

# Chronic Care Management (CCM): *An Overview for Pharmacists*

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*Developed Through a Collaboration Among:*



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## Overview of CCM and Complex CCM

Beginning January 1, 2015, the Medicare Physician Fee Schedule (PFS) reimburses qualified providers for Chronic Care Management (CCM) services for Medicare beneficiaries with two or more chronic health conditions.<sup>1,2</sup> CCM services include five core activities:

- Recording structured data in the patient’s health record;
- Maintaining a comprehensive care plan for each patient;
- Providing 24/7 access to care;
- Comprehensive care management; and
- Transitional care management.<sup>1</sup>

The Centers for Medicare & Medicaid Services (CMS) estimates that approximately two-thirds of Medicare patients have two or more chronic conditions,<sup>3</sup> and CCM aims to better coordinate the care these patients receive. Through CCM and complex CCM, CMS pays for non-face-to-face care coordination services furnished to Medicare beneficiaries who reside in the community setting that meet the following requirements:<sup>1,4</sup>

- 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; and
- Comprehensive care plan established, implemented, revised, or monitored.<sup>1</sup>

The distinction between CCM and complex CCM is based on the amount of time spent delivering services to the patient in the given month. CCM and complex CCM are defined by the American Medical Association’s (AMA) Current Procedural Terminology (CPT) codes. The chart below compares CCM and complex CCM:<sup>1</sup>

	CCM	Complex CCM
Duration of Services	At least 20 minutes	More than 60 minutes
CPT Code(s)	99490	99487
Services Provided	5 core CCM services	5 core CCM services that may additionally include: <ul style="list-style-type: none"> <li>• Moderate or high complexity clinical decision making</li> <li>• Establishment or substantial revision of care plan</li> </ul>
Average payment per unit of service <sup>5</sup>	\$43	\$94
Eligible for 30-minute add-on	No	Yes

The final line in the above chart highlights the opportunity for practitioners to bill CPT code 99489 for each additional 30 minutes of complex CCM services delivered in a month. It is important to note that 99489 cannot be used as an add-on to CCM (CPT 99490) or for less than 30-minute increments.<sup>1</sup> The average payment for each 30-minute unit of add-on time is \$47. Exact payment information can be found at [CMS's Physician Fee Schedule Look-Up Tool](#) and is dependent upon geography.<sup>5</sup>

## CCM: An Overview for Pharmacists

While pharmacists are not eligible to bill CMS directly for these services, CCM serves as an ideal opportunity for pharmacists to form collaborative and contractual partnerships with qualified healthcare professionals (QHPs) to provide CCM services that are within their scope of practice. CMS will only pay one QHP for CCM services per month, so coordination among the members of the patient's care team is very important.<sup>1</sup> Likewise, different members of the patient's health care team may take responsibility for delivering the various components of CCM. Terms for how the monthly bundled payment will be allocated among members of the care team will also need to be established.

This guide provides a summary of many resources related to CCM requirements and services. Nothing in this guide should be construed as legal advice, especially related to billing and payment for services. It is recommended that pharmacists who are interested in providing CCM services review the following key primary resources for an in-depth understanding of CCM requirements:

1. [CMS 2017 Guidance on Chronic Care Management Services](#)
2. [CMS 2017 FAQs on CCM](#)
3. [Medicare Learning Network National Provider Call on CCM 2017 - Understanding and Promoting the Value of Chronic Care Management Services Call](#)
4. [Electronic Code of Federal Regulations on Incident to Billing](#)

Additionally, pharmacists and their collaborating partners are encouraged to access the references included herein and consult with their own legal counsel and regional Medicare Administrative Contractors for guidance on payment and implementation requirements.

## The Care Team

Members of the CCM care team may include the physician or other QHP, clinical staff, and non-clinical staff. Each member of the team will be responsible for specific components of the services that must be provided during CCM, so it is important to understand the roles and responsibilities of these different team members.

