2018
Chronic Care Management
eQGuide
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According to the Center for Disease Control (CDC), about half of all adults—117 million people—have one or more chronic health conditions; and, one of four adults has two or more chronic health conditions\(^1\). Seven of the top 10 causes of death in 2010 were chronic diseases. Two of these chronic diseases—heart disease and cancer—together accounted for nearly 48% of all deaths\(^2\). To compound matters, 84% of all health care spending in 2006 was for 50% of the population who have one or more chronic medical conditions\(^3\).

Because of these staggering statistics, CMS recognized chronic care management (CCM) as one of the critical components of primary care that contributes to better health for individuals and reduced expenditure growth. To help cover the costs of chronic care management, CMS established CPT code 99490 in January 2015.

Several months after CMS established CCM, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 was signed as bipartisan legislation. Additionally, Congress directed CMS to enact a new physician payment system called Merit-based Incentive Payment System (MIPS). At the core of each of these programs and laws (CCM, MACRA and MIPS) are the goals of value-base care. Each program focuses on quality patient care and incentivizes efficiency rather than rewarding volume. The programs are complementary; clinicians and practices that participate in a Medicare CCM program are more prepared for MACRA and MIPS.

While the opportunity was great, for CCM in 2015, when CMS began the CPT Code 99490 Chronic Care Management Program, according to Medicare claims data, only about 275,000 unique Medicare beneficiaries received Chronic Care Management services (CCM) an average of 3 times each, totaling $37 million in allowable charges.

In 2018, CMS continues to refine care management requirements as it is still seen as an important element in providing quality care and delivering results to patients that qualify for this service. As part of the 2018 updates to care management, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are specifically affected by the changes made this calendar year. The main highlights of these updates include enhanced payment and simplified billing. (See more detail on page 4 of this guide for changes related to FQHCs and RHCs.)

For background, in 2017, CMS lifted many of the administrative burdens that presented program barriers to entry in 2015 and 2016, with the goal of increasing patient participation and expanding usage of CPT Code 99490 to provide care management services. CMS also improved payment accuracy by appropriately recognizing and paying for other codes in the newly expanded CPT family of CCM services.

As reference, on January 1, 2015, CMS began reimbursing chronic care management services for qualified Medicare beneficiaries at approximately $40 per member per month under CPT Code 99490. With the evolution of the program, in 2017, CMS has expanded its CPT family of CCM services to include not only CPT Code 99490 (Chronic Care Management Service), but now the addition of CPT Code 99487 (Complex Chronic Care Management) and CPT Code 99489 (add on code to Complex Chronic Care Management). CMS recognized the need for extended care services for some patients that required more than 20 minutes of care. The same CCM services elements are required for all three codes in the CCM family, however, the three codes will differ in the amount of clinical staff service time provided, the complexity of the medical decision making, and the nature of care planning with reimbursement rates ranging from approximately $43 to $94.

Click here to visit the CY 2018 PFS Final Rule Revisions.  
Click here to view the most up to date CMS CCM Fact Sheet.  
Click here to view the most up to date CCM FAQs.  

In 2018, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) are specifically affected by the changes made this calendar year. The main highlights of these updates include enhanced payment and simplified billing. As of January 1, 2018, CMS is requiring FQHCs and RHCS to bill either of the two newly established HCPCS codes for all chronic care services provided (G0511 and G0512) and NO LONGER bill CPT Code 99490. To note, in 2016, program requirements for FQHCs and RHCS to provide CCM services were established and then revised in 2017. In 2018, no changes to the program requirements were proposed. To learn more details on what the requirements are to execute and bill for CPT family of CCM services, continue to explore the eQHealth Solutions Chronic Care Management eQGuide for our processes and capabilities and/or click here to access full details in the 2018 CMS Provider Fee Schedule final ruling. Click here to view FAQs related to FQHCs and RHCS.

For background, on January 1, 2016, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) started receiving additional payment from CMS for the costs of services that are not already captured in the RHC all inclusive rate (AIR) or the FQHC prospective payment system (PPS) for chronic care management services to Medicare beneficiaries that qualify to receive such services (a qualified Medicare beneficiary is defined on page six of this eQGuide). In 2017, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) reflected the newly updated chronic care managment requirements for practitioners billing under the provider fee schedule (PFS).

