national government SERVICES

NGS PROVIDER EXPERIENCE
Innovation | Education | Collaboration

Care Management: Chronic Care Management Services

9/25/2024

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.*

NGSMU
NGS Medicare University
Meaningful | Informative | Simplified

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2396_0924

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.

Recording

Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events.

Objective

Care Management: Making all-inclusive care plan a reality and by offering these sessions, we hope that our J6 and JK providers have a better understanding on codes available that describe care management.

Today's Presenter

- Provider Outreach and Education Consultant
- Lori Langevin

- Care Management Team
  - Christine Obergfell
  - Carleen Parker
  - Jennifer Lee
  - Lori Langevin
  - Michelle Coleman
  - Nathan Kennedy

Agenda

- Chronic Care Management Services
  - General
  - Coding
  - Billing
  - Documentation
- FAQs
- Resources

Chronic Care Management Services: General

General Information

- CMS recognizes CCM as a critical primary care service that contributes to better patient health and care
- CCM service codes provide payment of care coordination and care management for patients with multiple chronic conditions
  - Multiple (two or more) chronic conditions
    - Expected 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/decompensation, or functional decline, are eligible for CCM services
- CCM services can also help reduce geographic and racial or ethnic health care disparities

General

- Billing practitioners may consider identifying patients who require CCM services using criteria suggested in CPT guidance
  - Number of illnesses, number of medications, or repeat admissions or emergency department visits
- The billing practitioner cannot report both complex and noncomplex CCM for a given patient for a given calendar month
  - Do not report 99491 in the same calendar month as 99487, 99489, 99490

General – Who Can Bill

- Physicians and the following NPPs may bill CCM services
  - Certified Nurse Midwives
  - Clinical Nurse Specialists
  - Nurse Practitioners
  - Physician Assistants
- 99491 includes only time that is spent personally by the billing practitioner
  - Clinical staff time is not counted towards required time threshold for reporting this code
- 99487, 99489 and 99490 – Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month
- CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the direction of the billing practitioner on an "incident to" basis

General – Chronic Conditions

- Examples of chronic conditions include, but are not limited to, the following
  - Alzheimer's disease and related dementia
  - Arthritis (osteoarthritis and rheumatoid)
  - Asthma
  - Atrial fibrillation
  - Autism spectrum disorders
  - Cancer
  - Cardiovascular disease
  - COPD
  - Depression
  - Diabetes
  - Hypertension
  - Infectious diseases such as HIV/AIDS

Chronic Care Management Services: Coding

Chronic Pain Management and Treatment Codes

- G3002 - Chronic pain management and treatment, monthly bundle including
  - Diagnosis; assessment and monitoring
  - Administration of a validated pain rating scale or tool
  - Development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes
  - Overall treatment management
  - Facilitation and coordination of any necessary behavioral health treatment
  - Medication management
  - Pain and health literacy counseling
  - Any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate.
  - Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month (when using g3002, 30 minutes must be met or exceeded)
- G3003 - Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month
  - List separately in addition to code for G3002
  - When using G3003, 15 minutes must be met or exceeded
- Telehealth applies to both codes

Coding – 99490

- 99490 – Chronic care management services
  - Provide 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
  - Assumes 15 minutes of work by the billing practitioner per month

Coding – 99439

- 99439 – Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
  - List separately in addition to code for primary procedure
  - Use 99439 in conjunction with 99490
  - Report additional 20-minute increments of service time (maximum of 60 minutes total)
  - Do not report 99439 for care management services of less than 20 minutes additional to the first 20 minutes of CCM services during a calendar month
  - Do not report 99490, 99439 in the same calendar month as 99487, 99489, 99491

Coding – 99491 and 99437

- 99491 – Chronic care management services
  - Provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, 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
- 99437 – add-on code for CPT code 99491
  - Each additional 30 minutes
  - By a physician or other qualified health care professional, per calendar month

Coding - 99487

- 99487 – Complex chronic care management services
  - 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
  - Establishment or substantial revision of a comprehensive care plan
  - Moderate or high complexity medical decision making
  - 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Coding – 99489

- CPT 99489 – Complex chronic care management services
  - Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
    - List separately in addition to code for primary procedure
  - Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately
  - Report 99489 in conjunction with 99487, do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month
  - CCM (sometimes referred to as “noncomplex” CCM) and complex CCM services share a common set of service elements. They differ in the amount of clinical staff service time provided; the involvement and work of the billing practitioner; and the extent of care planning performed

