# Chronic Care Managment FAQ

1. **What are the basic CCM components?**

| Code | Description | Elements |
|---|---|---|
| 99490 | Minimum 20 minutes of clinical staff time, directed by a physician or other qualified health care professional per calendar month | Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient<br>• Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline<br>• Comprehensive care plan established, implemented, revised, or monitored |
| 99487 | Complex Chronic Care Management | Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient<br>• Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline<br>• Establishment or substantial revision of a comprehensive care plan • Moderate or high complexity medical decision making<br>• 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month |
| 99489 | Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month | |

2. **Does the care plan have to be electronic or can it be paper?**
   - The care plan has to be electronic.

3. **We have electronic medical records we have to then scan a singed consent form into the record?**
   - Patient consent can be given verbally but CCM requires documentation of the patient agreement in the patient's health record.

4. **Which team members are considered by CMS to be Qualified Healthcare Professionals in Michigan?**
   - **CMS' rules apply to Michigan.** Qualified Healthcare Professionals are individuals qualified by education, training, licensure/regulation (when applicable) and facility privileging (when

applicable) who performs a professional service within his/her scope of practice and Independently reports that service. This includes: physicians and certain NPPs (non-physician providers) which include Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioner, Physician Assistants.

5. **Which team members are considered to be clinical staff in Michigan? Can Master of Social Work provide CCM? Who develops the care plan, the provider or clinical staff?**
   - The "Instructions for Use of the CPT Codebook" defines clinical staff as follows: A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.
     - Registered dieticians, pharmacists, MAs, RNs, LPNs, LMSW, MSW, BSW, may contribute time to CCM (Medicare also suggests consulting CPT for the comprehensive definition of clinical staff)
   - A Master of Social Work can contribute "time only" to monthly CCM services under the supervision of the billing practitioner. They are not qualified to serve as the billing practitioner.
   - The provider identifies the patient's needs, develops and initiates the care plan. CCM staff work as a team to provide the service. They can contribute time, work with physician, document patient's chart, etc. However, they cannot develop care plan.

6. **What activities can a non-licensed staff member (e.g. Care coordinator or front desk staff) provide that contribute to CCM requirements?**
   - Only QHPs and clinical staff may contribute time towards CCM services. Non clinical staff time may not be counted towards CCM.

7. **Can a CHW contribute time or do they need to be a licensed member of the team such as a LPN, RN, or MSW?**
   - That depends on what facility it is, its privileges and license regulation. If the facility is granting the CHW to see patients and to take notes in the chart, then the CHW is a clinical staff person who works under "incident to". In Michigan, Community Health Workers receive certification through a third party (Michigan Community Health Worker Alliance or MCHWA) which began offering certification in 2016.

8. **Can we still use Complex Chronic Care Coordination services codes 99487 & 99489 if we are CPC+?**
   - Practices participating in CPC+ **cannot** bill for CCM.
   - Practices participating in CPC+ **can** bill for TCM

9. **Is Complex Chronic and Chronic Care different than just Care Management?**
   - Complex Chronic Care Management (CCCM) and Chronic Care Management (CCM) refers to specific CMS services. Unlike "Care Management," CCCM and CCM are paid for separately under the Medicare Physician Fee Schedule as CCM services furnished to Medicare patients with multiple chronic conditions and have specific CPT codes associated with them. There are specific requirements, including patient and practitioner eligibility, supervision, and documentation.

**10. Are tracking codes to be submitted to each plan individually, or is processing done through CHAMPS for all the plans?**

- CHAMPS is only for Medicaid tracking codes, not for Medicare coding and billing.
- The CCM codes (99490, 99487, 99489) are not a part of the 2017 SIM PCMH Initiative Care Management and Coordination Tracking Codes and should be submitted through normal CMS submission methods.