### Summary of 2018 CCM Coding Changes for FQHCs and RHCS

<table>
<thead>
<tr>
<th>Biling Code Description</th>
<th>2017 HCPCS Code</th>
<th>HCPCS Code Effective January 1, 2018</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Care Management for FQHCs and RHCs only</td>
<td>GCCC1</td>
<td>G0511</td>
<td>~$62.28</td>
</tr>
<tr>
<td>Psychiatric CoCM Code for FQHCs and RHCs Only</td>
<td>GCCC2</td>
<td>G0512</td>
<td>~$145.08</td>
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</tbody>
</table>

### Nonmetropolitan Federally Qualified Health Centers

![Map of Nonmetropolitan Federally Qualified Health Centers](image)
CPT Codes 99490, 99489, and 99487 - Navigate the Requirements

To learn more about all the necessary provisions that must be satisfied to bill CMS for the CPT family of CCM services, follow our four-step guide that will help navigate your organization to CCM program success.

1. Medicare Beneficiary Requirements
2. Technology Requirements
3. Service Requirements
4. Billing Requirements
MEDICARE BENEFICIARY REQUIREMENTS

1. Qualify the Medicare Beneficiary
   A patient who has been diagnosed with two or more chronic conditions expected to last for at least 12 months (or until death of the patient) and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

2. Classify the Medicare Beneficiary into Appropriate CCM Program
   a. Chronic Care Management (CPT Code 99490).

   OR

   b. Complex Chronic Care Management (CPT Code 99487).

   NOTE: CMS suggested criteria and guidance for placing a patient in the Complex Chronic Care Management versus the Chronic Care Management Program will be determined based on number of illnesses and number of medications or repeat admissions or emergency department visits.

   The requirements for each CPT Code above is the same, but differ in the amount of clinical staff service time provided, the complexity of the medical decision making, and the nature of care planning. See on next page for information on service requirements.

3. Initiating Visit
   In 2015 and 2016, an initiating visit (AWV, IPPE, or face-to-face E/M) was required for a beneficiary to become enrolled in a CCM program and for practitioners to bill CMS. Now, in 2017, initiating visits are ONLY required for new patients or patients that have not been seen within one year at an AWV, IPPE, or face-to-face E/M visit.

4. Beneficiary Consent
   Billing practitioners must inform the beneficiary of the currently required information (see bullet list below) and document in the beneficiary’s medical record that this information was explained and note whether beneficiary accepted or declined CCM services instead of obtaining a written agreement, as was required in 2015 and 2016.

   Beneficiaries must be informed of the following program details by the physician:
   • CCM program description.
   • Manner in which CCM services will be provided.
   • The right to stop the CCM services at any time.
   • Only one practitioner can provide these services during a calendar month.
   • Health information will be shared with other practitioners involved in their care.
TECHNOLOGY REQUIREMENTS

EHR Technology Requirements

• Structured recording of demographics, problems, medications, and medication allergies using certified EHR technology. A full list of problems, medications, and medication allergies must inform the care plan.
• Must be certified—satisfying either the 2011 or 2014 edition of the certification criteria for the EHR Incentive Programs.
• CMS no longer specifies the use of a qualifying certified EHR to document communication to and from home and community-based providers regarding the patient’s psychosocial needs and functional deficits and to document beneficiary consent.
• No longer requires standardized content for the CCM Continuity of Care documents. (In 2016, these documents were called “clinical summaries”. CMS is now moving toward using this new term “Continuity of Care”).
• Provider must be able to transmit the summary record for purposes of care coordination.
• Houses the beneficiary consent to CCM service, either verbal or written.
• Records the beneficiary receipt of care plan (electronic and/or hard copy).

Electronic Care Plan Requirements

• The use of any specific electronic technology is not required in managing a beneficiary’s care transitions as a condition of payment for CCM services. The billing practitioner is required to create and exchange/transmit continuity of care document(s) with other providers in a timely manner.
• Electronically capture and create a comprehensive care plan based on the physical, mental, psychosocial, cognitive, functional, and environmental assessment of beneficiary.
• Timely electronic sharing of care plan information within and outside of the billing practice, but not necessarily on a 24/7 basis, and allow transmission of care plan by fax.
• Opportunities for beneficiary and any caregiver to communicate with the practitioner.
• Care plan copy given to beneficiary (electronic, paper, or fax).
CHRONIC CARE MANAGEMENT SERVICE REQUIREMENTS

1. Beneficiary Classification:

• Chronic Care Management (CPT Code 99490)
  a. Provide 20+ minutes of non-face-to-face care management services per month.
  b. Beneficiary access to urgent care services 24/7.
  c. Continuity of care with a designated care team member – ability to get successive routine appointments.
  d. Comprehensive care management - care for chronic conditions that includes systematic assessment of the beneficiary’s medical, functional, and psychosocial needs.
  e. Ensure beneficiary’s timely receipt of preventive care services.
  f. Medication reconciliation with review of adherence and potential interactions.
  g. Oversight of the beneficiary’s self-management of medications.
  h. Follow-up after ER visits, discharge from hospitals, skilled nursing facilities or other health facilities.
  i. Help coordinate transitions of care.

