



## CMS Now Pays for Chronic Care Management Services

Mary Jean Sage, CMA-AC

The Sage Associates

The financial and human cost of chronic diseases – such as cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions and mental illness – is staggering. Consider these Centers for Disease Control and Prevention statistics<sup>1</sup>

- 133 million Americans – one-third of the total population – suffer from at least one chronic disease.
  - 70 percent of all deaths result from chronic diseases.
  - 85 percent of all healthcare dollars go to treatment of chronic diseases.
- More than two-thirds of Medicare dollars are spent on patients with five or more chronic diseases

Historically, payers have taken the position that payment for non-face-to-face care management services (e.g., medication reconciliation, coordination among providers, arrangements for social services, remote patient monitoring) is bundled into the payment for face-to-face evaluation and management (E&M) services. These payments, however, do not cover the significant staffing and technology investments required for chronic care management, and therefore many providers cannot afford to provide a full range of these services. As a result, chronic disease patients are too often left to manage for themselves between episodes of care. That pattern of sporadic care translates into higher complication rates that, in turn, mean more suffering and costly care.

The Centers for Medicare and Medicaid Services (CMS) recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending. By offering clinicians incentives to actively manage patients with multiple chronic illnesses, CMS sees an opportunity to improve the quality of care while cutting costs. In a study of Medicare fee-for-service beneficiaries with 15 major chronic illnesses, such as hypertension, hyperlipidemia and ischemic heart disease, the agency found that seniors with four or more conditions accounted for 37 percent of all beneficiaries, but 74 percent of total Medicare spending in 2010.

Beginning January 1, 2015, Medicare pays separately under the Medicare Physician Fee Schedule (PFS) for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. Paying for this new benefit is part of the “broader multi-year strategy to appropriately recognize and value primary care and care management services,” CMS has stated. Just last year, CMS introduced similar coverage for “transitional care management services” for patients discharged from a hospital or skilled nursing facility.

CPT code 99490 is used to report these new services known as Chronic Care Management (CCM). This service may be billed as a complement to face-to-face services such as office visits. The definition of CPT 99490 is:

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<sup>1</sup> Lochner KA, Cox CS. “Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries, United States, 2010.” *Prev Chronic Dis* 2013;10:120137. DOI: <http://dx.doi.org/10.5888/pcd10.120137>. Available at [http://www.cdc.gov/pcd/issues/2013/12\\_0137.htm](http://www.cdc.gov/pcd/issues/2013/12_0137.htm)

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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



January

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25	26	27	28	29	30	31

20 minutes

per calendar month

*\*\*Only one practitioner may be paid for the CCM service for a given calendar month*

## Eligible Providers

Physicians and non-physician clinicians, such as certified nurse midwives, clinical nurse specialists, nurse practitioners and physician assistants, may bill for the CCM service. Eligible practitioners must act within their state licensure, scope of practice and Medicare statutory benefit. The CCM service is not within the scope of practice of limited license practitioners such as clinical psychologists, podiatrists or dentists; therefore, these practitioners cannot furnish or bill the service. CMS expects referral to or consultation with such practitioners by the billing physician or clinician to coordinate and manage care, however.

Services provided directly by an appropriate physician or non-physician practitioner, or by clinical staff incident to the billing physician or non-physician practitioners, count toward the minimum amount of time required to bill the CCM service (20 minutes per calendar month). Non-clinical staff time cannot be counted. Every provider should consult the CPT definition of "clinical staff" and the Medicare PFS "incident to" rules to determine whether time by specific individuals may be counted toward the minimum time requirement. Practitioners may use individuals outside the practice (such as contract employees or agencies) to provide CCM services, subject to the Medicare PFS "incident to" rules and regulations and all other applicable Medicare rules.

CMS provides an exception under Medicare's "incident to" rules that permits clinical staff to provide the CCM service incident to the services of the billing physician or other appropriate practitioners under the general supervision rather than direct supervision of a physician or other appropriate practitioners.

## Eligible Beneficiaries or Patients

Patients with 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 the CCM service.

Examples of chronic conditions include, but are not limited to:

- Alzheimer’s disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Health Failure
- Hypertension
- Ischemic heart disease
- Osteoporosis

CMS requires the billing practitioner to furnish an Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), or comprehensive evaluation and management visit to the patient prior to billing the CCM service, and to initiate the CCM service as part of this exam/visit.

A practitioner must inform eligible patients of the availability of and obtain consent for the CCM service before furnishing or billing the service. Informed patient consent need be obtained only once prior to furnishing the CCM service, or if the patient chooses to change the practitioner who will furnish and bill the service.

Some of the patient agreement provisions require the use of certified electronic health record technology. For a complete listing of the Patient Agreement Requirements, Scope of Service Elements, Billing Requirements and Related EHR Requirements, see Medicare Learning Network (MLN) publication *Chronic Care Management Services* at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf>.

## Payment

CMS pays for the CCM service separately under the Medicare PFS. To find payment information for a specific geographic location, access the Medicare PFS Look-Up tool on the CMS website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup>.

Although patient cost-sharing applies to the CCM service, CCM may help avoid the need for more costly face-to-face services in the future by proactively managing patient health, rather than only treating disease and illness. While the CCM service provides payment of care coordination and care management for a Medicare beneficiary with multiple chronic conditions within the Medicare Fee-For-Service Program, Medicare will not make duplicative payments for the same or similar services for beneficiaries with chronic conditions already paid for under the various CMS Multi-Payer Advanced Primary Care Practice (MAPCP) or the Comprehensive Primary Care (CPC) initiatives. As CMS implements new models or demonstrations that include payments for care management services, or as changes take place that affect existing models or demonstrations, the agency has said it will address potential overlaps with the CCM service and seek to implement appropriate payment policies.