

## FREQUENTLY ASKED QUESTIONS: MEDICARE'S CHRONIC CARE MANAGEMENT (CCM) SERVICES

(Updated as of March 9, 2015)

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### Patient eligibility

**Q:** Who is eligible to receive CCM services under Medicare?

**A:** According to the Centers for Medicare & Medicaid Services (CMS), CCM is for "patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline."

**Q:** Does CMS have a specified list of chronic conditions that meet this definition?

**A:** No, CMS has not specified or otherwise limited the eligible chronic conditions that meet this definition. CMS does have a databank regarding chronic conditions (<http://www.ccwdata.org>) that you can use as a starting point. However, this databank is neither an exhaustive nor definitive list. As long as you clearly communicate within the care plan that the chronic conditions you are treating pose a significant risk of death, acute exacerbation or decompensation, or functional decline and will last the expected length of time, the requirement is satisfied.

**Q:** Will CCM codes be available to "dual eligible" patients (i.e., Medicare beneficiaries who are also eligible for Medicaid)?

**A:** Yes.

**Q:** Must a patient have received a Medicare annual wellness visit (AWV) in the past 12 months for a provider to be able to bill separately for CCM services?

**A:** CMS requires you to furnish to the patient an AWV, Initial Preventive Physical Examination (also known as a "Welcome to Medicare Visit"), or comprehensive evaluation and management visit before billing the CCM service and to initiate the CCM service as part of this exam/visit.

### Scope of services

**Q:** How does CMS define the scope of CCM services?

**A:** CMS has established eight elements that it uses to define the current scope of CCM services:

1. Access to care management services 24-hours-a-day, 7-days-a-week, which means providing patients with a means to make timely contact with health care providers in the practice to address the patient's urgent chronic care needs regardless of the time of day or day of the week.
2. Continuity of care with a designated provider or member of the care team with whom the patient is able to get successive routine appointments.
3. Care management for chronic conditions including:
  - Systematic assessment of 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.
4. Creation of a patient-centered care plan document to assure that care is provided in a way that is congruent with patient choices and values. A plan of care is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues.
5. Management of care transitions between and among health care providers and settings, including the following:
  - Referrals to other clinicians,
  - Follow-up after a patient visit to an emergency department,
  - Follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities.
6. Coordination with home and community based clinical service providers as appropriate to support 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 patient's care through not only telephone access but also the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.
8. Use of certified electronic health record (EHR) or other health information technology or health information exchange platform that includes an electronic care plan accessible to all providers within the practice, including those who are furnishing care outside of normal business

hours, and can be shared electronically with care team members outside of the practice.

**Q:** What does CMS expect the plan of care to include?

**A:** The plan of care should typically include, but is not limited to, the following elements:

- Problem list,
- Expected outcome and prognosis,
- Measurable treatment goals,
- Symptom management,
- Planned interventions,
- Medication management,
- Community/social services ordered,
- How the services of agencies and specialists not connected to the practice will be directed/coordinated,
- The individuals responsible for each intervention,
- Requirements for periodic review and, when applicable, revision of the care plan.

Additionally, CMS expects the provider to reflect a full list of problems, medications, and medication allergies in the EHR to inform the care plan, care coordination, and ongoing clinical care.

**Q:** Where can we find the Medicare verbiage on CCM?

**A:** The best source is a fact sheet on CCM published by CMS. You can find that fact sheet online at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

**Q:** Do I have to provide the patient with a copy of the care plan?

**A:** Yes. CMS requires you to provide the patient with a written or electronic copy of the care plan and to document in the EHR that the care plan was provided to the patient.

**Q:** What does CMS expect with respect to management of care transitions?

**A:** The practice must be able to communicate relevant patient information through electronic exchange of a summary care record with other health care providers regarding these transitions. The practice must also have qualified personnel who are available to deliver transitional care services to a patient in a timely way so as to reduce the need for repeat visits to emergency departments and readmissions to hospitals and skilled nursing facilities.