### Qualified Healthcare Professionals

QHPs are the only team members eligible to bill for CCM services. QHPs include:

- Physicians; or
  - *Note: CCM is not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, therefore these practitioners cannot furnish or bill the service.*<sup>1</sup>
- Non-physician practitioners (NPPs):
  - Nurse practitioners;
  - Physician assistants;
  - Clinical nurse specialists; and
  - Certified nurse midwives.<sup>1</sup>

Most often, a primary care physician will be the QHP that pharmacists should partner with, but NPPs and some specialty physicians can also bill for CCM.<sup>1</sup> QHPs can be employed by or working in hospitals but must care for patients who reside in the community setting to bill for CCM services.<sup>4</sup>

### Clinical Staff

Clinical staff includes any practitioner whose services can be billed incident to a physician or NPP, as defined within the CPT.<sup>1</sup> The CPT defines clinical staff as “a person who works under the 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.”<sup>6</sup> This definition can encompass advanced practice registered nurses (APRNs), registered nurses (RNs), licensed specialist clinical social workers (LSCSWs), licensed practical nurses (LPNs), pharmacists, and certified medical assistants (CMAs).<sup>7</sup> The state scope of practice, licensure, and Medicaid statutory benefit for the clinical staff must include the CCM services that are being provided.<sup>1</sup> Collaborative practice agreements may expand the scope of practice to include or facilitate CCM service delivery.

### Non-Clinical Staff

Non-clinical staff are any personnel who are not clinical staff or QHPs. Their time cannot be counted toward the CCM time requirements. However, they can facilitate service delivery to maximize the pharmacist’s time with the patient.<sup>1</sup> Potential non-clinical staff team members include pharmacy support staff and physician office managers. For example, pharmacy support staff can help schedule appointments with patients, communicate results of CCM services with other members of the care team, and facilitate information sharing between care team members.

## Team-based Care as the Basis of CCM

### Location of the Care Team

Patients eligible for CCM are those residing in the community setting, and therefore, the most common location of QHPs and their employers will be in the community as well.<sup>1,4</sup> While incident to the physician's services regulations state that clinical staff can only provide services under direct supervision, CMS made an exception to this rule for CCM, stating that CCM can be provided under general supervision.<sup>1</sup> General supervision relaxes the requirement for QHPs and the clinical staff to be co-located (e.g. in the same office practice) when CCM services are delivered, however, all Medicare incident to and other rules and regulations must be met.<sup>1</sup> For example, under general supervision, a physician could collaborate with a community pharmacist to deliver CCM services as long as all incident to requirements are met. The QHP supervising the clinical staff need not be the same QHP who is treating the patient more broadly.<sup>9</sup> However, only the supervising QHP may bill Medicare for incident to services.<sup>9</sup>

### Types of Supervision<sup>8</sup>

**Direct** – The physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

**General** – The procedure is furnished under the physician's overall direction and control, but the physician's presence is not required.

### Contractual Relationships between Team Members

As part of incident to requirements, clinical staff must be employed, contracted, or leased by the QHP (or the QHP's practice) with CCM services provided under general supervision by the QHP.<sup>7</sup> This means that pharmacists who want to provide CCM services in collaboration with a QHP must either be directly employed, independently contracted, or leased by that QHP or their practice to meet the requirements of incident to billing.<sup>7</sup> Definitions for each of these types of partnerships between the pharmacist and physician are below:

- *Directly employed* means that an individual is hired as an employee of the QHP or QHP's practice.
- *Independent contractor* means an individual (or an entity that has hired such an individual) who performs part-time or full-time work for which the individual (or the entity that has hired such an individual) receives an IRS-1099 form.<sup>9</sup>
- *Leased employment* means an employment relationship that is recognized by applicable state law and that is established by two employers by a contract such that one employer hires the services of an employee of the other employer.<sup>9</sup>

Pharmacists can explore these forms of business partnerships with local QHPs who are interested in working with the pharmacist to provide CCM services. During partnership formation or as partnerships grow over time, pharmacists and their collaborating QHP may determine that the care of the patient can be enhanced by granting more authority to the pharmacist to make medication adjustments based on physician delegation through a collaborative practice agreement (CPA). While CCM services are within the state scope of practice for most pharmacists in America, a CPA can facilitate refill authorizations, dosage adjustments, ordering of laboratory tests, and other activities that typically require authorization from a QHP *before* action can be taken. It will be up to each pharmacist and QHP to determine how a formalized CPA can fit into the collaborative care they deliver to patients.

