CONNECTED CARE

THE CHRONIC CARE MANAGEMENT RESOURCE

HEALTH CARE PROFESSIONAL TOOLKIT

GO.CMS.GOV/CCM

Overview of CCM

Chronic care management (CCM) is a critical component of primary care that contributes to better outcomes and higher satisfaction for patients. The Centers for Medicare & Medicaid Services (CMS) recognizes CCM takes time and effort. CMS established separate payment under billing codes for the additional time and resources you spend to provide the between-appointment help many of your Medicare and dual eligible (Medicare and Medicaid) patients need to stay on track with their treatments and plan for better health.

CCM payments can be made for services furnished to patients with two or more chronic conditions who are at significant risk of death, acute exacerbation/decompensation, or functional decline. CMS data show that two thirds of people on Medicare have two or more chronic conditions, which means many of your patients may benefit from a CCM program, including the help provided between visits. CCM can help deliver the coordinated care your patients need and deserve.

This toolkit includes information for health care professionals, including tips for getting started, fact sheets on the requirements for implementing a CCM program, and educational materials to share with patients.

Information about CCM

Below is an overview of the codes for practitioners billing under the Physician Fee Schedule:

CMS adopted a separately payable Medicare Part B billing code for CCM services in 2015 (CPT code 99490). This code allows eligible practitioners to bill for at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month, spent on activities to manage and coordinate care for Medicare and dual eligible beneficiaries with two or more chronic conditions that are expected to last at least 12 months or until death. To recognize the costs of providing these services to Medicare and dual eligible patients managing multiple chronic conditions, CMS adopted three additional codes that recognize additional costs, including those related to more complex medical management beginning January 1, 2017.

CPT code 99489 is an add-on code to complex CCM (CPT 99487) for each additional 30 minutes of clinical staff time.

CPT code 99487 is for complex CCM that requires establishment or substantial revision of a care plan, moderate or high complexity medical decision making, and 60 minutes of clinical staff time.

HCPCS code G0506 is an add-on code to the CCM initiating visit that describes the work of the billing practitioner in a comprehensive assessment and care planning to patients outside of the usual effort described by the initiating visit code.

Making Coordinated Care Happen: Benefits to Your Patients and Practice

Thank you for working to implement a successful CCM program at your practice. CCM is a critical component of primary care that contributes to better health and care for individuals.

CMS data shows that two thirds of people on Medicare have two or more chronic conditions, which means many of your patients may benefit from a CCM program. CCM will help you deliver the coordinated care your patients need and deserve.

Why Is CCM Important?

Patients Benefit from CCM

- **Your patients will gain a team of dedicated health care professionals who can help them plan for better health and stay on track.** Services such as monthly check-ins and ready access to their care team improves their care coordination, including improved communication and management of care transitions, referrals, and follow-ups.

- **Patients will receive a comprehensive care plan**. The plan will help support their disease control and health management goals, including physical, mental, cognitive, psychosocial, functional, and environmental factors. Patients may also receive a list of suggested resources and, if available, community services, and may be encouraged to keep track of referrals, community support, and educational information.

- **Encouraging patients to use CCM will give them the support they need between visits.** Having a regular touch point may help patients think about their health more and engage in their treatment plan, for example, becoming more conscious of taking their medications and other self-management tasks. Getting this help may also help patients stay on track and improve adherence to their treatment plan.

CCM Supports Your Practice

- **Improve care coordination.** Chronic care management can help improve care coordination and health outcomes, and now you will receive payment specifically in support of your provision of care using this approach. Encouraging patients to use CCM services will give them the support they need between visits to your office.

- **Support patient compliance and help patients feel more connected:** Some health care professionals say CCM services may help improve their efficiency, improve patient satisfaction and compliance, and decrease hospitalization and emergency department visits.

- **Sustain and grow your practice.** Ongoing care management work has not always been separately recognized, making it difficult for practices to sustain. Appropriate billing for CCM services may help sustain your ongoing work. Offering CCM may provide you with additional resources to help your practice care for more patients in need.

Read on to find out how your practice can begin to provide and seek separate payment for CCM services.

CMS has developed fact sheets and FAQs with information about CCM services and payment: **CCM Services Fact Sheet**, the **Chronic Care Management Services Changes for 2017,** the **Frequently Asked Questions about Physician Billing for Chronic Care Management,** and the **Chronic Care Management (CCM) Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) FAQs**

Getting Your Practice Started with CCM

CCM will help you deliver the coordinated care your patients need and deserve. Offering CCM may enable you to sustain and grow your practice. The full details for implementing CCM in your practice, including eligibility, included services, billing requirements, how to spend time, and payment amounts can be found on the Connected Care Hub.