**11. What are the documentation requirements under CCCM?**

- The required documentation for Complex Chronic Care Management includes:
    - Patient consent
    - Detailed accounting of the time spent furnishing non-face-to-face services, including the performing clinical staff and details of time spent provisioning care
    - Patient demographics, problems, medications, and allergies
    - A comprehensive care plan including:
        - Problem list
        - Expected outcomes and prognosis
        - Measureable treatment goals
        - Symptom Management
        - Medication Management
        - Community social services ordered
        - Planned interventions – including the identification of the individuals responsible for each intervention
        - Description of how agency services and specialists outside of the practice will be directed and/or coordinated
        - Scheduled periodic review and plan revision as necessary

**12. Can the CCM codes by used by pediatric practices?**

- In order to bill for CCM services, the patient must be a Medicare patient. Typically, this will be patients over the age of 65.

**13. What is the payment for CCM?**

- The average reimbursement for CCM codes are as follows:
    - 99490: $42
    - 99487: $93
    - 99489: $47

**14. Where is the 20-minute minimum coming from? If we are talking about 99487 I thought it had to be a minimum of 30 minutes?**

- Code 99490 (CCM) requires at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
- Code 99487 (Complex CCM) requires 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
    - Code 99489 (Complex CCM) can be billed for each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

**15. Could you please clarify if we can bill for CCM codes if the patient is receiving home health care services?**

- Yes, CCM codes can be billed for patients receiving home health care services. It is necessary to coordinate with the patient's home health care provider and communicate with them regarding the patient's psychosocial needs and functional deficits. This must be documented in the patient's medical record.

**16. Is Medicare the only payer that pays for CCM?**

- This varies among payers. Many Medicare Advantage plans will reimburse for CCM codes. However, it is important to verify with the payer before billing for these codes.

**17. Should we have a plan of working with the patient for 12 months in order to have them participate in CCM?**

- No, not necessarily. However, the patient is required to have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.

**18. What does "incident to" mean?**

- "Incident to" services are defined as those services that are furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within an institution) or in a patient's home. To qualify as "incident to," services must be part of your patient's normal course of treatment during which a physician personally performed an initial service and remains actively involved in the course of treatment.
- Per the Federal Registry these services are usually provided under DIRECT supervision of the billing provider meaning the provider must be present in the office suite and be immediately available. CMS has however, made an exception for CCM services. "Incident to" may be provided under the GENERAL supervision of the billing provider meaning the services are provided under the overall direction and control of the provider, however, the provider does not need to be present.
- The "incident to" requirements are listed out below. Practices should defer to the definition of clinical staff listed above and CCM requirements in regards to the role of clinical staff to determine who from their practice is eligible to contribute time to CCM services.
    - Services are provided in a physician's office or physician's clinic;
    - Physician sees Medicare patient on initial visit, establishes a diagnosis and treatment plan.
    - For established Medicare patients with a new problem, the physician sees the patient first for the new problem, establishes a diagnosis and treatment plan, clinical staff sees patient on follow up visit;
    - Services are within the clinical staff's state law scope of practice; and
    - The clinical staff member represents a direct financial expense to the physician billing (W-2 or leased employee, or independent contractor).

**19. Per CMS, I was advised the time used to complete the assessment and care plan can only be the time of the provider. Time of other QHP's could not be used to add to this. Can you confirm this?**

- Yes, the initial face-to-face assessment/exam should be done by the provider. From the initial assessment, provider will construct a care plan and start the process for CCM.

**20. For the incident to - would a retail pharmacist, system pharmacist, etc. if working directly with the provider be able to submit time to the provider to use in the allotted time?**

- While pharmacists are not eligible to bill CMS directly for these services, CCM serves as an ideal opportunity for pharmacists to form collaborative and contractual partnerships with qualified healthcare professionals (QHPs) to provide CCM services that are within their scope of practice.
- As part of the incident to requirements, clinical staff must be employed, contracted, or leased by the QHP (Qualified Health Professional) or the QHP's practice with CCM services provided under general supervision by the QHP. This means that pharmacists who want to provide CCM services in collaboration with a QHP must either be directly employed, independently contracted, or leased by that QHP or their practice to meet the requirements of incident to billing. Definitions for each of these types of partnerships between the pharmacist and QHP include:
    - Directly employed means that an individual is hired as an employee of the QHP or QHP's practice
    - Independent Contractor means an individual who works full- or part-time for which the individual receives an IRS-1099 form
    - Leased employment is an established relationship that is recognized by applicable state law and that is established by two employers by a contract such that one employer hires the services of an employee of the other employer