**Q:** Are patients required to use secure messaging, Internet, or other asynchronous, non-face-to-face consultation methods?

**A:** No. While CMS expects practices to provide these communication options, it does not require the practice to ensure that every patient and caregiver makes use of these options.

**Q:** Does my EHR have to be certified?

**A:** Yes. You must use an EHR that meets the National Coordinator for Health Information Technology's certification criteria for the prior year. For 2015, providers furnishing CCM services are allowed to use an EHR certified to either the 2011 or 2014 certification criteria.

**Q:** Does doing prior authorizations for medications and tests over the phone or ordering them electronically satisfy the CCM scope of service?

**A:** The CCM scope of service includes "medication reconciliation with review of adherence and potential interactions" as well as "oversight of patient self-management of medications." It is debatable whether time spent on the phone doing prior authorization for medications and tests or time sending in such prior authorization electronically would count for this purpose. At this point, it is probably safer not to count time spent on prior authorizations as CCM time, although CMS has not explicitly addressed the question.

**Q:** Can only the physician create the care plan, or can the physician delegate it to other clinical staff? Also, can a mid-level provider, such as a nurse practitioner or physician assistant, acknowledge/sign the care plan?

**A:** In the final rule on the 2015 Medicare physician fee schedule, in its discussion of the scope of the CCM service, CMS states, "In consultation with the patient, any caregiver, and other key practitioners treating the patient, the practitioner furnishing CCM services must create a patient-centered care plan document to assure that care is provided in a way that is congruent with patient choices and values." I interpret this to mean that the physician or non-physician practitioner who is nominally furnishing CCM services and, presumably, under whose provider number the services will be billed is responsible for creating the care plan. Also, CMS uses the word "practitioner" rather than "physician," so I believe that a mid-level provider, such as a nurse practitioner or physician assistant, could acknowledge/sign the care plan if he or she created it.

**Q:** Who can provide services after the care plan has been generated?

**A:** The definition states that "clinical staff" must provide the 20 minutes to qualify. "Clinical staff," as defined by CPT, "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." If the physician or other qualified health care professional (e.g. nurse practitioner or physician assistant) supplies the time, that time may also count toward the 20 minutes.

**Q:** What constitutes "electronic sharing" of the care plan and transitions of care?

**A:** The care plan and transitions of care must be recorded in

a certified EHR. This allows for remote access to the information among those in the practice who are providing the CCM service when they are away from the office setting. This information can then be electronically shared with/or sent to other care entities by any form other than fax. The electronic sharing includes (but is not limited to) secure messaging, encrypted email, and EHR-to-EHR connectivity, where it exists. CMS has not mandated how the information is received, only how it is sent. If the receiving practice transforms the electronic information into a fax, your transmission of the data may still be considered electronic, as long as you did not send it as a fax.

### 24/7 access to care

**Q:** Is 24/7 access to care management defined as a phone call? Would 24/7 access for “urgent chronic care needs” by a patient portal be acceptable under the guidelines?

**A:** Regarding 24/7 access to care management, CMS states, “To accomplish this, the patient must be provided with a means to make timely contact with health care providers in the practice to address the patient’s urgent chronic care needs regardless of the time of day or day of the week.” Elsewhere, CMS states that the scope of CCM services includes “Enhanced opportunities for the beneficiary and any relevant caregiver to communicate with the practitioner regarding the beneficiary’s care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non face-to-face consultation methods.” Based on this information, 24/7 access is not necessarily defined as a phone call.

**Q:** If I am reading this right, we are not being asked to be available for “urgent acute care needs” but “urgent” issues regarding their chronic care conditions. Does Medicare define how quickly the provider must respond to the patient’s urgent care needs?

**A:** As noted, CMS states, “To accomplish this, the patient must be provided with a means to make timely contact with health care providers in the practice to address the patient’s urgent chronic care needs regardless of the time of day or day of the week.” Thus, this access is related to “urgent chronic care needs.” Medicare does not define “timely” in this context.

