CCM services.

CMS has not provided a standard written agreement for obtaining patient consent to CCM services. However, the tool included with this article should facilitate meeting these requirements, especially if a signed copy is kept in the patient's medical record along with a note that all of the CCM services were explained and offered to the patient and that the patient accepted or declined the services. (See the sample patient agreement on page 9. An electronic copy can be downloaded from the online version of this article.)

The patient can revoke the agreement for CCM services at any time verbally or in writing. However, the revocation is not effective until the end of the month. You must record the date of the revocation in the patient's medical record and provide the patient with

written confirmation that you will not be providing CCM services beyond the current calendar month.

Coding, billing, and documentation

To bill Medicare for CCM services, use CPT code 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,
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
- Comprehensive care plan established, implemented, revised, or monitored." ►

FREE WEBINAR ON JAN. 27

Kent Moore will present a webinar, "Getting Paid for Chronic Care Management Under Medicare in 2015," on Jan. 27 from 12:30 p.m. to 1:30 p.m. CT. A portion of the time will be allotted for questions and answers. Space is limited. Reserve your seat now at <https://www3.gotomeeting.com/register/581953510>.

The Medicare payment allowance (unadjusted geographically) for Medicare participating physicians is approximately \$42 per month. As noted, the service is subject to the usual Medicare beneficiary cost sharing (i.e., deductible and coinsurance).

If you participate in either CMS's Multi-Payer Advanced Primary Care Practice Demonstration or the Comprehensive Primary Care Initiative, you may not bill Medicare for CCM services furnished to any patient attributed to your practice for purposes of participating in one of these initiatives. CMS believes the payment for CCM services would be duplicative of the per-patient-per-month payment practices already receive for participating in these initiatives. However, you may bill Medicare for CCM services furnished to eligible patients who are not attributed to your practice for these purposes.

Similarly, you cannot bill CCM services for a patient during the same calendar month in which you are otherwise billing Medicare for transitional care management services (99495 and 99496), home health care supervision (G0181), hospice care supervision (G0182), or certain end-stage renal disease services (90951-90970). CMS believes that care management is an integral part of all of these services and that there is significant overlap between the care management of these services and the care management inherent in CCM. Thus, CMS has concluded that paying separately both for CCM and the care management included in these other services would result in duplicate payment.

The 20 minutes per calendar month is a minimum threshold (i.e., you may not round up your time spent in order to meet it), and you can count the time of only one clinical staff member for a particular segment of time (e.g., if two staff people meet about a patient for 10 minutes, that only counts as 10 minutes, not 20 minutes). Documenting this time in the patient's record will be a necessity to

reduce your audit risk. The CCM services log on page 10 provides one way to do this; you can download a copy from the online version of this article.

CCM and "incident to" rules

As stated in the Medicare code descriptor, CMS presumes that CCM services will be primarily provided by clinical staff under the direction of a physician or other qualified health care professional. This presumption implicates Medicare's "incident to" policies and how those policies relate to CCM services.

In particular, Medicare's rules typically require "incident to" services to be furnished under direct supervision. This means that the supervising provider must be present in the office suite and immediately available to give assistance and direction throughout the service. However, CMS has created an exception and is requiring only general, rather than direct, supervision when CCM services are furnished incident to a provider's services. This means the supervising provider must only be available by telephone. All other requirements related to "incident to" services would still apply to CCM services.

New beginnings

This article addresses many of the questions you may have about this new Medicare service. (For additional information, see "Answers to frequently asked questions about chronic care management services," in the online version of this article.)

In the end, Medicare coverage of and payment for CCM services offers an opportunity to be compensated for the non-face-to-face work that you and your staff provide to effectively manage Medicare patients with multiple, chronic conditions that place them at risk. Hopefully, you now have the knowledge and tools necessary to take advantage of that opportunity. **FPM**

■ The CPT code for CCM is 99490.

■ Twenty minutes of physician-directed staff time per month is required for CCM billing and should be documented in the patient's record.

■ CMS is requiring only "general supervision" when CCM services are furnished incident to a provider's services.

Send comments to fpmedit@aafp.org, or add your comments to the article at <http://www.aafp.org/fpm/2015/0100/p7.html>.

PATIENT-CENTERED CARE PLAN

Patient name: _____ Date: _____

Provider name: _____

Complete the next four sections prior to your visit:

Top concerns and barriers

The main things I would like to fix or improve about my health are:

-
-
-

The main things preventing me from improving my health are:

-
-
-

Symptom management

The main symptoms I wish to reduce or eliminate are:

-
-
-

To treat these, your provider will help you complete the "Summary of things I need to do," next page, at your appointment.

Health care providers

List any other providers you see regularly for health care (for example, ophthalmologist, cardiologist, therapist):

-
-
-

Resources and supports

Besides your health care team, who could you turn to for help for health-related problems (for example, family members, friends, a spiritual leader)?

-
-

Complete the remaining sections with your provider at your appointment:

My medications*

I agree to do the following:

- Discuss concerns I have about taking any of my medications with my primary care provider (PCP) and/or pharmacist,
- Advise my PCP if I choose to stop my medication(s), including my reasons for stopping, and discuss potential alternatives,
- Advise my PCP of bothersome side effects from my medication(s),
- Inform my PCP if new medications are added by other providers.

I have reviewed the current medication list (see above) and confirm that it is accurate.

My allergies*

My conditions*

I have reviewed my list of conditions.

Treatment goals/targets

These are mutually agreed upon, measurable goals to help me improve or control my medical conditions or manage their symptoms (for example, LDL cholesterol <100; BP <150/90; weight of 150 pounds; 7 hours of uninterrupted sleep; average pain level of 5; ability to walk to my mailbox daily):

-
-
-

Summary of things I need to do

List action needed and time frame for each item. If not applicable, indicate N/A or none:

Tests to complete _____

Other health professionals to see _____

Community resources to use _____

Medication changes to make _____

Other treatments to get _____

Health-related education to pursue _____

Short-term activities to do _____

Lifestyle changes to make (for example, quit smoking, lose 10 pounds, buy a pedometer and walk 5,000 steps per day; SMART goals – specific, measurable, achievable, realistic, time-bound – are recommended):

Diet _____

Exercise _____

Stress management _____

Safety _____

Smoking _____

Other habits _____

Frequency of planned future appointments here: _____ per year

Care manager

If I need help arranging care outside this office or have questions or concerns about any of the things I need to do (above), I can contact:

Name: _____ Phone/email address: _____

I will ask other providers to send a summary of their care to this office.

Expected outcomes/prognosis

If I follow the treatment/action plan above, I can expect the following to happen:

-
-
-

Patient signature: _____

Provider signature: _____

* Data for these sections may be imported from the patient record when this form is used as the basis for an electronic health record template. The following elements should also be incorporated: date created, patient name and identifiers, and provider name.