Chronic Care Management Services: Billing

Billing Requirements - Consent

- Practitioner must obtain patient consent before furnishing or billing CCM
  - Ensures patient is engaged, aware of applicable cost sharing and will prevent duplicative practitioner billing
- Consent may be verbal or written, but shall be documented in medical record, and includes
  - Availability of CCM services and applicable cost sharing
  - Informs that only one practitioner can furnish and be paid for CCM services during a calendar month
- Patient's right to stop CCM services at any time
  - Effective at the end of the calendar month
- Patients need to provide informed consent only once unless they switch to a different CCM practitioner

Billing Requirements - Initiating Visit

- Medicare requires an initiating visit for new patients or patients who the billing practitioner hasn't seen within one year
  - Annual wellness visit
  - Initial preventive physical exam
  - Other face-to-face visit with billing practitioner
- If practitioner doesn't discuss CCM during initiating visit, then it can't count as the initiating visit
- Initiating visit is not part of CCM service and is separately billed

Billing G0506

- Practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code G0506
  - G0506 – Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services
    - Billed separately from monthly care management services
    - Add-on code, list separately in addition to primary service
    - G0506 is reportable once per CCM billing practitioner, in conjunction with CCM initiation visit
    - Telehealth applies

CCM Services - Concurrent Billing Reminders

- CCM cannot be billed during same service period by same practitioner as
  - Home health care supervision (G0181) or hospice care supervision (G0182)
  - Certain End-Stage Renal Disease services (90951–90970)
- Complex CCM and prolonged E/M services cannot be reported in the same calendar month
- You can report CCM codes 99487, 99489, 99490 and 99491 by the same practitioner for services furnished during the 30-day TCM service period (CPT 99495, 99496)
- Time reported under or counted towards the reporting of CCM service code cannot also be counted towards any other billed code

CCM Services: Billing – POS

- Place of Service (POS)
  - CCM is priced under physician fee schedule in both facility and nonfacility settings
  - Billing practitioners report the POS for location where s/he would ordinarily provide face-to-face care

Chronic Care Management Services: Documentation

Documentation

- Comprehensive Care Management
  - Systematic assessment of patient's medical, functional, and psychosocial
  - System-based approach to ensure timely receipt preventive care
  - Medication reconciliation review of potential interactions
  - Oversight of patient self-management of medications
  - Coordinating care with home/community-based clinical service providers
  - Manage transitions between/among health care providers and settings
    - Referrals to other clinicians, follow-up after emergency department visitor facility discharge
  - Timely create and exchange/transmit continuity of care document(s) with other practitioners

Documentation - Plan of Care

- Comprehensive Plan of Care
  - Health issues focus on chronic conditions being managed
    - Patient-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources
    - Provide patient and/or caregiver with copy of plan of care
  - Make sure electronic care plan is available and shared timely within and outside billing practice to individuals involved in patient's care

Documentation – Comprehensive Care Plan Check List

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and identification of individuals responsible
- Medication management
- Community or social services ordered
- Description of how services of agency and specialists outside practice are coordinated
- Schedule periodic review and revision of plan of care

Documentation - Extensive

- CCM is extensive and includes
  - Structured recording of patient health information
  - Maintaining comprehensive electronic care plan
  - Managing transitions of care
  - Care management services and coordinating
  - Sharing patient health information timely within and outside practice

Documentation – MDM

- Medical Decision Making (MDM)
  - Complex CCM services require and include moderate to high complexity medical decision making by the physician or other billing practitioner

Documentation Provided Outside Face-to-Face Visits

- CCM services typically provided outside face-to-face visits
  - Continuous relationship with designated member of care team
  - Patient support for chronic diseases to achieve health goals
  - Patient access 24/7 to care and health information
  - Delivery of preventive care
  - Patient and caregiver engagement
  - Timely sharing and use of health information

Documentation – Electronic Recording of Patient Health Information

- Structured Recording Using EHR
  - Record the patient's demographics, problems, medications, and medication allergies using a version of certified electronic health record (EHR) that's acceptable under the EHR Incentive Programs

Chronic Care Management Services: FAQs

FAQ One

- What date of service should be used on the practitioner claim and when should the claim be submitted?
  - For complex CCM (CPT codes 99487, 99489), billing practitioners should report the service code(s) at the conclusion of the service period.
    - In addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making; medical decision-making is determined by the problems addressed by the practitioner throughout the service period.
  - For CCM provided by clinical staff (CPT codes 99490, 99439) and CCM furnished directly by practitioners (CPT codes 99491, 99437), the billing practitioner may report the appropriate claim(s) at the conclusion of the service period. Practitioners may also choose to report the appropriate claim(s) after completion of the service time for the code.
    - When the time threshold to bill is met, the practitioner may choose that date as the date of service and need not hold the claim until the end of the month.

