

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services



MLN Matters® Number: MM9234 **Revised** **Related Change Request (CR) #:** CR 9234

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Chronic Care Management (CCM) Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Note: This article was revised on December 8, 2015, to clarify language and to emphasize some sections. All other information remains unchanged.

Provider Types Affected

This MLN Matters® Article is intended for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) submitting claims to Medicare Administrative Contractors (MACs) for Chronic Care Management (CCM) services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 9234, which provides instructions to MACs regarding payment for CCM services for dates of service on or after January 1, 2016, to RHCs billing under the RHC All-Inclusive Rate (AIR) and FQHCs billing under the FQHC Prospective Payment System (PPS).

Background

The Centers for Medicare & Medicaid Services (CMS) recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending. On January 1, 2015, CMS began making separate payment under the Medicare Physician Fee Schedule (PFS) for CCM services under American Medical Association (AMA) Current Procedural Terminology (CPT) Code 99490.

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CMS finalized aspects of the payment methodology, scope of services, and requirements for billing and supervision for practitioners permitted to bill Medicare under the PFS in the Calendar Year (CY) 2014 PFS final rule (78 FR 74414 through 74427) and made further refinements in the CY 2015 final rule (79 FR 67715 through 67730).

As authorized by the Social Security Act (Section 1861(aa)), RHCs and FQHCs are paid for physician services and services and supplies incident to physician services. In the CY 2016 PFS proposed rule (80 FR 41793), CMS proposed requirements and a payment methodology for CCM services furnished by RHCs and FQHCs. In the CY 2016 PFS final (80 FR 71080), CMS finalized the requirements and payment methodology for CCM services furnished by RHCs and FQHCs.

Beginning on January 1, 2016, RHCs and FQHCs may receive an additional payment for the costs of CCM services that are not already captured in the RHC AIR or the FQHC PPS for CCM services to Medicare beneficiaries having multiple (two or more) chronic conditions that are expected to last at least 12 months (or until the death of the patient), and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

RHCs and FQHCs can bill for CCM services when a RHC or FQHC practitioner furnishes a comprehensive evaluation and management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) to the patient prior to billing the CCM service, and initiates the CCM service as part of this visit.

CCM payment will be based on the Medicare PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. The rate will be updated annually and has no geographic adjustment. The RHC and FQHC face-to-face requirements are waived when CCM services are furnished to a RHC or FQHC patient.

Coinsurance would be applied as applicable to FQHC claims, and coinsurance and deductibles would apply as applicable to RHC claims. RHCs and FQHCs would continue to be required to meet the RHC and FQHC Conditions of Participation and any additional RHC or FQHC payment requirements.

RHCs and FQHCs cannot bill for CCM services for a beneficiary during the same service period as billing for transitional care management or any other program that provides additional payment for care management services (outside of the RHC AIR or FQHC PPS payment) for the same beneficiary.

Patient Agreement Requirements - Overview

The RHC or FQHC must inform eligible patients of the availability of CCM services and obtain consent for the CCM service before furnishing or billing the service. Some of the patient agreement provisions require the use of certified Electronic Health Record (EHR) technology. See Table 1 below for more detailed information.

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Patient consent requirements include:

- Informing the patient of the availability of the CCM service and obtaining written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers.
- Explaining and offering the CCM service to the patient and documenting this discussion in the patient's medical record, noting the patient's decision to accept or decline the service.
- Explaining how to revoke the service.
- Informing the patient that only one practitioner can furnish and be paid for the service during a calendar month.

This agreement process should include a discussion with the patient, and caregiver when applicable, about:

- 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; and
- How to revoke the service.

Informed patient consent should only be obtained once prior to furnishing the CCM service, or if the patient chooses to change the practitioner who will furnish and bill the service.

CCM Scope of Service Elements - Overview

The CCM service includes the 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. Some of the CCM Scope of Service elements require the use of a certified EHR or other electronic technology. For a complete listing of the CCM Scope of Service elements and electronic technology requirements that must be met in order to bill the service, see Table 1 below.

Structured Data Recording

- Record the patient's demographics, problems, medications, and medication allergies and create structured clinical summary records using certified EHR technology.

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Care Plan

- Create 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 with a written or electronic copy of the care plan and document its provision in the medical record.
- Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service.
- Share the care plan electronically outside the practice as appropriate.

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- 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 the care plan.