**Q:** Does an answering machine meet the criteria of 24/7 timely access to the practice?

**A:** Probably not. In general, 24/7 timely access is understood to mean that the patient can reach a live person who is a member of the care team or can connect them to the care team in a timely manner to address any urgent chronic care needs that the patient has.

**Q:** Does 24/7 access include email access?

**A:** Email access may count toward satisfying the requirement that the practice provide enhanced opportunities for the patient and any relevant caregiver to communicate with the physician/practitioner regarding the patient’s care. However, it seems unlikely to satisfy the requirement that the practice pro-

vide 24/7 access to address the patient’s urgent chronic care needs unless the email is being constantly monitored for that purpose.

**Q:** Regarding the access to care management, does this mean that the doctor needs to have access to the EHR chart and be on call or that any physician can access the EHR? Does the patient need to have online access to their care plan or just a paper copy?

**A:** All members of the care team within the practice are expected to have 24/7 access to the EHR. As long as that is the case and the patient has the ability to contact a member of the care team (not necessarily the physician) on a 24/7 basis for urgent chronic care needs, then access to care management is assured. The practice may provide the patient with a written or electronic copy of the care plan.

**Q:** Does the 24/7 access have to be with the direct care team or can it be with an after-hours call center staffed by nurses, provided that they have access to the EHR with the patient’s care plan.

**A:** CMS requires the provision of 24/7 access to address the patient’s urgent chronic care needs and states that, to accomplish this, the patient must be provided with a means to make timely contact “with health care providers in the practice” to address those needs.

**Q:** Does 24/7 access include portal access (electronic availability as opposed to the actual clinic being open 24 hours)?

**A:** Portal access may count toward satisfying the requirement that the practice provide enhanced opportunities for the patient and any relevant caregiver to communicate with the physician/practitioner regarding the patient’s care. However, it seems unlikely to satisfy the requirement that the practice provide 24/7 access to address the patient’s urgent chronic care needs unless the portal is being constantly monitored for that purpose.

**Q:** Do we need to provide patients with the physicians’ cell phone numbers when the office is closed?

**A:** No, but you do need to provide the patient with some means, such as a phone number, that will allow him or her to make timely contact with health care providers in the practice (not necessarily the physician) to address the patient’s urgent chronic care needs.

### Coding, billing, and payment

**Q:** What code should I use to report CCM services?

**A:** You should use code 99490, “Chronic care management services, 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.”

**Q:** Must you complete a patient-centered care plan before doing any charges?

**A:** The scope of service for CCM includes creation of a patient-centered care plan. CMS also requires that you provide a copy of that care plan to the patient. I believe CMS expects both of those things to be done before you report 99490 the first time.

**Q:** When billing 99490, do we use the diagnosis codes for the two chronic care conditions we are using?

**A:** CMS has not specified what diagnosis codes should be reported with code 99490. Absent guidance to the contrary, it seems reasonable to report at least the two primary chronic care conditions for which you are providing 99490.

**Q:** How many work relative value units (RVUs) are assigned to the CCM code?

**A:** The 2015 Medicare physician fee schedule assigns 0.61 work RVUs to code 99490.

**Q:** Is there an option to charge more if you spend a lot more than 20 minutes?

**A:** There is no current mechanism to charge Medicare more if you spend longer than 20 minutes. CPT has complex chronic care management codes that would facilitate that, and the AAFP encouraged CMS to use those codes for just this reason. However, for 2015, CMS is only recognizing and paying 99490, which is open-ended in terms of the time involved.

**Q:** How must my staff and I document this service?

**A:** CMS has not specified any documentation requirements for this service. *Family Practice Management* offers a tool for tracking time spent on CCM services.

**Q:** What do we use for a date of service?

**A:** CMS has not addressed this particular question. Code 99490 is intended to encompass a calendar month’s worth of work. Box 24 on the CMS-1500 claim form does permit a “from” and “to” date, so I would consider putting the first day of the month as the “from” date and the last day of the month as the “to” date for 99490 as a line item. (I presume electronic claims would also support this approach.) Medicare Administrative Contractors (MACs) may have differing policies on this. Best practice is to contact yours directly to see if they prefer a date range, the date you are submitting the claim, or some other date, such as the last day of the month.