Additional resources can be found on:

- CMS Care Management Site
- CCM Services Fact Sheet
- Care Management Physician Fee Schedule
- CCM Services Changes for 2017
- CCM Services FAQs
- RHC & FQHC CCM FAQs

Eligibility

Patients eligible for separately payable CCM services are Medicare and dual eligible (Medicare and Medicaid) beneficiaries with two or more chronic conditions expected to last at least twelve months or until the death of the patient, when those conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. These are the only diagnostic criteria.

Examples of chronic conditions include, but are not limited to, the following: Alzheimer's disease and related dementia, Arthritis (osteoarthritis and rheumatoid), Asthma, Atrial fibrillation, Autism spectrum disorders, Cancer, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease, Depression, Diabetes, Hypertension and Infectious diseases such as HIV/AIDS.

CCM services may be billed by*:

- Physicians and certain Non-Physician Practitioners (Physician Assistants, Clinical Nurse Specialists, Nurse Practitioners, and Certified Nurse Midwives)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Hospitals, including Critical Access Hospitals (CAHs)

**Only one physician, NPP, RHC or FQHC, and one hospital, can bill for CCM for a patient during a calendar month.*

Many activities can count toward the minimum monthly service time to bill for CCM. These include:

- Provide comprehensive care management for patients outside of in-person visits, such as by phone or through secure email. CCM includes, in large part, activities that are not typically or ordinarily furnished face-to-face with the patient and others, such as telephone communication, review of medical records and test results, self-management education and support, and coordination and exchange of health information with other practitioners and health care professionals. It may also include some face-to-face interaction with the patient or other providers.

- Share patient's health information, including their electronic health plan, with the patient's other health care professionals and providers.

- Manage care transitions, including providing referrals and facilitating follow-ups for patients after they are discharged.

- Coordinate with home- and community-based clinical service providers and document this activity in the patient's medical record.

For more information and tools to implement CCM, please visit: go.cms.gov/CCM.

Billing Codes and Payment for CCM

Getting up to speed may take some effort, but offering chronic care management services can help support quality care, may improve health outcomes and patient satisfaction, and may enable you to grow your practice.

The billing codes and Medicare physician fee schedule payments for CCM services are:

- CCM initiating visit (these include most standard face-to-face Evaluation and Management E/M visit codes as well as the Annual Wellness Visit (AWV), Initial Preventive Physical Exam (IPPE), or Transitional Care Management (TCM)): $44-$209. CCM initiating visits are only required for new patients or those not seem within a year prior to commencing CCM. The CCM initiating visit (where applicable) is billable separate from the monthly CCM services.
    - HCPCS G0506*: $64, add-on to the CCM initiating visit for the billing practitioner's time and effort personally providing extensive comprehensive assessment and CCM care planning to patients outside of the usual effort described by the initiating visit code.
- CPT 99490: $43 for 20 minutes or more of clinical staff time spent on non-complex CCM per calendar month that requires establishment, implementation, revision, or monitoring of a care plan.
- CPT 99487*: $94 for 60 minutes of clinical staff time for complex CCM that requires establishment or substantial revision of a care plan, and moderate or high complexity medical decision making per calendar month.
    - CPT 99489*: $47, add-on to use with CPT 99487 for each additional 30 minutes of clinical staff time for complex CCM per calendar month.

**These codes are for "complex CCM," which requires moderately to highly complex medical decision-making by the billing practitioner and substantial establishment or revision of the patient's care plan. They cannot be combined with CPT code 99490, since a patient's care management is either complex or not complex.*

Please note that RHCs and FQHCs can receive payment for CCM when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. RHCs and FQHCs are not currently authorized to bill codes 99487, 99489, or G0506.

The usual cost-sharing rules apply to these services, so many patients are responsible for the usual Medicare Part B cost sharing (deductible and copayment/coinsurance) if they do not have supplemental ("wrap-around") insurance. Please note that the majority of dual eligible beneficiaries (patients with Medicare-Medicaid) are exempt from cost sharing. Medigap plans must provide wrap-around coverage of cost sharing for CCM, and most beneficiaries have Medigap or other supplemental insurance.

The following is a sample of actions that are required to bill for CCM:

- Obtain verbal or written agreement to receive CCM services from patients, including: awareness of applicable cost sharing, information that they can stop participating at any time, and acknowledge that only one practitioner (and/or hospital) can provide CCM in a calendar month.