Access to Care

- Ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services, providing the patient with a means to make timely contact with health care practitioners in the practice who have access to the patient's electronic care plan to address his or her urgent chronic care needs.
- Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care. Do this through telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation

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methods, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Care Management

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.

Manage care transitions between and among health care 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.

EHR and Other Electronic Technology 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 the use of a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year (referred to as “CCM certified technology”). For more information, visit <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms> on the CMS website.

For CCM payment in calendar year (CY) 2016, practitioners may use EHR technology certified to the 2014 edition(s) of certification criteria.

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. These are described in Table 1, CCM Scope of Service and Billing Requirements.

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Table 1: CCM Scope of Service and Billing Requirements in RHCs and FQHCs

CCM Scope of Service Element/Billing Requirement	Certified EHR or Other Electronic Technology Requirement
Initiation during an AWW, IPPE, or comprehensive E/M visit (billed separately).	None.
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.	Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology.
Access to care management services 24/7 that provides the beneficiary with a means to make timely contact with health care practitioners in the practice who have access to the patient's electronic care plan to address his or her urgent chronic care needs regardless of the time of day or day of the week.	None.
Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.	None.
Care management for chronic conditions including systematic assessment of the beneficiary'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 beneficiary self-management of medications.	None.

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CCM Scope of Service Element/Billing Requirement	Certified EHR or Other Electronic Technology Requirement
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.	Must at least electronically capture care plan information; make this information available on a 24/7 basis to all practitioners within the practice whose time counts towards the time requirement for the practice to bill the CCM code; and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers.
Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.	Document provision of the care plan as required to the beneficiary in the EHR using CCM certified technology.
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.	Format clinical summaries according to CCM certified technology. Not required to use a specific tool or service to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by fax).
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 using CCM certified technology.
Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary'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.	None.
Beneficiary consent—Inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers.	Document the beneficiary's written consent and authorization in the EHR using CCM certified technology.

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CCM Scope of Service Element/Billing Requirement	Certified EHR or Other Electronic Technology Requirement
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.	
Beneficiary consent—Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of the calendar month) and the effect of a revocation of the agreement on CCM services.	None.
Beneficiary consent—Inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.	None.

Table 2: Billing Examples for CCM Services

The following examples are provided to assist RHCs and FQHCs in billing for CCM services:

CCM Furnished as a Stand-alone Service

Revenue Code	HCPCS	Service Date	Service Units	Total Charges	Payment	Coinsurance/ Deductible Applied (when applicable)
52x ¹	99490	01/01/2016 ²	1	\$XX.XX ³	Based on the PFS national average non-facility payment rate	Yes

¹Use the revenue code most appropriate for the service

²Any date of service on or after 1/1/2016

³Enter charge amount

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CCM Services Furnished with a Billable Visit

Revenue Code	HCPCS	Service Date	Service Units	Total Charges	Payment	Coinsurance/ Deductible Applied (when applicable)
52x ¹	A FQHC payment code and a qualifying visit HCPCS for FQHCs or A valid HCPCS for a billable service for RHCs	01/01/2016 ²	1	\$XX.XX ³	FQHC Prospective Payment System (PPS) Methodology for FQHCs or All-inclusive rate (AIR) for RHCs	Yes ⁴
52x ¹	99490	01/01/2016 ²	1	\$XX.XX ³	Based on the PFS national average non-facility payment rate	Yes

¹Use the revenue code most appropriate for the service

²Any date of service on or after 1/1/2016

³Enter charge amount

⁴Coinsurance and/or deductible is waived when an approved preventive service is billed

Additional Information

The official instruction, CR9234, issued to your MAC regarding this change is available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1576OTN.pdf>.

The following documents and websites provide additional information about CCM:

- CCM Services: See <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>.
- PFS and OPFS Frequently Asked Questions on CCM: See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service->

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[Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf](#)

- Chronic Conditions: See <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions>.
- Chronic Conditions Data Warehouse: See <https://www.cwdata.org/web/guest> on the Internet
- Final Rules in the Federal Register (policies governing CCM services):
 - CY 2014 Medicare PFS Final Rule (CMS-1600-FC) pages 74414-74427: See <http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28696.pdf> on the Internet.
 - CY 2015 Medicare PFS Final Rule (CMS-1612-FC) pages 67715-67730: See <http://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf> on the Internet.
 - CY 2015 Medicare PFS Final Rule; Correction Amendment (CMS-1612-F2), page 14853: See <http://www.gpo.gov/fdsys/pkg/FR-2015-03-20/pdf/2015-06427.pdf> on the Internet.

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