



Making Sense of MACRA: Simplifying Chronic Care Management (CCM)

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Learn how to optimize revenue today
by using this step-by-step approach
to add CCM to your practice.



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A Step-by-Step Approach to Adding Chronic Care Management (CCM) Services to Your Practice

Chronic care management (CCM) services are non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months. CCM services can help you optimize revenue today and prepare for value-based payment tomorrow.

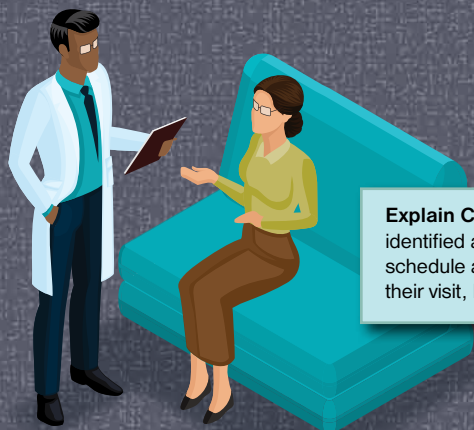
1

Identify patients. Your practice care team should identify patients with two or more chronic conditions expected to last at least 12 months. Chronic conditions might include diabetes, chronic heart failure, chronic obstructive pulmonary disease, etc. Make note of patients with multiple chronic conditions so they can be identified and explained the CCM process at their next office visit.



2

Explain CCM to the patient. Once your care team has identified a patient with two or more chronic conditions, schedule an appointment. When the patient arrives for their visit, have a team member explain the CCM process.



3

Obtain consent. Document that the patient was informed of the CCM services and process, and note whether the patient accepted or declined CCM services. **While you should do this for your own records, as of January 1, 2017, a signed consent is no longer required.**



The AAFP's Chronic Care Management Toolkit guides practices and patients through the CCM process. It contains patient introduction handouts to explain CCM, a personalized care plan template, coding tables, a CCM calculator, and much more. The CCM toolkit is available for purchase at www.aafp.org/ccm-toolkit.



4

Develop and share a personalized care plan. Designate a team member (such as a nurse or care manager) to formulate a personalized care plan. Document the personalized care plan in the patient's electronic health record (EHR). Provide a copy of the care plan to the patient or caregiver, and share the plan with other health care professionals who may be involved in treating the patient's health conditions.



5

Coordinate non-face-to-face care. A nurse or care manager continues to coordinate non-face-to-face care (e.g., follow-up on referrals, refill prescriptions, phone calls or emails, community services, etc.). This must be documented in the EHR. Also, document the total time spent on non-face-to-face care. It must amount to at least 20 minutes per calendar month.



6

Bill for CCM services. Bill CPT code 99490 (non-complex CCM) once all the required CCM elements have been met. Required CCM service elements include:

- Patient consent (verbal or signed)
- Personalized care plan in a certified EHR and copy provided to patient
- 24/7 patient access to a member of the care team for urgent needs
- Enhanced non-face-to-face communication between patient and care team
- Management of care transitions
- Twenty minutes per calendar month spent on non-face-to-face CCM services directed by physician or other qualified health care professional

Most patients have supplemental coverage that would cover any CCM coinsurance. However, patients will want to verify with their insurance that this is a covered service.

The Centers for Medicare & Medicaid Services (CMS) introduced complex CCM (99487) in 2017. Review the AAFP's CCM toolkit for additional details on complex CCM.

Tracking Time

You and your team may spend more time than you think providing the services covered in CCM. Time spent coordinating referrals, refilling prescriptions, and taking calls or emails from patients and caregivers can contribute towards the required time to bill CCM. Much of this work is completed in the course of day-to-day activities, but it is not necessarily tracked or documented. In order to bill for CCM services, it is required that at least 20 minutes per calendar month are spent on non-face-to-face CCM services.

Preparing for MACRA

Getting paid for CCM services, which are activities already provided by your team, will help position your practice for a strong performance in the Medicare Access and CHIP Reauthorization Act's (MACRA) Quality Payment Program (QPP).

Several measures within the improvement activities performance category of the Merit-based Incentive Payment System (MIPS) align with CCM requirements. CCM services not only proactively manage your patients' health, but also help satisfy MIPS reporting requirements without additional disruptions to your workflows.

One example is the creation of a patient-centered care plan. This aligns with two medium-weighted improvement activities (worth 10 points each) in MIPS. These are "engagement of patients, family, and caregivers in developing a plan of care" (Activity ID: IA_BE_15) and "implementation of practices/ processes for developing regular individual care plans" (Activity ID: IA_CC_9).

CCM services can ultimately help manage your performance on quality measures in MIPS, as well. Many quality measures relate to chronic conditions, such as diabetes, hypertension, major depressive disorder, chronic obstructive pulmonary disorder (COPD), and heart failure.

The following example allows for coordination of care and communication with another clinician to treat comorbid conditions, and could also satisfy a measure in the MIPS quality performance category. The measure is called "adult major depressive disorder (MDD): coordination of care of patients with specific comorbid conditions" (Quality ID: 325). This measure assesses communication between the family physician (likely treating the adult MDD) and the treating clinician for the comorbid chronic conditions (such as diabetes, coronary artery disease, or congestive heart failure).

It is likely that you and your team already spend time coordinating care for patients with such comorbid conditions. CCM allows you to bill for this time, while also working towards successful quality performance in MIPS.

Billing Providers and Payment Potential

Only one health provider who assumes the care management role for a particular beneficiary can bill for providing CCM services to that patient in a given calendar month.

The potential for additional payment through CCM services is significant. The table below represents potential monthly income (based on national averages) for billing CCM services.

Number of Patients Seen	Monthly Income*
25	\$1,050
50	\$2,100
100	\$4,200

*based on national averages

In order to engage more physicians in this service, the Centers for Medicare & Medicaid Services (CMS) relaxed CCM guidelines in 2017, and offered more payment opportunities. Once your care team identifies eligible patients and begins the CCM services, track the time spent on these services. CCM can help manage your patients' chronic conditions more effectively, improve communication among other treating clinicians, and provide a way to optimize revenue for your practice.

For additional information on how to implement CCM, including a calculator to help you scale up your CCM program, please see the AAFP's Chronic Care Management Toolkit at www.aafp.org/ccm-toolkit.