**Q:** When should I submit my claims for this service?

**A:** Because code 99490 does encompass the entire calendar month, one option is to refrain from billing it until the last

day of the month, in much the same way that CMS expects providers to wait until the end of the 30-day period to report transitional care management (TCM) codes. CMS has stated that once the 20 minutes have been documented, it would be acceptable to submit the claim. However, this could be cumbersome to manage, so your practice should probably determine a standard of submission that works for the practice and stick with it. You may want to consult with your MAC regarding any expectations or requirements it has in this regard.

**Q:** Can I bill CCM in the same month in which I see and treat a patient?

**A:** I am not aware of anything that would prohibit you from reporting 99490 in the same calendar month during which you saw the patient and reported an appropriate evaluation and management code for that encounter. CPT and the National Correct Coding Initiative (NCCI) edits identify services that should not be reported in addition to CCM services for a patient during the same time period, such as TCM services (99495 or 99496), home health care supervision (G0181), hospice care supervision (G0182), or certain end-stage renal disease services (90951-90970). Please consult CPT and the NCCI for a complete list of these codes. While evaluation and management and preventive services (IPPE/AWV) are billable when the services are not bundled on the same day as chronic care management, anything you do that is related to that E/M or preventive service should not be documented as time spent for CCM.

**Q:** Can you bill for CCM during the same month of an annual wellness exam?

**A:** Yes. CMS is requiring that a comprehensive visit, initial preventive physical exam, or annual well visit be performed prior to initial CCM billing and that the CCM service be initiated during such an encounter. This allows for the care plan to be discussed and formulated with a patient-centered focus. This can be in the same month as CCM, or in a prior month. CCM does not replace the course of regular office visits with the physician. The intent of CCM is to allow for reimbursement of care management by clinical support staff without requiring monthly face-to-face contact.

**Q:** How much does Medicare allow for this service?

**A:** The Medicare allowance will vary geographically. However, the geographically unadjusted amount is approximately \$42 per month.

**Q:** Are CCM services subject to Medicare’s deductible and coinsurance?

**A:** Yes. After the deductible is met, the 20 percent coinsurance will be about \$8 to \$9 for a month’s work of CCM.

**Q:** Can I routinely waive the deductible and coinsurance?

**A:** No. This is a violation of the Anti-Kickback rule.

**Q:** Will a patient’s Medicaid/supplemental/secondary insurance

cover the deductible and coinsurance?

**A:** Depends. Each patient must check individually with their plan coverage to determine benefits. As a general rule, if Medicare covers a service then Medicaid and/or supplemental insurance will also. Covered benefits and payment are not the same thing.

**Q:** How much leeway do we have to focus only on the pressing/relevant problems? It is unclear from documentation.

**A:** Code 99490 is for the management of chronic care conditions. Acute illness management is not considered in the reimbursement structure. If care is instigated in regards to the patient's chronic conditions, then this is what needs to be counted toward the billing of the code. If the minimum 20 minutes of management was not documented within a calendar month in relation to the chronic conditions and associated care plan, then you cannot bill 99490.

**Q:** Can I bill CCM services if I am participating in Medicare's Multi-Payer Advanced Primary Care Practice Demonstration (MAPCPD) or the Comprehensive Primary Care Initiative (CPCI)?

**A:** If you participate in either MAPCPD or CPCI, you may not bill Medicare for CCM services furnished to any patient attributed to your practice for purposes of participating in one of these initiatives. However, you may bill Medicare for CCM services furnished to eligible patients who are not attributed to your practice as part of these initiatives.

**Q:** Can CCM services related to medication management be delivered by a clinical pharmacist embedded in the clinic? If yes, would billing still be under the supervising physician or mid-level provider, or can the clinical pharmacist bill directly for the CCM service?

