UNIVERSITY HEALTHCARE ALLIANCE

CODING CORNER

Chronic Care Management

Care Management Services are defined as the management and support services rendered by clinical staff under the supervision of a qualified clinician for patients living in a personal residence, domiciliary, rest home, or assisted living facility. Some components of case management services include, but are not limited to, creating, implementing, altering, or monitoring a care plan; coordinating with other professionals and/or agencies; and providing education to the patient or caregiver on the patient's medical condition, care plan, and prognosis.
The clinician is also responsible for the oversight of those services, as well as for the patient's other medical conditions, psychosocial needs, and normal activities of daily living (ADL). Care plans address all the patient's health issues and are based on a thorough evaluation involving assessment of the patient's physical, mental, cognitive, social, and functional health, as well as an environmental review, and are revised as necessary.

- Comprehensive care plan typically includes:
  - Problem list
  - Expected outcome and prognosis
  - Measurable treatment goals
  - Symptom management
  - Planned interventions and identification of the individuals responsible for each intervention
  - Medication management
  - Community/social services ordered
  - A description of how services of agencies and specialists outside the practice will be directed/coordinated and
  - Schedule for periodic review and
  - When applicable, revision of care plan

- Complex Chronic Care Management patients typically have complex diseases and morbidities and, as a result, demonstrates one or more of the following:
  - Need for the coordination of several specialties and services;
  - Inability to perform ADL and/or cognitive impairment resulting in poor adherence to the treatment plan with or without substantial assistance from a caregiver;
  - Psychiatric and other medical comorbidities (e.g. Dementia, COPD, substance abuse, diabetes) that complicate their care; and/or
  - Social support requirements or difficulty with access to care

Chronic Conditions may include, but are not limited to:

Alzheimer's disease and related dementia	Chronic obstructive pulmonary disease
Arthritis (osteoarthritis and rheumatoid)	Depression
Asthma	Diabetes
Atrial fibrillation	Heart failure
Autism spectrum disorders	Hypertension
Cancer	Ischemic heart disease
Osteoporosis	Infectious diseases such as HIV/AIDS

Code	Chronic Care Management Code Descriptions
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. • Non face-to-face services • Two or more chronic conditions expected to last at least 12 months; • Chronic conditions place patient at significant risk of death, acute exacerbation / decompensation, or functional decline; • Comprehensive care plan established, implemented, revised or monitored • At least 20 minutes of directed clinical staff time per month
99491 (New code 2019)	Chronic care management services, **provided personally by a physician or other qualified health care professional,** at least 30 minutes of physician or other qualified health care professional time, 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. • At least 30 minutes of directed clinical staff time per calendar month • Multiple (two or more) chronic conditions expected to last at least 12 months; • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; • Comprehensive care plan established, implemented, revised, or monitored

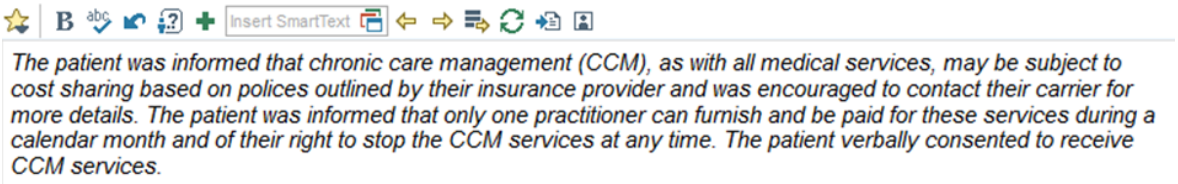
99487	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, 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 • Non face-to-face services • Two or more chronic conditions expected to last at least 12 months; • Chronic conditions place patient at significant risk of death, acute exacerbation / decompensation, or functional decline; • Establishment or substantial revision of comprehensive care plan; • Moderate or high complexity medical decision making; • At least 60 minutes of directed clinical staff time per month
99489+	Complex Chronic Care Management – Additional time • Each additional 30 minute of directed staff time beyond 60 minutes

- **General Billing Requirements:**
  - CMS requires a comprehensive visit with the patient prior to billing Chronic Care Management services and to initiate the CCM service as part of one of the services listed below:
    - Evaluation and Management visit (E&M);
    - Annual Wellness Visit (AWV);
    - Initial Preventive Physical Exam (IPPE)
  - Only one practitioner can bill CCM per month
  - Transitional Care Management (TCM) and other overlapping care management services cannot be billed during the same service period

- **Care Management Requirements:**
  - Care management services such as:
    - 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;
    - Oversight of patient self-management of medications
  - Manage care transactions between and among healthcare providers and settings, including referrals to other providers, including:
    - Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities
  - Coordinate care with home and community based clinical service providers

- **Patient Agreement Requirements:**
  - A practitioner must inform eligible patients of the availability of, and obtain consent for, the CCM service before furnishing or billing the service. Some of the patient agreement provisions require the use of Electronic Health Record (EHR) technology.
  - Patient consent requirements include:
    - Inform patient of the availability of the CCM service and **obtain agreement** to have the services provided, including authorization for the electronic communication of the medical information with other treating practitioners and providers.
    - Explain and offer the CCM service to the patient. In the patient's medical record, document this discussion and note the patient's decision to accept or decline the service.
    - The right to stop CCM services at any time (effective at the end of the calendar month).
    - Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.
  - Informed patient consent need only be obtained once prior to furnishing CCM, or if the patient chooses to change the practitioner who will furnish and bill CCM.

- **Epic Smart Phrase for Consent:**
  - Smart phrase available - .ccmconsent



Sources:
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