## Service Provided During CCM

The key components of CCM include structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice.<sup>1</sup> The QHP or their collaborating clinical staff must provide or complete the following services during CCM:



### Structured Data Recording:<sup>1</sup>

- Record demographics, problems, medications, and medication allergies in the certified EHR technology. Use this information to inform the care plan, care coordination, and ongoing clinical care;



### Comprehensive Care Plan:<sup>1</sup>

- Create, revise, and/or maintain a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues).
- Provide the patient/caregiver with a copy of the care plan.
- Ensure the care plan is available electronically (including fax) and timely to anyone within or outside the QHP's practice involved in the patient's care.



### 24/7 Access to Care:<sup>1</sup>

- Ensure 24-hour-a-day, seven-day-a-week (24/7) access to urgent care management services, providing the patient/caregiver with a means to make timely contact with QHPs or clinical staff in the practice. This 24/7 access can be through clinical staff that is not co-located with the QHP, meaning pharmacists in 24-hour pharmacies can serve as a resource to help QHPs meet this CCM requirement.
- Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to schedule successive routine appointments.
- Provide patient/caregiver with enhanced opportunities for communicating with QHP or clinical staff via telephone, secure messaging, internet, and asynchronous, non-face-to-face methods.

### Components of a Comprehensive Care Plan<sup>1</sup>

- 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
- A schedule for periodic review and, when applicable, revision of the care plan.



### Comprehensive Care Management:<sup>1</sup>

- Provide 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; and
  - Oversight of patient self-management of medications.
- Coordinate care with home and community-based clinical service providers. Document in the medical record any communication to home/community-based providers about the patient’s psychosocial needs and functional deficits.



### Transitional Care Management:<sup>1</sup>

- Manage care transitions between and among health care providers and settings, including:
  - Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities; and
- Refer patients to other providers as needed.<sup>1</sup>Timely creation and exchange/transmission of continuity of care documents with other practitioners.

CCM and complex CCM include activities that are not typically or ordinarily offered face-to-face, such as telephone communication, review of medical records and test results, and consultation and exchange of health information with other providers.<sup>4</sup> If these activities are occasionally provided by clinical staff face-to-face with the patient but would ordinarily be furnished non-face-to-face, the time may be counted towards the minimum time required to bill for CCM services.<sup>4</sup> The time spent does not need to be continuous or provided by a single individual staff member.<sup>3</sup>

### Services Provided by Various Care Team Members

	Qualified Healthcare Professional (Physician)	Clinical Staff (Pharmacist)	Non-clinical Staff (Pharmacy Staff, Office Manager)
Consent Patient	X		
Collect Structured Data	X	X	X
Develop Comprehensive Care Plan	X		
Maintain/Inform Updates for Care Plan	X	X	
Manage Care	X	X	
Provide 24/7 Access to Care	X	X	
Document CCM Services	X	X	
Bill for CCM Services	X		
Provide Support Services to Facilitate CCM		X	X



## Patient Enrollment in CCM

### Inclusion Criteria

QHPs and their staff should identify patients who are Medicare beneficiaries who have two or more chronic conditions that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline and that are expected to last at least 12 months or until the death of the patient. From this group, QHPs can begin to develop and document comprehensive care plans and initiate CCM services.