- Create and update an electronic "Comprehensive Care Plan" for the patient that tracks their health issues, and share it with the patient or their caregiver, when appropriate. Periodically review the plan with the patient, and share it with their other providers as appropriate.

- Provide continuity of care for patients through a designated care team member with whom the patient can schedule appointments, and who is regularly in touch with the patient to help them manage their chronic conditions.

- Record certain data through certified Electronic Health Records (EHR), including: patient's demographics, medical problems, medications, and medication allergies.

- Provide patients with a way to reach your practice at any time to address urgent needs.

For more information about billing and to review the details above, visit the Connected Care Hub or the: CCM Services Fact Sheet, Chronic Care Management Services Changes for 2017, CCM Services FAQs and RHC & FQHC CCM FAQs).

For more information and tools to implement CCM, please visit: go.cms.gov/CCM.

Speaking with Staff about Chronic Care Management

The information below is designed to help health care decision-makers talk to staff about what chronic care management services are, what payment for patient support (typically provided on a non-face-to-face basis) is under the billing codes, and what are the benefits to the practice and to the patients if such a program is implemented. This information does not replace the official guidance on implementing and seeking payment for CCM.

1. What Is CCM?

Chronic Care Management or CCM is the provision of coordinated care services to patients with multiple chronic conditions.

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
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS

2. What Do We Need to Do to Furnish and Bill for CCM?

Please note that the following is not a complete list. A comprehensive list of actions associated with a CCM program can be found on the CCM Fact Sheet.

- Our office performs a number of the tasks that will be required for a CCM program already, however we must meet specific requirements to be eligible to bill for them. While it may take some time and effort to fully get up to speed, I expect these changes and services will help us to continually improve the care we provide.

- We will provide comprehensive care management focused on management of the patient's chronic conditions and preventive care. We will ensure the patient receives all recommended preventive services.

- We will complete a comprehensive assessment and develop and maintain a comprehensive care plan for all health issues, including medical and psychosocial issues, with special focus on the patient's chronic conditions.

    - We will engage and educate the patient by developing and sharing the care plan with him or her (and any applicable caregiver).

    - The care plan will be reviewed periodically and revised as needed.

    - We will provide care that is tailored to the individual (also known as "person-centered" care).

    - We will work with home- and community-based clinical service providers as needed by the patient.

- We will educate the patient and give them the tools they need to monitor and manage their chronic conditions and any medications. We will ensure their safety and provide continuous care by reconciling our medication list with medications prescribed by other providers (e.g., by a specialist or during a hospital stay).

- We will manage any care transitions (referrals or discharges from facilities) by sharing information timely within our practice and with other providers who are involved in the patient's care. We will follow up with our patients on a timely basis after facility stays or referrals.

- We will use some standardized electronic technology to assist us in sharing information on a timely basis with other providers. We will record "core" patient health information (demographics, problems, medications, and allergies) in the medical record using our certified Electronic Health Record.

- We will provide the patient with continuous care, such as:
    - 24-hour-a-day, 7 day-a-week access to a qualified health care professional who has access to necessary health information to address any urgent needs after hours.
    - We will offer enhanced methods of patient communication. Patients will be able to contact us at any time by methods other than just telephone (e.g., secure email portal).
- We will keep track of the time we spend providing these services by [insert recommended workflow based on practice needs].
- Though not required, please consider documenting the name of the billing physician overseeing the patient and who will be reviewing the care plan monthly. For example: [Insert billing physician's name] will be overseeing the care for [insert patient's name].

3. What Is Required of Patients?

Patients must give advance consent to ensure they are involved with their treatment plan and aware of any applicable cost sharing. They must understand that only one health care practitioner and/or one hospital can provide these services, so they can't receive it from each doctor they see and should not provide consent to receive these services from anyone else. They should also know that they can request to stop CCM at any time. Please note that beginning January 1, 2017, the informed consent can be given verbally, though you may choose to do it electronically or via a paper form.

4. How Will Our Practice Be Paid for Providing CCM Services?

- There are several Medicare billing codes to pay for chronic care management services (payment rates noted below are under the Medicare physician fee schedule):
    - CCM initiating visit (AWV, IPPE, TCM or other qualifying face-to-face E/M): $44-$209. CCM initiating visits are only required for new patients or those not seem within a year prior to commencing CCM. The CCM initiating visit (where applicable) is billable separate from the monthly CCM services.
    - HCPCS G0506*: $64, add-on to the CCM initiating visit for the billing practitioner's time and effort personally providing extensive comprehensive assessment and CCM care planning to patients outside of the usual effort described by the initiating visit code.
    - CPT 99490: $43 for 20 minutes or more of clinical staff time spent on non-complex CCM that requires establishment, implementation, revision, or monitoring of a care plan.

