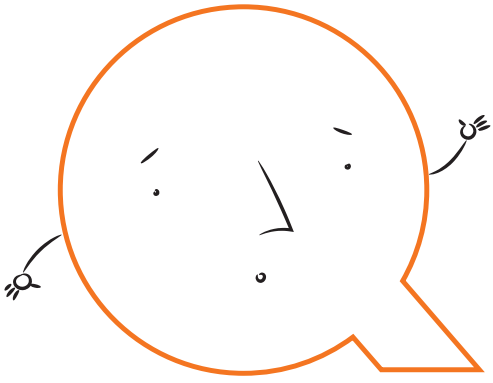
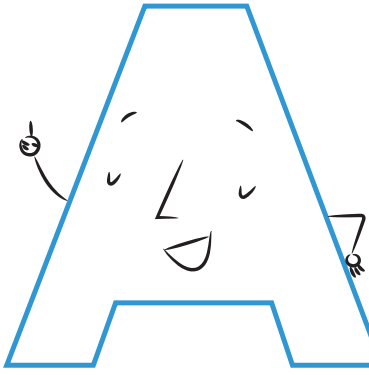
From what constitutes 24/7 access to how to document the 20 minutes of required monthly services, we fill in the blanks about this new Medicare benefit.



Answers to Your Questions About



CHRONIC CARE MANAGEMENT

Kent Moore and Barbara Hays, CPC, CPMA, CPC-1, CEMC

The Centers for Medicare & Medicaid Services (CMS) began paying for chronic care management (CCM) services on Jan. 1 of this year. While many physicians have embraced the opportunity to finally be paid for the non-face-to-face services associated with managing patients' chronic conditions, meeting Medicare's billing requirements is challenging.

An article in *FPM*'s January/February issue (http://www.aafp.org/fpm/2015/0100/p7.html) summarized them and provided several tools for developing the necessary patient care plan, getting patient approval for the service, and documenting the necessary 20 minutes of clinical staff time. The article, as well as a follow-up webinar (http://bitly.com/1K07rgn), generated a number of good questions. We've compiled the most frequently asked questions and their answers here.

Q: What is "calendar month" billing?

A: A claim for CCM, using code 99490, may be submitted to Medicare once per month when the requirements of the service are met. Twenty minutes of clinical staff time must be spent in non-face-to-face care management of chronic conditions as outlined in the patient's care plan. Only one unit of 99490 per month may be submitted for each patient, even if the time spent exceeds 20 minutes.

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. A clinical staff member, as defined by CPT, "is a person who works under the

About the Authors

Kent Moore is senior strategist for physician payment for the American Academy of Family Physicians (AAFP) and is a contributing editor to *Family Practice Management*. Barbara Hays is coding and compliance strategist for the AAFP. Author disclosure: no relevant financial affiliations disclosed.

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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 a physician or other qualified health care professional (e.g., nurse practitioner or physician assistant) supplies the service, that time may also count toward the 20 minutes. Although the CCM code is intended to pay practices for nonphysician time, it is understood that some physicians do deliver non-face-to-face services that fall under the CCM umbrella.

Medicare's new chronic care management (CCM) code has created confusion for some physicians.

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 (also known as the Welcome to Medicare visit), or annual wellness visit be performed prior to billing CCM. The CCM service may be initiated during such an encounter, with the discussion and creation of a patient-centered care plan. This CCM can follow in the same month, or in a later month. CCM does not replace regular office visits with the physician.

Only one unit of CCM may be submitted for each patient per month, even for more than 20 minutes of service.

Q: Do we have to focus only on the patient's chronic conditions, or can we spend some time treating pressing/relevant problems?

A: Code 99490 is for the management of chronic illnesses. Acute care is not covered by this payment. You cannot bill 99490 if you did not provide 20 minutes or more of services related to the patient's chronic conditions.

Services provided by physicians, qualified health care professionals, and clinical staff count toward the required 20 minutes of CCM work per month.

Q: What place of service code should we use?

A: The place of service should reflect where the majority of the services were rendered. Typically, place of service 11 (office) or 22 (outpatient hospital) would apply.

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

A: Examples include phone calls and emails to and from the patient, managing referrals to other providers (does not include faxing), managing prescriptions (pharmacy phone time, counseling the patient, etc.), and talking with caregivers.

Q: Can the 20 minutes per calendar month be spread throughout the month, and can it be provided by multiple staff?

A: Yes. The service can be spread out over the entire month. The 20-minute threshold for a particular patient can include any time that clinical staff members in the practice spend providing CCM services to the the 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?

A: CMS and CPT simply state that a minimum of 20 minutes of clinical staff time must be recorded to bill 99490. Neither indicates how that time should 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 and not use a standard amount of time for each instance. If and when an auditor requests a set of notes to support 99490, seeing "five minutes spent" for every element of the CCM service may raise questions.