**A:** CMS has acknowledged that the services of pharmacists may be billed "incident-to" those of a physician or other qualified health care professional, such as a nurse practitioner or physician assistant, as long as all of the incident-to requirements are otherwise met. Thus, a clinical pharmacist could be counted among the clinical staff able to provide CCM services incident-to the services of the physician or mid-level provider under whose provider number the services will otherwise be billed to Medicare. I do not believe that Medicare recognizes clinical pharmacists as providers for purposes of billing Medicare directly under Medicare Part B or the physician fee schedule.

**Q:** Can the case manager of a Medicare Shared Savings Program accountable care organization (MSSP ACO) who works under the physician's direction be counted for doing work outside of the office?

**A:** If the MSSP ACO case manager is a clinical staff person and the work that he or she does otherwise meets Medicare's "incident-to" rules relative to the physician who will be reporting 99490 (understanding that, for CCM, CMS allows incident-to services to be provided under general, rather than direct, supervision), then his or her time may be counted toward the

20 minutes necessary to report code 99490, where appropriate.

**Q:** Can Medicare shared savings plans (i.e., Medicare accountable care organizations) bill for this service?

**A:** CMS has not excluded these plans from billing this service.

**Q:** May I bill Medicare for CCM and transitional care management (TCM) services provided to the same beneficiary during the same time period?

**A:** No. You cannot bill CCM services for a patient during the same 30-day period in which you are otherwise billing Medicare for TCM services (99495 or 99496), home health care supervision (G0181), hospice care supervision (G0182), or certain end-stage renal disease services (90951-90970).

**Q:** Can I bill CCM services for patients in a facility setting?

**A:** CMS says the resources required to provide CCM services to patients in facility settings significantly overlap with care management activities by facility staff that are included in the associated facility payment. Therefore, CPT code 99490 cannot be billed to the Medicare physician fee schedule for patients who reside in a facility that receives payment from Medicare for care of that beneficiary because the payment made to the facility under other payment systems includes care management and coordination. For example, CMS explicitly states that CPT code 99490 cannot be billed to the Medicare physician fee schedule for services provided to inpatients of either a hospital or skilled nursing facility. However, if the patient is not an inpatient for the entire month, time that is spent furnishing CCM services to the patient while they are not an inpatient can be counted towards the minimum 20 minutes of service time that is required to bill CCM for that month.

**Q:** How is "facility" defined?

**A:** In the final rule on the 2014 Medicare physician fee schedule, CMS stated, "The resources required to provide care management services to patients residing in facility settings significantly overlaps with care management activities by facility staff that is included in the associated facility payment." CMS did not define "facility" beyond that. I interpret facility in this context to be any health care entity (e.g., hospital, skilled nursing facility, etc.) that receives a facility payment from Medicare.

**Q:** Can you bill CCM for patients in an assisted living facility?

**A:** Per CMS, CPT code 99490 can be billed only for CCM services furnished to a patient who is not the inpatient of a hospital or SNF and does not reside in a facility that receives payment from Medicare for that beneficiary. Therefore, if an assisted living facility is receiving Medicare payments for a given patient residing in that facility, I do not believe that you can report CCM for that patient. Note that CPT defines the eligible residence of a patient as at home or in a domiciliary, rest home, or assisted living facility. Thus, from a CPT perspective, it would be entirely appropriate to report CCM for patients in an assisted living facility that did not receive a Medicare facility payment.

**Q:** What place of service (POS) code should we use?

**A:** The place of service to be submitted on the CMS1500 form should be where the majority of the services were rendered, such as the office setting. Typically, either POS 11 (office) or 22 (outpatient hospital) would apply.

**Q:** Can you bill CCM for Medicare Advantage patients?

**A:** You will need to check with the Medicare Advantage plans in your area regarding whether or not they will pay for 99490 in 2015. My understanding is that, in general, patients in Medicare Advantage plans are entitled to the same benefits enjoyed by patients covered under traditional Medicare. However, I have heard from some family physicians that some Medicare Advantage plans do not plan to cover and pay 99490.