FAQ Two

- What place of service should be reported on the practitioner claim?
  - The billing practitioner should report the place of service for the location where they would ordinarily provide face-to-face care to the beneficiary.
    - CCM is priced in both facility and nonfacility settings.

FAQ Three

- If the practitioner furnishes a “comprehensive” E/M, AWV or IPPE, and does not discuss CCM with the patient at that visit, can the visit count as the initiating visit for CCM.
  - No, if the practitioner furnishes a “comprehensive” E/M, AWV or IPPE, and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.

FAQ Four

- Do the billing practitioners need to see their CCM patients face-to-face?
  - Yes, for new patients or patients not seen by the billing practitioner within a year prior to the commencement of CCM services, CCM must be initiated by the billing practitioner during a “comprehensive” E/M visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE).

FAQ Five

- Is a new patient consent required each calendar month or annually?
  - There is not a requirement to obtain patient consent either monthly or annually. Consent must be obtained from the patient once prior to the start of CCM.
    - Patient consent must be obtained again if the patient changes billing practitioners – in which case, consent must be obtained and documented by the new billing practitioner prior to furnishing the service.

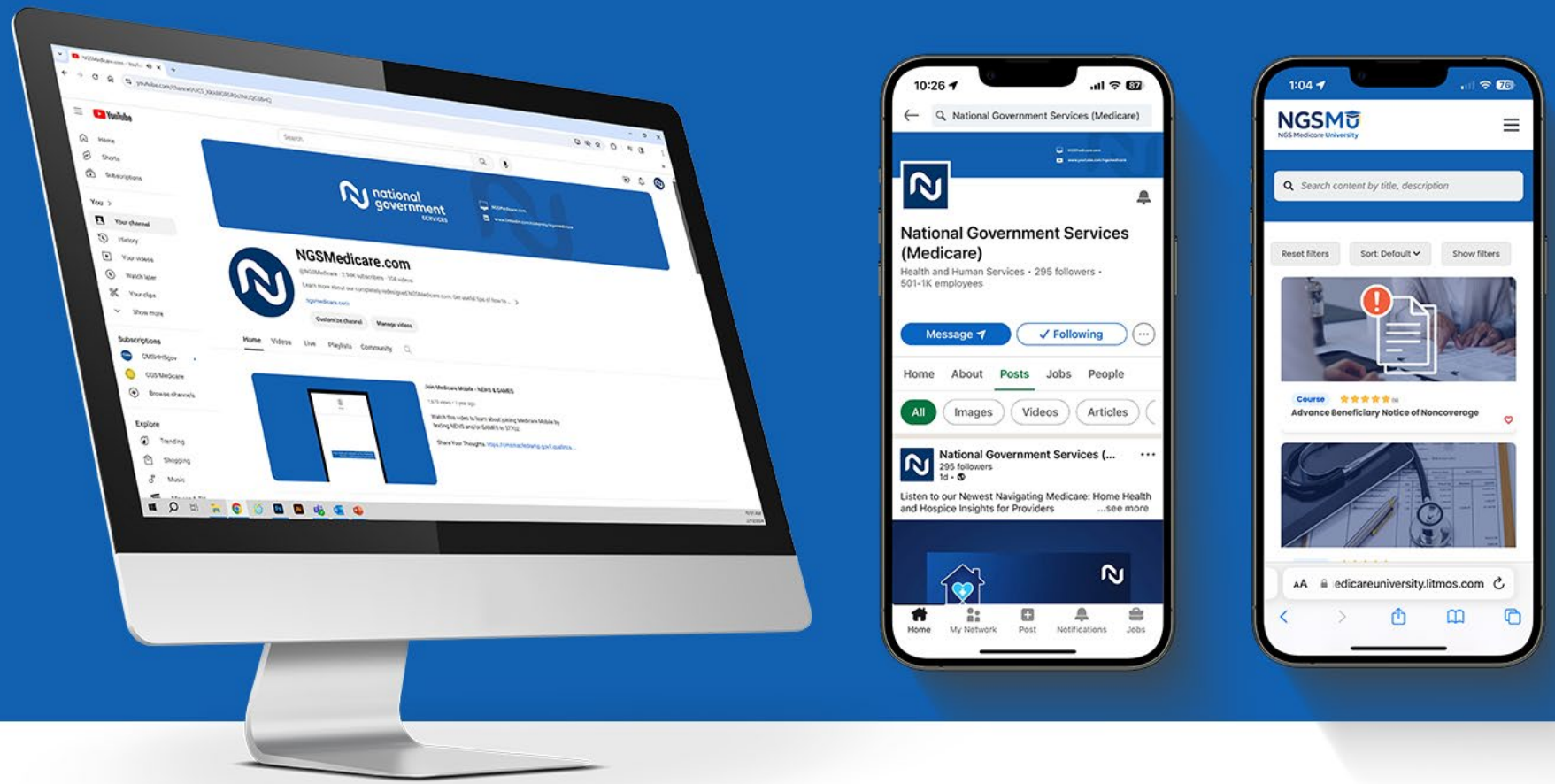
Chronic Care Management Services: Resources

