TIPS TO IMPLEMENT CHRONIC CARE MANAGEMENT SERVICES IN YOUR PRACTICE

What is Chronic Care Management and why you should consider implementing this service in your practice?

- Chronic Care Management (CCM) services are provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
- CCM services are recognized by The Centers for Medicare & Medicaid as critical components of primary care that promote better health and reduce overall health care costs.
- By utilizing CCM, your patients and your practice will benefit from improved patient care coordination and compliance, as well as potential practice growth and sustainability.

CCM REQUIREMENTS:

- Structured recording of patient health information
- Keeping comprehensive electronic care plans
- Managing care transitions and other care management services
- Coordinating and sharing patient health information promptly within and outside the practice

Implementing CCM services in your practice

Recommendations for the development and implementation of successful CCM services:

- CCM, improved functional and clinical outcomes for disease management are the result of productive interactions between informed, activated patients and the prepared, proactive practice team of clinicians and healthcare professionals.
- To achieve maximum outcomes improvement, it is recommended that you establish detailed workflow plans to maximize accountability; follow ups, and task completion.

The most effective interventions for improvements in chronic disease care include the combination of multi-pronged strategies. When developing an outcome improvement driven CCM process for your practice you should consider these primary components: **self-management support, delivery system design, decision support, and clinical information systems.**

Component	Purpose	Examples
Self-management support	- Emphasis on the importance of the central role that patients have in managing their own care - Enhancing skills and capacities for personal health and wellness	- Referral resources and recommendations (Health Education, -DSMES, Smoking Prevention and Cessation Programs) - Develop community collaborations/ strong referral resources (local food banks, referral providers) - Designated team member, staff, or support system to track, manage and follow up
Delivery system design	- Focus on teamwork and an expanded scope of practice to support chronic care - Effective communication sources between providers, patients, and community - Integration of evidence-based guidelines into daily clinical practice	- Emphasis in quality improvement on health and quality of life outcomes, not just clinical outcomes (SDOH) - Multiple methods of communication to give and receive relevant information regarding patient care/needs (patient portal, provider referral systems, after-hours procedure in place) - Practice guidelines and policies aligned with current clinical guidelines (ADA, AHA Standards of Care) - Designated team member, staff, or support system to track, manage and follow up

Decision Support	- Decision support systems are useful to professionals and lay people in dealing with the impact of disease and making choices that support health and well-being.	- Develop and/or establish a relationship with a strong professional, education, and community-based referral system - Establish practice patient communication and follow-up procedures to ensure physicians remain proactive and patients remain engaged and active with their treatment plans - Designated team member, staff, or support system to track, manage and follow up
Clinical information systems	- Establish and implement new and/or utilized current EHR system - Developing information systems based on patient population to provide relevant client data toward meeting the overall goal of improved patient ad practice outcomes	- Incorporates evidence-based guidelines and measures (ADA, AHA standards of care) - Designed to promote accurate and timely documentation (routine reminders and notifications) Includes follow-up, reminder, and missing documentation system

Implementing CCM billing services in your practice

CCM services can be billed by Physicians and Non-Physician Providers (NPP) to include:

- Physicians
- Certified Nurse Midwives (CNMs)
- Clinical Nurse Specialists (CNSs)
- Nurse Practitioners (NPs)
- Physician Assistant

CCM Complex Billing Codes	
Complex CCM Codes require patients to have two or more chronic conditions expected to last 12 months or until their death	
99487 - 60-minute timed service provided by clinical staff to substantially revise or establish a comprehensive care plan that involves moderate- to high-complexity medical decision making	99491 - CCM services provided personally by a physician or other qualified health care professional for at least 30 minutes
99489 - each additional 30 minutes of clinical staff time spent providing complex CCM directed by a physician or other qualified health care professional (report in conjunction with CPT code 99487; cannot be billed with CPT code 99490)	99437 - CCM services each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99490 - non-complex CCM is a 20-minute timed service provided by clinical staff to coordinate care across providers and support patient accountability	99439 - each additional 20 minutes of clinical staff time spent providing non-complex CCM directed by a physician or other qualified health care professional (billed in conjunction with CPT code 99490)
PCM Billing Codes	
Principle Care Management Codes (PCMs) are for patients with a single or multiple chronic conditions, but service is focused on a single high-risk condition that may be expected to last six months to one year or until the patient's death	
99424 - First 30 minutes of CCM services provided personally by a physician or other qualified health care professional per calendar month for a single high-risk disease	99426 - first 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99425 - each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	99427 - each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month (List separately in addition to code for primary procedure)

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