• Complex Chronic Care Management (CPT Code 99487)
  a. Provide 60+ minutes of non-face-to-face care management services per month.
  b. Care plan establishment or revisions to an already established care plan will be more intensive than Chronic Care Management care plan creation.
  c. Moderate or high-complexity medical decision making.

Same requirements as letters “b. through i.” above.

* If an additional 30 minutes of care management is delivered by clinical staff time in addition to the required 60 minutes for Complex Chronic Care Management (CPT Code 99487), then CPT Code 99489 can be billed in conjunction with CPT Code 99487.

* For each calendar month, a patient can only be classified as either complex or non-complex. Both services cannot be billed at the same time.

Click here to visit the CY 2018 PFS Final Rule Revisions.
Click here to view the most up to date CMS CCM Fact Sheet.
Click here to view the most up to date CCM FAQs.
# CHRONIC CARE MANAGEMENT SERVICE REQUIREMENTS

## Summary of CCM Coding Changes in 2017 and 2018

<table>
<thead>
<tr>
<th>CCM Requirement</th>
<th>Revised Requirements Since 2016</th>
</tr>
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</table>
| Initiating Visit                          | - Now only required for new patients or patients not seen within 1 year prior to commencement of CCM.  
- Extra payment for extensive initiating services by the CCM practitioner (G0506).                                                                                         |
| Certified EHR and Other Electronic        | - Certified EHR still required to standardize formatting in the medical record of core clinical information (demographics, problems, medications, medication allergies), but certified technology no longer required for other CCM documentation or transitional care management documents.  
- No specific technology requirements for sharing care plan information electronically within and outside the practice, and fax can count, as long as care plan information is available timely (meaning promptly at an opportune, suitable, favorable, useful time).  
- Individuals providing CCM after hours no longer required to have access to the electronic care plan, as long as they have timely information.  
- Remove standards for formatting and exchanging/transmitting continuity of care document(s).  
- Continue to encourage and support the use of certified technology and increased interoperability, but code-level conditions of Medicare Physician Fee Schedule (PFS) payment may not be the best means of accomplishing this. Practitioners are likely to transition to advanced electronic technologies due to incentives of the Quality Payment Program, independent of CCM rules. |
| Continuous Relationship with Designated Care Team Member | - Improved alignment with CPT language for administrative simplicity.                                                                                                                                                   |
| Comprehensive Care Management and Care Planning | - Improved alignment with CPT language for administrative simplicity and appropriate caregiver inclusion.  
- No longer specify format of the care plan copy that must be given to the patient (or caregiver, if appropriate).  
- Electronic technology use standards relaxed (see above).                                                                                                                |
| Transitional Care Management              | - Improved alignment with CPT language for administrative simplicity.  
- Clinical summaries used in managing transitions renamed “continuity of care document(s)”.  
- Electronic technology use standards relaxed (see above).                                                                                                           |
| 24/7 Access to Address Urgent Needs       | - Improved alignment with CPT language.  
- Clarifying the required access is for urgent needs.                                                                                                               |


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BILLING REQUIREMENTS

Once all the CCM technology and service requirements to bill have been met, note the following to ensure accuracy in billing for timely reimbursement:

• The service period for CPT Codes 99490, 99487, and 99489 is one calendar month.
• The date that the non-face-to-face CCM services requirement is met is the “date of service” used on the physician claim. Document one of the following: 20 minutes, 60 minutes or 60 minutes + 30 minutes.
• The claim does not need be held to the end of the month when the service threshold has been met.
• The place of service (POS) reported on a physician claim for the non-face-to-face services should be the location the billing practitioner would furnish a face-to-face visit with a patient.
• CPT Codes 99490, 99487, and 99489 cannot be billed in conjunction with transition care management, home health management, hospice care management, or certain ESRD services.
• If both an E/M visit and the CCM code are billed on the same day, modifier-25 must be reported on the CCM claim.
• CPT Code 99489 will also be used to report each additional 30 minutes of clinical staff time and care provided in each calendar month on top of the 60 minutes required for complex care management service (CPT Code 99487). CPT Code 99489 can only be billed in conjunction with CPT Code 99487 (complex chronic care management).
• **G0506 add-on code billed with initiating CCM visit**: Additional payment will been made when this add-on code is billed in conjunction with the initiating visit. It is intended for patients who require extensive assessment and care planning as part of the initiating visit by billing physician.