References

- MLN® Booklet: *Chronic Care Management Services*
- Chronic Care Management Frequently Asked Questions
- Manage Your Chronic Condition | CMS
- Chronic Conditions PUF | CMS
- Chronic Conditions Data Warehouse

Questions?

Thank you!



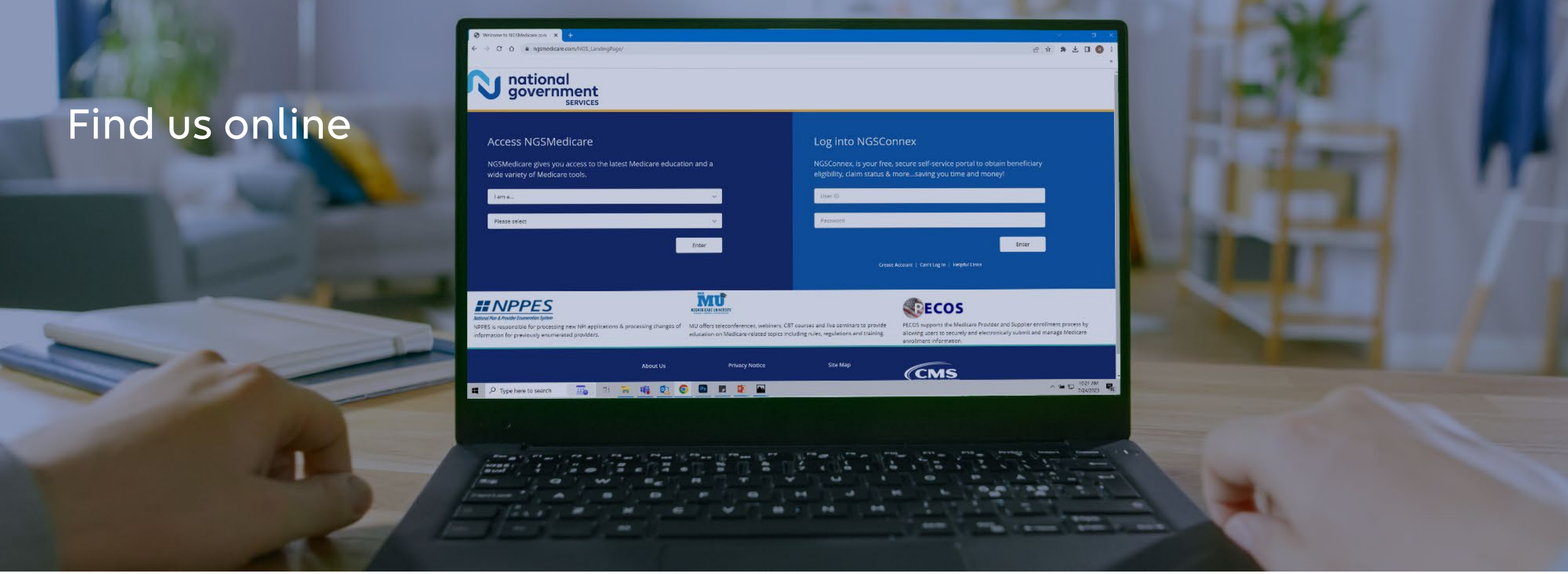
Connect with us on social media

[YouTube Channel](#)
Educational Videos

[Medicare University](#)
Self-paced online learning

[LinkedIn](#)
Educational Content

Find us online



www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

[IVR System](#)
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

[NGSConnex](#)
Web portal for claim information

[Sign up for Email Updates](#)
Subscribe for Email updates at the top of any NGSMedicare.com webpage to stay informed of news