**Q:** Is billing for CCM services limited to primary care physicians?

**A:** No. While CMS expects the CCM code to be billed most frequently by primary care physicians, specialists who meet the requirements may also bill for these services. Nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse midwives can also furnish the full range of these services under their Medicare benefit, to the extent permitted by applicable limits on their state scope of practice.

**Q:** Can you give examples of what types of activities would fall under this code?

**A:** The following activities would be covered:

- Phone calls and emails to/from the patient
- Time spent making referrals to other care givers (does not include time faxing)
- Prescription management (pharmacy phone time, counseling the patient, etc.)
- Conversations with caregivers

**Q:** Is there a time log already created?

**A:** There is a sample spreadsheet available for download in the FPM Toolbox. You can customize it for your practice. Some EHR programs have “tickler” functions that track and generate reports for billing recurring services. Check with your vendor for availability.

**Q:** Does any of the documentation in the EHR have to be structured data?

**A:** Demographics, problems, medications, medication allergies, and the clinical summary records must be in a CCM-certified EHR.

**Q:** Please explain “calendar month” billing.

**A:** A claim may be submitted once per month for payment when the requirements of the service are met. This is based on a minimum of 20 minutes of clinical staff time typically spent in non-face-to-face care management of the patient’s chronic conditions as related in the care plan. Only one unit of 99490 per month may be submitted for a given patient, even if the

clinical staff devotes much more than 20 minutes. If appropriately documented and submitted no more than once a month for a given patient, the physician should receive payment for that month’s CCM.

**Q:** If another doctor is billing CCM for a patient, can I still bill transition of care or vice versa?

**A:** Probably so, unless Medicare is treating the two physicians as one provider (e.g., because they are part of a group practice).

### 20 minutes of clinical staff time

**Q:** Does the 20 minutes per calendar month need to be all at one time or can it be spread out over the month? Also, does it need to be by one clinical staff person or could it be multiple staff doing five to 10 minutes each?

**A:** The service can be spread out over the entire month. The time of any clinical staff contributing to care of the patient that meets the list of typical services rendered can be counted toward that 20-minute threshold for a particular patient.

**Q:** What would be a minimum unit of time for the services that add up to 20 minutes or more? For example, is a prescription refill one minute or five minutes? Do you have information on what an audit would look for in particular?

**A:** CMS and CPT alike simply state a minimum of 20 minutes of clinical staff time must be recorded in order to bill 99490. Neither one indicates how that time is to be recorded nor the minimum units of time that make up that 20 minutes or more. It is probably best to record the actual number of minutes spent in each instance that adds up to the 20 minutes or more needed to report the service and not use a standard amount of time in each instance. If and when an auditor requests a set of notes to support 99490, seeing “five minutes spent” for each element of the CCM service will likely be questioned for validity. Not every service performed will take the same amount of time, be it one minute or five minutes.

**Q:** Can the non-face-to-face time spent creating the care plan count toward the 20 minutes necessary to bill 99490?

**A:** Yes.

**Q:** If my staff spends 10 minutes or more, can I round up and bill the service?

**A:** No. The 20 minutes is a minimum threshold.

**Q:** If two staff are providing CCM services simultaneously to a patient (e.g., in a team meeting related to the patient’s care), can I count the time of both staff toward the 20 minutes?

**A:** No. You can count the time of only one clinical staff member for a particular segment of time. So, in your example, you would count 10 minutes, not 20 minutes.

**Q:** If we don’t do 20 minutes of CCM in a month, but our work over two or three months adds up to 20 minutes, can we bill at that time for a month?

**A:** No. Code 99490 is for 20 minutes “per calendar month.” You cannot add time up over multiple months to report 99490.

**Q:** Does the 20 minutes count if a patient gets lab work or radiology work done, and I or my staff has to call them with the results and my recommendations based on those results?

**A:** Yes, this is part of the care management services and transitions of care management that are part of the CCM scope of services.

**Q:** Every time we speak to the patient on the phone during the month, does that count toward the 20-minute time threshold?

