Chronic Care Management Services

Chronic Care Management Services (CCM)

- CPT code 99490 (CCM Services) requires at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month to patients who meet 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

Elements that 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.

Elements that define the current scope of CCM services

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.

Elements that define the current scope of CCM services

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 comprehensive care plan of care is based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports.

Elements that define the current scope of CCM services

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.
     - Providers must format their clinical summaries according to, at a minimum, the standard that is acceptable for the EHR Incentive Program as of Dec. 31 of the calendar year preceding each payment year.

Elements that define the current scope of CCM services

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.

Cost Sharing and CCM Service

- CCM services are based on the fee-for-service model and is not a preventative service that is exempt from cost-sharing.
- Patients will be responsible for approximately $8 per CCM service month billed
- Providers are required to explain the cost-sharing obligation to patients receiving CCM services and obtain consent prior to furnishing the services

Payment for CPT 99490

- 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 a revocation of the agreement to receive CCM services.
- Inform the beneficiary that only one practitioner can furnish and be paid for these services during the calendar month service period.
- Provide the beneficiary a written or electronic copy of the care plan and document in the electronic medical record that the care plan was provided to the beneficiary.

Patients Not Eligible for CCM Services

- You can not bill CCM services on patients who receive the following four types of services in the same calendar month:
  1. Transitional care management (CPT 99495 and 99496),
  2. Home healthcare supervision (HCPCS G0181)
  3. Hospice care supervision (HCPCS G0182)
  4. Certain end-stage renal disease (ESRD) services (CPT 90951-90970)
- If the provider furnishing CCM performs any other services for the beneficiary (such as an office visit or an immunization), the provider should bill for that service in addition to CCM.
- Providers not providing CCM to a beneficiary may provide and bill for the four services listed above.

Patient Notification

- Front desk has forms that they will begin to distribute to all Medicare patients
  - Proactive notification of all patients rather than identifying patients to receive CCM services and then attempting to gain consent at that time
- Explain the benefits of CCM services
  - Increased allocation of time for the care team to:
    - Managing Referrals
    - Medication reconciliation
    - Phone/portal communications
    - Completing forms and documents
    - Care plan review

: PrimeSUITE -- Clay Platte Family Medicine Clinic -- SITE5230025RV

File

A/R Management | Chart | Registration | Reporting | Schedule | System | Help

Patient Charts

Wednesday, January 14,
Test, Alpha "Alphie" (13734

Select Visit

Import Document

Select Template

Create Note

Sections
- CC
- HPI
- PFSH
- ROS
- Vitals
- PE
- Drawings
- In-Office Proc. Results
- Assessment
- Plan
- E&M

Note Options
- Preview
- Save (Charges Ready)
- Save (Hold Charges)
- Save & Sign
- Close Note

Facesheet | Summary | Documents | Progress Note

Note Date: 01/14/201

Template Library

Browse By Category | View Alphabetical List | User: CPFMC Templates

- BMI Test Wellness Document
- Carpal Tunnel Syndrome AJ4.1.12
- Cerumen Impaction (FP v3.8) CPMFC SHK 5.8.13
- Chest Discomfort/Pain CPFMC 5.13.13
- CHF Home Health Diuretic Protocol - Standing Orders 4.9.14 HRB
- Chronic Care Mgmt 12.31.14
- COPD (AJ)
- CPAP/BiPAP Follow Up CPFMC 11.3.14
- Cryotherapy to Actinic Keratosis CPFMC 5.19.13
- Depression/Anxiety CPFMC SHK 11.12.13
- Depression/Fall Screening js 6.12.13
- Dexa Order js 11.14.12
- Diverticulitis (FP v3.9) CPMFC SHK 6.4.13
- Ear Infections, Adult (FP v3.10) CPFMC SHK 2.23.13
- Elevated Blood Pressure (>140/90 no prev dx of HTN) CPFMC
- Erectile Dysfunction cpfmc 12.20.13 hrb
- Excision; simple CPFMC SHK 5.20.13
- Fall Prevention/Depression Screening js 6.12.13
- Fatigue (Brief) (FP v3.10) CPFMC SHK 2.17.13
- GI Complaints (Adult) CPFMC SHK 2.17.13
- GYN complaint age 35 and Older w/Uterus (FP v3.11) DK
- GYN Exam LAT 12-18-14
- Headaches LAT

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File

GREENWAY

A/R Management | Chart | Registration | Reporting | Schedule | System | Help

Patient Charts

Wednesday, January
Test, Alpha "Alphie" (13

Facesheet | Summary | Documents | Progress Note

Select Visit

Select Template
Chronic Care Mgmt 1...

Create Note

Sections
- CC
- **HPI**
- PFSH
- ROS
- Vitals
- PE
- Drawings
- In-Office Proc. Results
- Assessment
- Plan
- E&M

Note Options
- Preview
- Save (Charges Ready)
- Save (Hold Charges)
- Save & Sign
- Close Note

History of Present Illness Sketch Pad

Note Date: 01/14/

Paragraph   Fo

Add Sketch Pa

Chronic Care Managment Care Plan

Alpha Test patient is a 46 year old White female. Alpha Test is followed by **SELECT PRIMARY CARE PROVIDER** as the pr care provider.

The patients current conditions include: **PROBLEM LIST**

Top concerns and barriers

The main things I would like to fix or improve about my heatlh are: **ENTER HEALTHCARE CONCERN**

The main things preventing me from improving my heatlh are: **ENTER FIRST THING PREVENTING IMPROVED HEAL**

Sympton management

The main symptoms I wish to reduce or eliminate are: 1. **ENTER SYMPTOM(S) TO ADDRESS**

Health Care Providers

Has the collaboration of care flowsheet been updated: **COLLABORATION OF CARE UPDATED**

Resources and supports

Flowsheet -- Webpage Dialog

CPFMC Chronic Care Management Timesheet

Edit | Export	Help	01/13/2015
CCM Care Plan		completed
CCM activity		Diabetes care review
Time spent in minutes		7
Initials of team member		