### Initiating CCM

CCM services can be initiated via a phone call or in-person for patients who have had a visit with their QHP within the last year. For patients who have not been seen by the QHP in the past year, the QHP must initiate CCM by discussing the service during an annual wellness visit (AWV), comprehensive evaluation and management (E/M) visit (levels 2 through 5 using CPT codes 99212 through 99215), initial preventive physical exam (IPPE), or face-to-face comprehensive transitional care management (TCM) visit.<sup>1,4</sup> The QHP must bill for this visit prior to billing for CCM services.<sup>1</sup> CPT codes that do not involve a face-to-face visit by the billing practitioner or are not separately payable by Medicare (such as CPT 99211, anticoagulant management, online services, telephone and other E/M services) do not meet the requirement for the initiating visit that must occur before CCM services are furnished. If the practitioner provides a “comprehensive” E/M, AWV, or IPPE and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.<sup>4</sup>

When QHPs perform extensive assessment and CCM care planning that is over and above the usual effort described by the initiating visit code, the QHP may also bill HCPCS code G0506. This code was specially created for when QHPs perform a comprehensive assessment of and care planning for patients requiring chronic care management services. It is an add-on code and should be listed separately in addition to the primary service code. G0506 is reportable once per CCM billing practitioner, in conjunction with CCM initiation.<sup>1</sup>

### Obtaining Patient Consent

Consent can be given verbally or in writing by the patient.<sup>1</sup> Consent must be obtained from the patient before providing or billing for CCM, but it does not have to be obtained during the AWV, E/M, IPPE, or TCM visit.<sup>1,4</sup> As long as the provider discusses CCM with the patient during one of these visits, patient or caregiver consent can be obtained at a later date. The discussion between the QHP and the patient and/or caregiver must include the following information:

- What the CCM service is;
- How to access the elements of the service;
- How the patient’s information will be shared among practitioners and providers;
- How cost-sharing (co-insurance and deductibles) applies to these services;
  - As with other Medicare services, the patient is obligated to make a 20% copayment for CCM services (~\$8/ month) and complex CCM services (~\$20/month or higher if the monthly service exceeds 90 minutes).<sup>3</sup> However, some of this payment may be fully or partially addressed by coinsurance (e.g., Medicaid for dual eligible beneficiaries or Medigap) and will not be required for the majority of dual eligibles.<sup>3,10</sup> CCM was

designed to provide Medicare QHPs the funding to invest in additional resources, including personnel and technology, needed to address the complex needs of patients with multiple chronic conditions.<sup>12</sup> Explaining the value the program brings to each patient's care may encourage them to participate.<sup>12</sup>

- When speaking with patients, a potential talking point related to cost-sharing is that although CCM will cost them an additional fee per month (approximately \$8), 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.<sup>1</sup>
- That only one practitioner can furnish and be paid for the service during a calendar month;<sup>1</sup> and
- How to stop the service.<sup>1</sup>

For consent to be in compliance with CCM requirements, the QHP must document in the patient's EHR that the QHP discussed CCM services (i.e., cost sharing, one billing practitioner requirement, and right to opt out) and the patient agreed to receive CCM service.<sup>1</sup>

QHPs need only to obtain consent once for each patient (i.e., consent does not need to be obtained each year).<sup>1,4</sup> If the patient would like CCM furnished and billed by a new QHP, consent must be obtained by the new QHP.<sup>1</sup> Practitioners who choose to collect written consent may choose to model their form after a [template CCM patient consent agreement](#).<sup>11</sup>

## Requirements for Provider Who is Billing for CCM

### Medicare Incident to Rules and Regulations

Incident to physician services are health care services provided to a patient by auxiliary personnel under the supervision of the billing provider. To qualify for reimbursement by CMS, the incident to services must be an integral part of the patient's treatment course; commonly rendered without charge (i.e., normally included in the billing provider's bill), commonly furnished in the billing provider's office; and an expense to the billing provider. All QHPs are eligible to bill incident to for pharmacists' services.<sup>9</sup>