**A:** If the phone conversation is between the patient and a clinical staff person in the practice and if the conversation addresses management of the patient’s chronic conditions, then you may count that time toward the 20-minute threshold required to bill 99490.

**Q:** Does time reading specialist consults, reviewing labs and other tests, etc., count toward the 20 minutes?

**A:** Yes, CPT guidelines preceding the CCM code state that care management includes “ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service.”

**Q:** How would a care manager or other staff member document the 20 minutes per calendar month that is required? Using a work log, we can generate a report in our EHR documenting where someone was, but it is more difficult to track how much time was spent. Would a simple checkbox built into a template saying “I spent at least 20 minutes providing CCM to this patient” suffice?

**A:** CMS has not dictated the mechanics of how practices are to document the time spent on CCM for a given patient each month. That said, I do not believe that a simple checkbox built into a template saying “I spent at least 20 minutes providing CCM to this patient” would suffice in the event of a Medicare audit. Rather, I believe that a Medicare auditor would be looking for some record of which clinical staff did what elements of the CCM service on which dates during the month and for how long they did so on each date and that the total of that time met or exceeded 20 minutes for the month. Because AAFP recognized that some EHRs are not set up to capture documentation in this way, we provided a sample service log as a tool with the FPM article for those that might find it helpful.

### Getting patient agreement

**Q:** What do I need from the patient before I bill the service?

**A:** CMS requires you to:

- Inform the patient about the availability of CCM services from the provider and obtain his or her written agreement to have the services furnished, including authorization for electronic communication of the patient’s medical information with other treating providers as part of care coordination.

- Document in the patient’s medical record that all of the CCM services were explained and offered to the patient, and note the patient’s decision to accept or decline these services.

- Inform the patient of the right to stop CCM services at any time (effective at the end of a calendar month) and the effect of a revocation of the agreement on CCM services.

- Inform the patient that only one provider can furnish and be paid for these services during a calendar month.

**Q:** Is there a standard written agreement for this purpose?

**A:** CMS has not provided a standard form for this purpose. You may want to use the one provided by *Family Practice Management*.

**Q:** When do I have to obtain the patient’s agreement?

**A:** CMS requires a written agreement before initiating the service.

**Q:** Who must obtain the consent? Does it have to be a “practitioner,” or can non-clinical support staff (e.g. a receptionist) do it?

**A:** The CMS Medicare Learning Network downloadable frequently asked questions specifically states that it must be a “practitioner.”

**Q:** How often do I need to get the patient’s agreement?

**A:** The agreement process need only occur once at the outset of furnishing the service, and it only needs to be repeated if the patient opts to change the provider who is delivering the services. You do not need to inform the beneficiary each time a bill for CCM services is submitted.

**Q:** Can a patient revoke his or her agreement?

**A:** Yes, the patient can revoke the agreement for CCM services at any time. However, if the revocation occurs during a current chronic care management calendar month, the revocation is not effective until the end of that month. The patient can notify the provider of revocation verbally or in writing. The date of revocation must be recorded in the patient’s medical record, and the practice must give the patient written confirmation that it will not be providing CCM services beyond the current calendar month.

**Q:** If a patient signs two CCM agreements with two different providers, on two different dates, which of the two providers gets paid? Is the patient held liable for the second CCM agreement and any related CCM services?

**A:** Technically, whichever provider has the agreement signed first is the eligible billing party, assuming the patient has not revoked that agreement to sign the second one. Practically speaking, it is likely that the MAC will pay whichever provider bills first for the month in question; if that happens to be the second provider, the first provider may have to file an appeal to get paid. It is unclear at this time if Medicare will hold the beneficiary liable for a sec-

ond claim even if a signed patient agreement is produced. I suggest you contact your local MAC for verification.

**Q:** Who should be identified as the rendering provider on the claim?

**A:** This has not been defined, although one MAC has stated that it should be the provider who is in the office when the claim is billed. I would recommend that the rendering provider be identified as the physician who developed the plan of care and whom the patient identified in the agreement. If that practitioner is not in the office or is not overseeing the care plan, then the claim should be submitted under the current supervising practitioner.