- CPT 99487*: $94 for 60 minutes of clinical staff time for complex CCM that requires establishment or substantial revision of a care plan, and moderate or high complexity medical decision-making.

- CPT 99489*: $47, add-on to use with CPT 99487 for each additional 30 minutes of clinical staff time for complex CCM.

**These codes are for "complex CCM," which requires moderately to highly complex medical decision-making by the billing practitioner and establishment or substantial revision of the patient's care plan. They cannot be combined with CPT code 99490, since a patient's care management is either complex or not complex.*

Please note that payments for RHC and FQHC services are not adjusted for length or complexity of the visit. RHCs and FQHCs are not authorized to bill 99487, 99489, and G0506 codes. RHCs and FQHCs can receive payment for CCM when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim.

Benefits

The Benefits of Implementing a CCM Program to Our Practice:

- Improved care for patients.
- Increased payment to practice for the coordinated CCM services we provide outside of face-to-face visits.

The Benefits of Providing a CCM Program to Our Patients:

- By implementing a CCM program and billing for it under Medicare, we can provide our eligible patients with help from a member of our team who is dedicated to overseeing their care. That team member can help them plan for better health and stay on track with treatments, medication, referrals, and appointments through regular check-ins and reminders.
    - For regular or "non-complex" care, patients will receive at least 20 minutes a month of time dedicated to care coordination services.
    - For complex chronic care management, patients will receive additional time and services.
- Encouraging patients to use CCM services may offer them the support they need between visits.

Explaining CCM to Patients

The information below is designed to help practice or health system decision-makers talk to patients and caregivers about what CCM services are, their benefits to the patients and their caregivers, and their role in the process of coordinating these services.

What Is CCM?

- If you have Medicare or Medicare and Medicaid, and have two or more chronic conditions, Medicare is offering chronic care management (CCM) services to help you manage your health and spend more time doing the things you love.
- If you have a chronic condition like Alzheimer's disease and related dementia, arthritis (osteoarthritis and rheumatoid), asthma, atrial fibrillation, Autism spectrum disorders, cancer, cardiovascular disease, chronic obstructive pulmonary disease, depression, diabetes, hypertension, and infectious diseases such as HIV/AIDS, chronic care management could be an important piece of the care your provider can offer.

What Are the Benefits of CCM?

- Regular chronic care management, or connected care, means you can better manage your care and spend more time focusing on your health. CCM can help you work towards your health and quality of life goals.
- Coordinated care means you'll get personal attention and help.
    - You can feel secure knowing you'll gain a comprehensive care plan, and at least 20 minutes a month of chronic care help when you need it, and regular check-ins.
- Someone I work with (or I) will help you keep track of your health care needs, so your loved ones can spend more quality time with you.
- You don't always have to come into the office to get help; you can also make a call.
- Reaching me or the designated person will help you make the best choices for your health, all from the comfort of your own home.
- Having a regular touch-base between doctor's visits will help keep you on track and stay focused on your health.

Informed Consent Notification

Patients must give consent to receive CCM services. Effective January 2017, a change was made to allow a verbal consent that is documented in the medical record, though written consent can still be obtained. It must be documented in the medical record that consent included informing patients they can stop at any time and that only one health care professional or hospital can provide CCM in a calendar month. Information about applicable cost sharing should be included as well. The language below is intended to be a guide for conversations seeking verbal consent. Please consider the key points below.

- Your dedicated care team will review your records and may contact you if needed. They may also connect with you about how they are working for you and your health.
    - Do you have any questions about these services?
    - Do you agree to receive these services?
    - How do you prefer to be contacted?
    - Tip: Refer to Agency for Healthcare Research and Quality (AHRQ) Use the Teach-Back Method
- This also means the care team will share information about your health with me to make sure we can talk about everything when we meet again.
    - Do you have any questions about these services?
    - Do you agree to receive these services?
    - How do you prefer to be contacted?
    - Tip: Refer to Agency for Healthcare Research and Quality (AHRQ) Use the Teach-Back Method
- (If applicable): We want to work with [specialist/service agency 1], [specialist/service agency 2], and [specialist/service agency 3] to coordinate care and services for you with the goal of improving your health. This is called chronic care management. You can ask us to stop doing this at any time.
    - Do you have any questions about these services?
    - Do you agree to receive these services?
    - How do you prefer to be contacted?
    - Tip: Refer to Agency for Healthcare Research and Quality (AHRQ) Use the Teach-Back Method

Contact information for CCM

For more information and updates on chronic care management, visit the CMS OMH Connected Care Hub, the Medicare Physician Fee Schedule Look-up Tool, and the CMS Care Management site. For general questions, please send an email to CCM@cms.hhs.gov.