CMS uses the term "auxiliary personnel" instead of clinical staff. Auxiliary personnel are defined as any individual who is acting under the direct or general supervision of a QHP; is an employee, leased employee, or independent contractor of the QHP or of the legal entity that employs or contracts with the QHP; has not been excluded from Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his Medicare enrollment revoked; and meets any applicable requirements to provide incident to services, including licensure, imposed by the state in which the services are being furnished.<sup>9</sup>

#### Clinical Staff vs. Auxiliary Personnel

**Clinical staff** is the terminology used by CPT for the licensed practitioner who can assist in the delivery of services, in this case CCM, under general supervision by a QHP.

**Auxiliary personnel** is the terminology used by CMS for those individuals working under physician or other QHP supervision in an incident to arrangement and whose services are billed by the QHP.

Pharmacists should check their state scope of practice authority for delivering various aspects of CCM both as clinical staff and auxiliary personnel.

## EHR Requirements

CMS requires the use of certified EHR technology to satisfy some of the CCM scope of service elements. In furnishing these aspects of the CCM service, CMS requires QHPs use of a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31 of the calendar year preceding each Medicare PFS payment year (referred to as “CCM certified technology”).<sup>1</sup> For example, CCM payment in calendar year (CY) 2015 requires practitioners to use EHR technology certified to either the 2011 or 2014 edition(s) of certification criteria.<sup>1</sup> QHPs using an acceptable EHR technology that loses its certification mid-year may still use that technology to fulfill the certified EHR criteria for billing CCM CPT codes during the applicable payment year.<sup>4</sup> For more information, visit the [CMS EHR Incentive Programs website](#).<sup>1</sup> It is important to note that CMS does not necessarily require clinical staff have their own certified EHR in order to provide CCM services.

### Quick Reference: Information that must be documented in QHP’s EHR

- Documentation of the patient’s consent for CCM services
- Structured data (demographics, problems, medications, medication allergies)
- Information contained in the care plan
- Documentation that the care plan was provided to patient

At this time, CMS does not require the use of certified EHR technology for some of the services involving the care plan and clinical summaries, allowing for broader electronic capabilities. The EHR requirements for various CCM services are described in the Table 1.<sup>1</sup>

## Clinical Staff Documentation and Communication

Documenting CCM services provided, tracking cumulative time per patient per month, and generating defensible audit reports are some of the logistical challenges associated with the CCM program. QHPs and clinical staff are encouraged to investigate how EHRs, documentation and documentation retention policies and procedures, practice management or scheduling systems, manual workflow modifications, or third party "time tracking" applications can empower documentation accountability that could be required during future audits.<sup>12</sup> All clinical staff engaged in CCM should consider retaining the information shared by QHPs related to patient care. Any questions about audit-related requirements should be directed toward Medicare Administrative Contractors (MACs).<sup>3</sup>

In an ideal environment, clinical staff, including pharmacists would have the ability to access and exchange clinical information with the QHP’s EHR. However, understanding this is not always possible, an acceptable alternative is for the QHP to maintain the electronic care plan and share it with the clinical staff electronically (e.g., secure messaging). The clinical staff would report information about CCM services and patient care to the QHP for official documentation in the EHR. Regardless of the documentation procedures, the QHP and clinical staff should ensure there are processes to accurately document which CCM services were provided and the time spent providing CCM as part of the 20-minute monthly minimum or complex CCM as part of the 60-minute monthly minimum.