**Q:** How do we know if another doctor is billing? Does CMS allow non-primary care doctors to use this code?

**A:** CCM allows for physicians, certified nurse midwives, clinical nurse specialists, nurse practitioners, and physician assistants to bill for CCM. There is not a specialty-specific restriction. Unfortunately, you will not know another provider is billing for the same patient until one of you receives a denial from Medicare. Production of the patient agreement will be imperative for date verification in this instance.

**Q:** From a patient's standpoint, this is a cost share to the patient. How would you explain that this is a benefit to them in order to obtain consent?

**A:** CCM allows for dedicated staff time to assist with care coordination. While some areas of care may have been delivered prior to this program, the beneficiary, by consenting, becomes eligible for care that must meet minimum requirements set by CMS. I would also direct physicians' attention to the sample letter to patients that is among the tools provided by FPM.

**Q:** What do we do if patients do not sign the consent for this service?

**A:** If a patient does not sign the consent, then you may not bill the service to Medicare. You may still provide CCM services to the patient, if you wish, but Medicare will not compensate you for them.

**Q:** Do Medicare patients have to opt in or opt out of receiving CCM services?

**A:** Because there is beneficiary cost-sharing involved and because the service will typically not be face-to-face with the patient, CMS wants to ensure that beneficiaries make a conscious decision to receive the service. Thus, CMS has made it "opt in" rather than "opt out."

**Q:** In one part of the FPM article on CCM, the author says written agreement is a requirement. But six paragraphs later he says, "CMS believes it is prudent to require a written agreement prior to initiating CCM." So, am I to believe that while these letters are prudent they are optional?

**A:** The CMS absolutely requires a signed beneficiary agreement before providing the service, although it is recognized that "prudent" does not necessarily carry that connotation. In

this case, CMS considers it both prudent and a requirement that you get the beneficiary's agreement in writing before initiating CCM services.

### Miscellaneous

**Q:** Medicare's "incident to" rules generally require the physician to be present in the office suite and immediately available to provide assistance and direction throughout the service when ancillary staff are involved in the provision of a service billed under the physician's provider ID. Will that apply to CCM services, too?

**A:** No. For purposes of providing CCM services, CMS has created an exception to the requirement that "incident to" services must be furnished under direct supervision. Specifically, CMS is requiring only general, rather than direct, supervision when CCM services are furnished incident to a provider's services. This means that the supervising physician must be available by telephone only. All other requirements related to "incident to" services would still apply to CCM services.

**Q:** Who may cover call? We have an arrangement for doctors not in our group to cover call. Will that count for the 24/7 access requirement?

**A:** Call may be covered by anyone you have a contractual relationship with that meets "incident-to" guidelines. This applies to all care coordination companies that a provider might contract with to provide CCM services.

**Q:** Are federally qualified health centers (FQHCs) and rural health clinics (RHCs) excluded from billing this service?

**A:** RHCs and FQHCs are not currently able to bill Medicare for CCM services. CMS has indicated that it is considering the possibility of allowing RHCs and FQHCs to bill for CCM services in the future.

**Q:** If you have midlevel providers providing the CCM services, can they bill "incident-to," or must they bill under their own provider number (i.e. 85 percent allowable)?

**A:** You can bill a midlevel provider's CCM services incident-to those of a physician as long as all of the incident-to requirements are otherwise met. As noted, for CCM purposes, the level of incident-to supervision required is general rather than direct.

*Source: Kent Moore, senior strategist for physician payment, American Academy of Family Physicians. These FAQs are drawn from CMS's discussion of CCM services in the final rule on the 2014 Medicare physician fee schedule as published in the Federal Register on Dec. 10, 2013, and in the proposed rule on the 2015 Medicare physician fee schedule as published in the Federal Register on July 11, 2014, as well as the final rule on the 2015 Medicare physician fee schedule as published in the Federal Register on Nov. 13, 2014.*

See the related article at <http://www.aafp.org/fpm/2015/0100/p7.html>.

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