For more information and tools to implement CCM, please visit: go.cms.gov/CCM.

CCM Tools & Resources

Learn more about what CCM is, why it is important, and how to get resources for a successful program.

Information about CCM

- **Chronic Care Management Fact Sheet**
  Read a primer on CCM services separately paid by CMS, requirements, and how to bill for CCM.

- **Chronic Care Management Services Changes for 2017**
  Read about changes to CCM services separately paid by CMS in 2017.

- **Chronic Care Management (CCM) Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions**
  Learn how to use the CCM payment codes at Federally Qualified Health Centers and Rural Health Clinics.

- **Frequently Asked Questions about Physician Billing for Chronic Care Management Services**
  Answers to common questions about CCM, what is separately paid by CMS, and requirements for billing.

- **Final Rule: Payment Policies under the Physician Fee Schedule CY 2017**
  Find out more about the fee schedule changes, including the addition of new separate payments in the Final Rule published in the *Federal Register*.

- **Care Management Resources**
  Additional CMS resources for CCM and other care management services.

Tools for Educating Patients, Caregivers, Advocates, and Community Members

- ***Connected Care* Postcard for Patients in English and Spanish**
  Share this postcard with patients, caregivers, advocates, and other community members to explain what CCM is, who it is for, why it is beneficial, and how patients can ask for it.

- ***Connected Care* Poster for Patients in English and Spanish**
  Download and hang this poster in your practice for patients and caregivers to see.

- ***Connected Care Animated Video for Patients*** (Coming Soon)
  Use this video to help you explain the benefits of CCM services to patients.

- **Sample Language for Newsletter Articles, Blog Posts and Emails for Patient, Advocate, and Community Constituents**
  Use this sample language to communicate with patients, community advocates, and leaders about the benefits of CCM and the *Connected Care* initiative.

- **Shareable Connected Care Posts and Graphics for Social Media**
  Share social media posts through your Facebook and Twitter accounts.

- **Agency for Healthcare Research and Quality (AHRQ) Use the Teach-Back Method**
  The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. It is a way to confirm that you have explained things in a manner your patients understand.

Tools for Health Care Professionals

- ***Connected Care* Postcard for Health Care Professionals**
  Designed for health care professionals, this postcard explains what CCM is and its benefits.

- **Sample Language for Newsletter Articles, Blog Posts, and Emails for Health Care Professionals**
  Use or adapt this language for communicating with your constituents.

- **Shareable Connected Care Posts and Graphics for Social Media**
  Share social media posts through your Facebook and Twitter accounts.

- ***Connected Care Health Care Professional Testimonial Video*** (Coming Soon)
  Share the experiences of health care professionals who have implemented CCM programs.

- ***Connected Care* Health Care Professionals Presentation** (Coming Soon)
  Share this presentation with health care professionals to help them learn about the *Connected Care* public education campaign and start a successful program in their practice.

- **Connected Care Web Badge**
  Post this graphic on your website to link directly to the CMS CCM page.

- **Certified Electronic Health Record Technology (CEHRT)**
  For information on EHRs and additional links for guidance on standards and incentive payments.

Additional Resources on CCM

- **Noridian Healthcare Solutions Chronic Care Management Page**
  Noridian is a private health insurer awarded a Medicare Administrative Contract (MAC)

- **PowerPoint: Chronic Care Management (CCM) Services Presented by Noridian Part B Medicare**
  This presentation offers an overview of CCM, eligibility, scope of services, billing, and additional resources.

- **TMF QIN CCM Network**
  TMF is one of CMS's Quality Innovation Network (QIN) Quality Improvement Organizations tasked with improving the quality of health care for all Medicare beneficiaries through data-driven initiatives that increase patient safety, make communities healthier, better coordinate post-hospital care, improve clinical quality, and spread best practices. The TMF QIN offers a CCM network including fact sheets, infographics, a business case, calculators, sample care plan, sample tracking log, checklist, and step-by-step guides.

- **Agency for HealthCare Research and Quality**
  AHRQ offers a Shared Care Plan to help health care professionals develop a patient-centered health record designed to facilitate communication among members of the care team, including the patient and providers.

Where to Go for Help

For more information and updates on chronic care management, visit the CMS OMH Connected Care Hub, the Medicare Physician Fee Schedule Look-up Tool, and the CMS Care Management site. For general questions, please send an email to CCM@cms.hhs.gov.

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