M-CEITA | Michigan Center for Effective IT Adoption

# *Leveraging The Billing Code for Chronic Care Management (CCM) Services*

*Kelly Schonhardt - Regulatory Analyst*
*Steven M. Ariss, Jr., M.D. – Clinical Advisor*

*November 9, 2016*

# Disclaimer

- This presentation was current at the time of presentation or publication.
- This presentation was prepared as a service, it is not intended to grant rights or impose obligations.
- This presentation may contain references or links to statutes, regulations, or other policy materials. We encourage participants to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.
- The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations.

# Legislation

- **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), H.R. 2, Pub. Law 114-10**
  - **Sec. 103. Encouraging care management for individuals with chronic care needs**
    - In order to encourage the management of care for individuals with chronic care needs the Secretary shall, subject to subparagraph (B), **make payment** (as the Secretary determines to be appropriate) under this section **for chronic care management services furnished on or after January 1, 2015**, by a physician (as defined in section 1861(r)(1)), physician assistant or nurse practitioner (as defined in section 1861(aa)(5)(A)), clinical nurse specialist (as defined in section 1861(aa)(5)(B)), or certified nurse midwife (as defined in section 1861(gg)(2)). ``(B) Policies relating to payment.--In carrying out this paragraph, with respect to chronic care management services, the Secretary shall-- ``(i) make payment **to only one applicable provider for such services furnished to an individual during a period**; ``(ii) not make payment under subparagraph (A) if such payment would be duplicative of payment that is otherwise made under this title for such services; and ``(iii) not require that an annual wellness visit (as defined in section 1861(hhh)) or an initial preventive physical examination (as defined in section

# Patient Eligibility

- Medicare Beneficiaries with 2 or more chronic conditions which:
  - Place patient at significant risk of death, acute exacerbation/decompensation or functional decline, and
  - Are expected to last at least 12 months or until the death of the patient

# Eligible Practitioners (EPs)

- Physicians
- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants

# Time Requirements

- Non-face-to-face care coordination services, minimum 20 minutes per month of clinical staff time
  - Services provided by EP
  - Services provided by consultants
  - Services provided by clinical staff
    - "incident to", general supervision

# Service Initiation

- Evaluation and Management (E/M) visit
- Annual Wellness Visit (AWV)
- Initial Preventive Physical Examination (IPPE)

# Informed Consent Requirements

- Explain and offer the CCM service to the patient
- Document
- Obtain written consent
- Explain how to revoke the service

# Patient Consent Agreement Process

- Consent Discussion should explain the following:
  - What the CCM service is;
  - How to access service elements;
  - How the patient's information may be shared among practitioners and providers;
  - How cost-sharing (co-pays and deductibles) applies to CCM services.

# CCM Scope of Service Elements - Overview

- Structured Data Recording
- Comprehensive Care Plan
- Access to Care
- Care Management

# Structured Data Recording

- Demographics
- Problems
- Medications
- Medication Allergies
- Clinical summary records

# Care Plan

- Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues);
- Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record;
- Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service;
- Share the care plan electronically outside the practice as appropriate.

# Comprehensive Care Plan Elements

- Problem List:
- Expected outcome and prognosis;
- Measurable treatment goals;
- Symptom management;
- Planned interventions and identification of the individuals responsible for each intervention;
- Medication management;
- Community/social services ordered;
- Description of how external agencies and specialists will be directed/coordinated; and
- Schedule for periodic review and, when applicable, revision of the care plan.

# Access to Care

- Ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services.
- Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care by telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods, in compliance with HIPAA.

# Care Management

- Systematic assessment of the 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; and
- Oversight of patient self-management of medications.

# Care Management (cont.)

- Manage care transitions between and among health care providers and settings, including referrals to other providers, including:
  - Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.
- Coordinate care with home and community based clinical service providers.

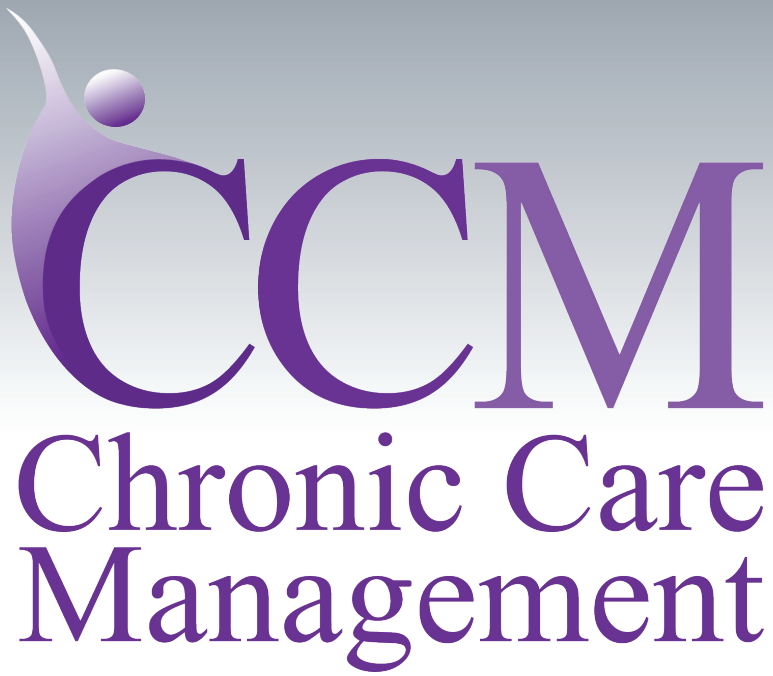
# FQHC and RHC Participation

- Effective January 1, 2016;
- CCM is a RHC and FQHC benefit, but is paid based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim;
- Coinsurance is applied as applicable to FQHC claims, and coinsurance and deductibles are applied as applicable to RHC claims.
- The RHC and FQHC face-to-face requirement is waived for CCM services;
- No exception to “Direct Supervision” requirement.

# Resources

- Medicare Learning Network CCM Services Fact Sheet
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- CCM Services for RHCs and FQHCs
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9234.pdf
- FAQ about CCM Services
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf
- FAQs about CCM Services in RHCs and FQHCs
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf
- Medicare Benefit Policy Manual – RHCs and FQHCs (Rev 01/15/2015)
  - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf

# A new service offering from:


# Questions?

www.mceita.org

Kelly Schonhardt
Kelly.Schonhardt@altarum.org
734.680.6599

Steven Ariss, Jr., M.D.
Steven.Ariss@altraum.org
419.320.1515