Q: Does time spent calling patients with test results and follow-up instructions count toward the 20-minute requirement?

Yes, this time counts as long as you or your clinical staff are doing the work.

Q: Can we count toward the 20-minute requirement every phone conversation we have with the patient during the month?

A: If the phone conversation is between the patient and a clinical staff person in the practice and 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 spent reading consultants' reports and reviewing labs and other test results count toward the 20-minute requirement?

A: Yes. According to CPT, care management includes "ongoing review of patient status, including review of laboratory and other studies not reported as part of an evaluation and management service."

Q: How would staff document the time spent on CCM? Using a work log, we can generate a report in our electronic health record (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. That said, we do not believe that an auditor would accept the template checkbox you describe. An auditor would probably be looking for some record of which clinical staff provided CCM services, on which dates, and for how long. Some EHRs are not set up to capture documentation in this way. A service log spreadsheet may be downloaded from the *FPM* Toolbox (http://bit.ly/1G3LEQY).

Q: If I initiate a care plan well after the first day of the month, do I have to wait until the following month to bill for CCM?

A: No. As long as a full 20 minutes of CCM services are documented within the calendar month, the care plan does not need to be initiated within the first days.

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 should allow for 24/7 access to the information among authorized staff who are providing the CCM service. This information can then be electronically shared with other providers via any means other than fax. This 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 is still acceptable.

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

A: It probably does not. We understand this requirement to mean that patients must be able to 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 their urgent chronic care needs.

Q: Does 24/7 access include email or portal access?

A: Email or 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 or other provider 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 email or portal is being constantly monitored for that purpose. ➤

- The place of service code reflects where the majority of services were performed.
- It's best to record the actual time spent performing a service instead of relying on standard amounts in case of an audit.
- Reading consultant reports and reviewing labs and other test results count toward the 20-minute requirement.

CMS wants to ensure that beneficiaries make a conscious decision to receive the service.

Q: To ensure access to care management, does the patient's primary doctor need to have 24/7 access to the EHR and be on call, or is it sufficient that another member of the care team can access the EHR? Does the patient need online access to the 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 reach 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.

Answering machines likely don't meet the 24/7 patient access requirement, which infers interaction with a live person.

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: A call center by itself would not meet the definition of 24/7 access unless it was able to quickly connect the patient with a member of his or her care team to address the patient's urgent chronic care needs.

Email and portals must be constantly monitored for them to meet the 24/7 access requirement.

Q: Do we need to provide patients with physicians' cell numbers to facilitate access when our office is closed?

A: No, but you do need to provide patients with some means of making timely contact with health care providers in the practice (not necessarily the physician) to address urgent chronic care needs.

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

Beneficiaries must opt in to receive CCM services before physicians can bill the CCM code.

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

Q: The January/February *FPM* article on CCM says, "CMS believes it is prudent to require a written agreement prior to initiating CCM." Does this mean it is optional?

A: No, CMS absolutely requires a signed beneficiary agreement before providing the service, although we recognize that "prudent" does not necessarily carry that connotation. To be clear, CMS considers it a requirement to get the beneficiary's agreement in writing before initiating CCM services.

Q: Who must obtain the patient consent? Does it have to be a "practitioner," or can nonclinical support staff (e.g., a receptionist) obtain the consent?

A: CMS says it must be a "practitioner."

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 Medicare Administrative Contractor (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 second claim even if a signed patient agreement is produced. We 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 the rendering provider should be the provider who is in the office when the claim is billed. We would recommend that the rendering provider be identified as the physician who developed the care plan and was named in the CCM consent agreement. If that provider is not in the office or is not overseeing the care plan, then the claim should be submitted under the current supervising provider.

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

A: CMS allows 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 CCM for the same patient until one of you receives a denial from Medicare. Producing the patient agreement will be imperative for date verification in this instance.

Q: How would you explain to the patient that the amount he or she must pay for CCM services is worth it?

A: CCM allows for dedicated staff time to assist with care coordination. While some aspects of CCM may have been delivered prior to this program, the beneficiary who consents to receive CCM services becomes eligible for care that meets Medicare program requirements. A sample letter to patients may be downloaded from the *FPM* Toolbox (http://bit.ly/1G1jLcs).

Q: If you have midlevel providers providing CCM services, can they bill "incident-to," or must they bill under their own provider number?

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. CCM requires "general" incident-to supervision (i.e., the physician does not have to be on site) as opposed to "direct" supervision (i.e., the physician must be in the office suite).

Q: What do we do if patients do not sign the consent for CCM services?

If a patient does not sign the consent, then you may not bill the service to Medicare.

Q: If another doctor is billing CCM for a patient, can I still bill transitional care management services?

A: Probably, unless Medicare is treating you and the other physician as one provider, for instance, because you are both part of a group practice.

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