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Medicare's CCM Code 99490: Now we know, but what will we do?

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With the publication of the CY 2015 Physician Fee Schedule (PFS) Final Rule in November 2014, the Centers for Medicare and Medicaid Services (CMS) resolved much of the uncertainty surrounding the new chronic care management (CCM) service code 99490. The content stipulations remain daunting with workflow and patient-doctor relationship implications. Any Medicare patient with two or more chronic conditions would qualify for the CCM code—roughly 70% of all Medicare patients. Individual practices must now determine whether the payment is sufficient to cover the resources required to support the service expectations.

The CCM code is designed to pay for care management not adequately covered by the evaluation and management (E&M) codes (Table 1). The post-visit time expectation for the standard comprehensive outpatient E&M code 99214 is 10 minutes—an understatement of the usual communication and results management following a complex face-to-face interaction. In addition, there is no Medicare payment for telephonic and electronic care or night and weekend on-call coverage.

How was CCM changed with 2015 Final Rule?

With the Final Rule, CMS relaxed its position on several of the originally proposed CCM requirements:

1. CMS will not expect a higher level of electronic health record (EHR) support than what a practice has chosen to meet in previous year, either 2011 or 2014. In other words, there is no requirement for Meaningful Use Stage 2 (MU2) certification.
2. CCM provides a waiver of Medicare's traditional "incident to" requirements. Services can be delivered by staff working with a practice but do not have to be delivered by employees of the practice per se. This will permit the development of standalone vendors that provide CCM services for a charge—likely a percentage of collections—or the centralization of CCM within enterprises. CMS has removed any concerns that CCM services can be delivered by facility-based practices.
3. Once the patient contract is signed, it will not have an expiration date. This could confuse Medicare beneficiaries who want to move away from a primary care practice but fail to cancel their contact. Presumably a CCM contract will automatically renew if a provider chooses to bill for post-discharge transitional care management (TCM) services after the 30 days of care, but CMS has not clearly stated this.
4. There are no added practice standards. Patient-centered medical home certification is not a precondition to CCM billing.
5. Interactive EHR data access must be available within a practice but not between practices. For example, if two cross-covering practices have different EHRs, both are allowed to bill for CCM coverage even though the systems are not interoperable. An electronic (not a fax) patient summary must be accessible to the cross-covering practice.
6. The CCM codes cannot be used by practices participating in the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration and the Comprehensive Primary Care (CPC) Initiative, with the exception of patients who are not otherwise attributed to a participating practice. All others, including those in accountable care organizations, can.

CMS has been deliberately vague about several components of the CCM service code. This was done in response to criticisms received by the agency that the annual wellness visits and TCM codes had excessively detailed requirements.

1. The plan of care (POC) required must be developed by the doctor and the patient. CMS will provide some guidance, but there will be no nationwide convention.
2. The wording of the contract will be up to individual practices.
3. The documentation expectations are not clarified beyond the need for "an electronic footprint." CMS has not stated that a practice must submit time tallies, but the expectation is that there will be both documentation of care management and a total time attestation of 20 or more minutes of care management in the EHR each month. Documentation time itself will count. The time attestation could be as simple as a statement such as the following, "At least 20 minutes of combined staff time was allocated to the chronic care management of this patient this month," along with

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notations in the record of care management dated that month.
4. Billing can be submitted with just one diagnosis, but it would be most prudent to have at least two.

Will CCM payment improve physician pay?

Payment for this code will be $32.94 for facility (e.g. academic medical centers) and $44.34 for non-facility practices per patient per calendar month (not per 30 days). Patients will be liable for 20% of this per usual Medicare rules. This works out to $395.28 per patient per year for four hours of care spread evenly over 12 months at a facility (e.g. hospital based) practice and $532.08 for a non-facility (e.g. community or private office) practice. For the hospital-based practice, with an overhead (conservatively) at 50%, this calculates to an hourly payment rate of roughly $50. Since the requirement is for a minimum of 20 minutes per month, those with higher care management needs will consume resources that are not compensated.

Will this be sufficient? A practice with a high level of efficiency, a large Medicare enrollment, and the ability to distribute CCM work to existing staff could employ these codes with the appropriate workflow redesign and EHR support. Smaller practices may struggle due to the distractions the detailed CCM documentation expectations would

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Table 1. Brief Summary of Chronic Care Management Code 99490

Which patients:
• Any Medicare patient with at least two chronic medical conditions, estimated up to 70% of all Medicare patients
Practice capabilities:
• EHR, MU certified 2011 or 2014
• 24/7 coverage
• Telephonic and asynchronous electronic communication
Scope of services:
• Continuity of care, one accessible primary physician (or NP/PA if the primary clinician) identified for each patient
• Routine health maintenance and disease prevention (screening, vaccinations, etc.)
• Oversight of chronic condition management (condition-specific monitoring)
• Medication oversight (compliance, interactions, reconciliation at transitions of care, patient understanding)
• Care coordination (home health care covered by the VNA supervision code HCPCS G0181 and the hospice care code HCPCS G0182) cannot be submitted if the CCM code is submitted and vice versa.
• Transitions of care oversight (Outside of those covered by TCM service codes 99495-6 cannot be submitted if the CCM code is submitted and vice versa.)
Documentation:
• Plan of care (POC) developed jointly between the patient and the primary care physician (or NP/PA if the primary clinician) and updated over time, no stipulated interval
• Contract signed and scanned, no need for periodic renewal
• Patient summary, electronically accessible to all covering physicians
• 20 minutes total per calendar month, documentation time included
Payment:
• $32.94 per calendar month for facility (e.g. academic medical centers) and $44.34 for non-facility practices; patient responsible for 20%, which would be covered by Medicare supplemental insurance

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add. No one will likely hire new staff without knowing that the costs will be fully covered. As a result, the CCM code may have limited appeal. It is possible that there will not be any payment available for the supervising physician despite the chronic conditions oversight expectations, the need to negotiate and update the plan of care, 24/7 access, and the time spent with staff supervision.

As with all new codes, CMS will be monitoring the use of CCM. SGIM members should be mindful that this code is not necessarily payment for work already being done since there are significant added expectations and personnel requirements. That said, a robust response to the CCM code will send a powerful message to CMS and Congress that the primary care community is committed to comprehensive and continuous care. With increased utilization, there will be opportunities to advocate for expanded payments for the most complex patients.

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