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*Table 1: EHR Requirements for CCM Services*

CCM Scope of Service Element/Billing Requirement <sup>1</sup>	Certified EHR or Other Electronic Technology Requirement <sup>1</sup>
<p>Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications, and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.</p>	<p>Structured recording of demographics, problems, medications, medication allergies.</p>
<p>Creation of a 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. Share the care plan as appropriate with other practitioners and providers.</p>	<p>Must at least electronically capture care plan information; care plan should be available to all practitioners in a timely manner (meaning promptly at an opportune, suitable, favorable, useful time); and care plan information should be shared (electronically, by fax or other means) as appropriate with other practitioners and providers.</p>
<p>Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.</p>	<p>Document provision of the care plan as required to the beneficiary in the EHR using CCM certified technology.</p>
<p>Coordination with home and community-based clinical service providers.</p>	<p>Communication to and from home and community-based providers regarding the patient's psychosocial needs and functional deficits should be documented in the patient's medical record using CCM certified technology, but it is not required to exchange information electronically.</p>
<p>Beneficiary consent—Inform the beneficiary of the availability of CCM services and obtain his or her agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers. Document in the beneficiary's medical record that all of the CCM services were explained and offered, and note the beneficiary's decision to accept or decline these services.</p>	<p>Document consent in the EHR using CCM certified technology.</p>

# CCM Business Model for Pharmacists and Collaborating Prescribers

## Billing Practices

Billing for CCM is performed by the QHP for the eligible Medicare beneficiaries who receive the full scope of services each month. In 2017 CMS guidance documents, a specific amount of time that billing practitioners work on services is listed associated with CCM and complex CCM. It is important to note that these times are not required to bill for services but instead were assumed by the AMA in the development and valuation of CCM CPT codes.<sup>4</sup> There are many nuances to consider when billing for CCM services, and a number of those are summarized below. For full guidance, QHPs should contact their regional Medicare Administrative Contractor (MAC).

## Timing of Billing Each Month

The service period for CCM is one calendar month, and CMS expects the billing practitioner to continue furnishing services during a given month as applicable after meeting the 20-minute time threshold to bill the service.<sup>10</sup> Practitioners may bill the PFS for CCM CPT codes at the conclusion of the service period or after completion of at least 20 minutes of qualifying services for the service period.<sup>4</sup> When the 20-minute threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month.<sup>4</sup> However, since the introduction of complex CCM codes, it may be prudent to wait until the end of the month to assure all time dedicated to CCM services is counted when selecting the appropriate billing code for that month (20, 60, or 90+ minutes).

## Point of Service and Payment Implications

QHPs must report the point of service (POS) for the billing location (i.e., where the billing practitioner would furnish face-to-face care to the patient), which may include the QHP's office, a skilled nursing facility, assisted living facility, or another location.<sup>4</sup> CMS pays for CCM separately under the Medicare Physician Fee Schedule (PFS) and hospital Outpatient Prospective Payment System (OPPS) and the rate at which CCM is paid is dependent upon the QHP's geographic area and the billing provider's practice setting (facility vs. non-facility).<sup>1,4</sup>

Accordingly, practitioners who provide CCM in the hospital outpatient setting, including provider-based locations, must report the appropriate place of service for the hospital outpatient setting. Payment for CCM furnished and billed by a practitioner in a facility setting will trigger PFS payment at the facility rate.<sup>4</sup> Billing practitioners in hospital-owned outpatient practices that are not provider-based departments are working in a non-facility setting, and may, therefore, bill CCM CPT codes and be paid under the PFS at the non-facility rate.

Time spent on CCM services should not be counted toward PFS billing when the patient is an inpatient in a hospital, resides in a facility such as a skilled nursing facility, or takes place on the same day that the patient is seen for an evaluation and management (E/M) visit by the attending provider.<sup>3</sup> However, QHPs may be employed by hospitals, including hospital outpatient departments (HOPD) either in provider-based locations or non-provider-based departments.<sup>1,4</sup> Additionally, care teams located in federally qualified health centers and rural health clinics can only bill for CCM (CPT 99490), not complex CCM.<sup>10,13</sup>

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For specific information about payment rates in specific geographies, visit [CMS's Physician Fee Schedule Look-Up Tool](#).<sup>1</sup> The Medicare Access and CHIP Reauthorization Act (MACRA) does not change any of the requirements of or services under CCM.<sup>4</sup>

### Eligible Patients

Patients are required to be Medicare beneficiaries with two chronic conditions. However, CMS has indicated that their software would not reject claims based on ICD diagnosis codes used to support claims for CCM services. Rather, it is up to QHP to determine whether the patient has at least two chronic health conditions.<sup>3</sup> While not defining factors, complex CCM patients often have higher needs for coordination of specialties and services, an inability to adhere to treatment plans, psychiatric or other comorbidities, and/or a need for social support to access care.<sup>6</sup> Although rare, an eligibility rule that should be noted is that CCM can be billed even if the patient dies during the service period as long as the time requirements of qualifying services were provided during that month before the patient's death.<sup>4</sup>

### Billing Restrictions

#### Concomitant Service Restrictions

CCM CPT codes can only be billed by one QHP per month. In addition, the following billing codes cannot be billed during the same service period as CCM CPT codes:<sup>1</sup>

- Transitional Care Management: CPT Codes 99495–99496,<sup>1</sup> unless TCM ends earlier in the service period and 20 minutes of qualifying CCM services are provided after TCM concludes (this will be an exceptional circumstance);<sup>4</sup> CCM should not be billed during the 30-day transitional care period for TCM.<sup>1</sup>
- Home Health Care Supervision: Healthcare Common Procedure Coding System (HCPCS) code G0181;<sup>1,4</sup>
- Hospice Care Supervision: HCPCS code G0182;<sup>1,4</sup>
- Certain End-Stage Renal Disease services: CPT codes 90951–90970; and<sup>1</sup>
- Patient Monitoring Services: CPT 99090 and 99091 (often bundled with other services). While these services are a component of CCM services, all CCM requirements must be met to bill CCM CPT codes, and 99090 or 99091 cannot be billed during the same service period as CCM CPT codes.<sup>4</sup>

Additional restrictions related to concurrent billing may apply and QHPs should consult CPT instructions for the most updated guidance. Practitioners engaged in CMS-sponsored model or demonstration programs, including Multi-payer Advanced Primary Care Practice (MAPCP) or the Comprehensive Primary Care (CPC) Initiatives, may also encounter additional restrictions on CCM billing and should contact a CMS staff member responsible for the model or demonstration program before billing for CCM.<sup>1</sup>

### Overlapping Services

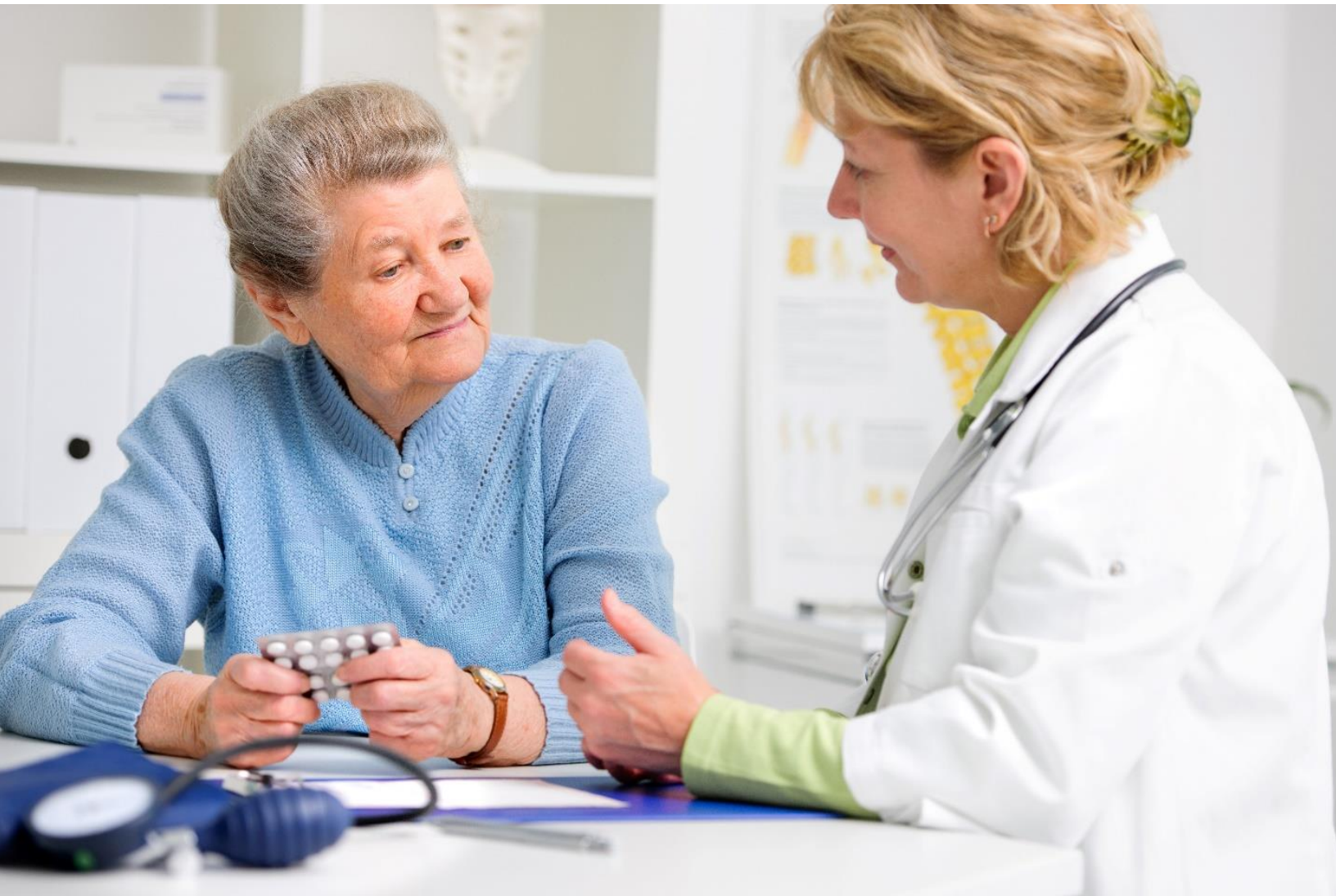
Additionally, it is important to note that longstanding Medicare guidance for only billing one E/M service per day should be observed. Time cannot be counted twice, whether it is face-to-face or non-face-to-face time. Face-to-face time that would otherwise be considered part of the E/M service that was furnished cannot be counted towards CCM. However, time spent by clinical staff providing non-face-to-face services within the scope of the CCM service can be counted towards CCM. If both an E/M and the CCM code are billed on the same day, the value modifier of -25 must be reported on the CCM claim.<sup>4</sup> Value modifiers adjust Medicare payments on a per claim basis. Complex CCM should never be billed in the same month as prolonged E/M services.<sup>1</sup> Ultimately, time and effort counted toward CCM cannot also be counted toward another billing code.<sup>10</sup>

### Facility Care Management Restrictions

For patients who reside in facilities that receive Medicare payments for care management of that patient (e.g., skilled nursing facility or hospital inpatient billing under Medicare Part A), CCM CPT codes cannot be billed because care management is included in the facility fee. However, QHPs can bill for CCM services during the month that patients were in a facility receiving payment for care management as long as at least 20 minutes of CCM services were provided while the patient was residing in the community.<sup>4</sup>

## Conclusion

CCM and complex CCM represent a significant opportunity for pharmacists to serve as collaborators and clinical staff to QHPs in the ongoing management of their chronic disease patient populations. Pharmacists and QHPs must enter a business relationship for the QHP to bill incident to for CCM services, but pharmacists need not be co-located in the QHP's practice in order to deliver the core CCM services. Pharmacists would be well-suited to have access to the QHP's EHR to facilitate care delivery, but this is not required for implementation. During comprehensive and transitional care management components of CCM, pharmacists also have the potential to influence key quality metrics of interest to QHPs.





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