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CPT Codes 99490, 99489, & 99487 - Scenario for a New Patient

START

Beneficiary Visits Doctor for AWV as a New Patient

NOTE: AWV, E/M, and IPPE visits in 2017 are only necessary for new patients or patients not seen within one year to enroll in a CCM Program.

Beneficiary Qualified to Receive CCM Services

G0506 Add-On Code Billed With Initiating CCM Visit:
Comprehensive Assessment and Care Planning by Billing Physician

NOTE: Not all patients will require comprehensive assessment.

Chronic Care Management
CPT Code 99490
20+ Minutes

OR

Additional 30 Minutes of Clinical Staff Time
CPT Code 99489

Complex Chronic Care Management
CPT Code 99487
60+ Minutes

Beneficiary Classified to Receive Either
Initiating Visit:
- Initiation during an AWV, 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 chronic care management (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 beneficiary is able to schedule successive routine appointments.

Comprehensive Care Management:
- 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.

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 (may include fax) and timely within and outside the billing practice to individuals involved in the beneficiary’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 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.

Beneficiary Consent:
- Inform the beneficiary of the availability of 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 services at any time (effective at the end of the calendar month).
- Document in the beneficiary’s medical record that the required information was explained and whether the beneficiary 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).
**eQCare®**

**eQCare® Chronic Care Management Services**, which is inclusive of eQSuite® Technology, support providers by administering a full turnkey solution to meet all requirements to bill for CPT Codes 99490, 99487, and 99489. Our goal is to help improve the health of patients while growing practice revenue and profitability. **eQCare® Chronic Care Management Services** allow providers to oversee the program, while we take on the burden of hiring, staffing, and operating this program with experienced clinicians to give the best care to your patients. Our experience in providing the right care management team along with advanced care coordination software will give providers the confidence that their patients are well cared for, along with the opportunity to increase practice revenue.

**Key Features/Benefits:**
- Care management staff is hired within the community and works closely with the providers’ staff
- Embedded care coordinators provide care management to identified members monthly on behalf of the care team
- Experienced in complex care coordination assessments
- Monitor beneficiary’s condition and update chronic care management activities as needed
- Perform ongoing medication adherence and reconciliation
- Ensure beneficiaries schedule preventative services
- Educate beneficiaries regarding their conditions
- Facilitate routine appointment scheduling and reminders
- URAC certified in Disease Management

**eQCare® Services and eQSuite® Technology help you meet ALL the requirements for Chronic Care Management CPT Codes 99490, 99487, and 99489.**
eQSuite® Technology - Chronic Care Management

eQSuite®

eQSuite® Chronic Care Management Technology is a cloud-based, modular platform. It is tailored to meet all the electronic care plan requirements for CPT code 99490, 99487 and 99489. The intuitive design helps providers, care teams and administrators leverage a sophisticated engine to identify and manage beneficiaries with 2+ chronic conditions. Of these identified beneficiaries with 2+ chronic conditions, the technology is also capable of identifying beneficiaries that would potentially be classified as having a complex chronic condition. eQSuite® CCM Technology is the ideal platform to create and manage care plans for these identified patients. It includes feature rich capabilities beyond typical electronic care plan software.

Key Features/Benefits:
- 24/7 care plan access
- Claims/billing (medical & pharmacy) data integrations necessary for CCM
- Healthcare analytics to identify CCM qualified members
- Comprehensive assessments
- Individualized plan of care (issues, goals, and interventions)
- Secure messaging
- Health education material
- Satisfaction surveys
- Patient portal
- Reporting
  - Population health
  - Productivity (used for billing for CPT Codes 99490, 99487, and 99489 activities)

- Care coordinators/care managers workflow engine
  - Daily work queue
  - Patient dashboards
  - Patient level claims history (if applicable)
  - Patient level comprehensive clinical profile
  - Clinical tracker (for biometrics data)
  - Session notes
  - Correspondence
  - Attachments
  - Drug alerts (Drug-Drug Interactions, Duplication, Drug-Food Interactions)
  - Provider channeling (if applicable)

eQCare® Services and eQSuite® Technology help you meet ALL the requirements for Chronic Care Management CPT Codes 99490, 99487, and 99489.
Why Choose eQHealth Solutions?

- 30 Years Experience with Medicare Populations
- Improve Patient Outcomes
- Cloud-Based Technology
- Clinically Focused
- Local Care Management Team, No Matter Where You Are

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800.720.2578

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