

SUMMARY OF CY 2017 CHRONIC CARE MANAGEMENT (CCM) AND
COMPLEX CHRONIC CARE MANAGEMENT (COMPLEX CCM)
SERVICE ELEMENTS AND BILLING REQUIREMENTS

I. CHRONIC CARE MANAGEMENT (CCM) SERVICES

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

Work RVUs: 0.61

Florida Allowance in non-facility setting: \$42.34

Florida Allowance in facility setting: \$32.73

Georgia Allowance in non-facility setting: \$40.73

Georgia Allowance in facility setting: \$31.70

II. COMPLEX CHRONIC CARE MANAGEMENT (COMPLEX CCM) SERVICES

99487 Complex chronic care management services, 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,
- establishment or substantial revision of a comprehensive care plan,
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month.

(Complex CCM services of less than 60 minutes duration, in a calendar month, are not reported separately).

+ 99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

(Report 99489 in conjunction with 99487)

Do not report 99489 for Complex CCM services of less than 30 minutes additional to the first 60 minutes of Complex CCM services during a calendar month)

Refer to CPT for a list of codes that Complex CCM services may not be reported with if performed during the same month.

If the physician or qualified nonphysician practitioner personally performs the clinical staff activities, his or her time may be counted toward the required clinical staff time to meet the elements of the code.

Time of care management with the emergency department is reportable using 99487, 99489, or 99490, but time while the patient is inpatient or admitted as observation is not.

Work RVUs 99487: 1.00

99487 Florida Allowance in non-facility setting: \$91.95

99487 Florida Allowance in facility setting: \$52.83

99487 Georgia Allowance in non-facility setting: \$88.03

99487 Georgia Allowance in facility setting: \$51.25

Work RVUs 99489: 0.50

99489 Florida Allowance in non-facility setting: \$46.15

99489 Florida Allowance in facility setting: \$26.59

99489 Georgia Allowance in non-facility setting: \$44.18

99489 Georgia Allowance in facility setting: \$25.78

III. SERVICE ELEMENTS AND BILLING REQUIREMENTS

CMS established a set of scope of service elements and payment rules in addition to or in lieu of those established in CPT guidance (in the CPT code descriptor and CPT prefatory language), that the physician or nonphysician practitioner must satisfy to fully furnish CCM or Complex CCM services for Medicare patients.

CMS wants to help ensure that the billing practitioner is not merely handing the patient off to a remote care manager under general supervision while no longer remaining involved in their care. CMS believes that the practitioner billing CCM or Complex CCM services should be actively reassessing the patient's chronic conditions, reviewing whether treatment goals are being met, updating the care plan, performing any medical decision-making that is not within the scope of practice of clinical staff, performing any necessary face-to-face care, and performing other related work.

Initiating Visit—Initiation during an AWW, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of CCM or Complex CCM services.

Structured Recording of Patient Information Using Certified EHR Technology— Structured recording of demographics, problems, medications and medication allergies using certified EHR technology. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.

24/7 Access & Continuity of Care:

- Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week.
- Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.

Comprehensive Care Management—Care management for chronic conditions including systematic assessment of the 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; and oversight of patient self-management of medications.

Comprehensive Care Plan:

- Creation, revision and/or monitoring (as per code descriptors) of an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues.
- Must at least electronically capture care plan information, and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the patient's care.
- A copy of the plan of care must be given to the patient and/or caregiver.

Management of Care Transitions:

- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.
- Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers.

Home- and Community-Based Care Coordination:

- Coordination with home and community based clinical service providers.
- Communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record.

Enhanced Communication Opportunities—Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient'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.

Patient Consent:

- Inform the patient of the availability of CCM or Complex CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM or Complex CCM services at any time (effective at the end of the calendar month).
- Beneficiaries must receive advance notice that Part B cost-sharing applies especially given the non-face-to-face nature of CCM or Complex CCM services.
- Document in the patient's medical record that the required information was explained and whether the patient accepted or declined the services.

Medical Decision-Making—Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner).