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Chronic Care Coordination

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Chronic care management describes the services provided to patients with two or more chronic conditions that pose risks of exacerbation, clinical deterioration, or death. These services extend beyond the typical face-to-face office visit and require coordination and oversight by a physician or other qualified health-care professional to maintain and modify as necessary a comprehensive and multidisciplinary plan of care. New codes for 2015 describe chronic care management services per calendar month. While the new services acknowledge the role and importance of coordination by primary care providers, they are also appropriate for specialists who oversee the management of all of the chronic conditions of a patient and provide access, education, care coordination, communication, and health information exchange with other providers.

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ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; CPT = Current Procedural Terminology; EHR = electronic health record

Approximately one-half of the adult population in the United States has at least one chronic medical condition, and one in four have multiple conditions.[1] The majority of deaths and health-care expenditures are due to multiple chronic diseases. Characteristics including male sex, number of comorbidities, hospital admission, and pressure ulcers are associated with higher risk of 1-year mortality.[2] While there is no uniform definition, and overlap with other terms describing long-term disease management, chronic care coordination usually refers to services provided by physicians and other health-care professionals, typically registered nurse care coordinators, to a patient who resides at home, in a nursing facility, or in a setting of assisted living.[3] Care coordination including primary care supervision, home health nursing, telephone counseling, addressing of psychosocial factors, and self-management can improve communication, increase the knowledge of patient and family, improve the use of community resources, and decrease health-care costs.[4,5] Benefits of care management may be observed across ethnic and racial groups.[6] The description of chronic care management services has evolved in recognition that existing coding for usual face-to-face evaluation and management does not adequately describe the care of chronic conditions. This review will consider new codes for chronic care management services established for 2015 by the Current Procedural Terminology (CPT) Panel of the American Medical

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Association, and specific expectations for reimbursement by the Centers for Medicare & Medicaid Services (CMS) for the new CPT code 99490.[7,8]

Personnel and Services

While care management occurs under the direction of a physician or other qualified health-care professional (eg, nurse practitioner, physician assistant), a variety of personnel may be engaged (eg, registered nurse, therapist, other clinical staff) and multiple services are commonly delivered. The staff providing services are not necessarily employed by the physician or practice, but could be leased to establish the relationship and expense to the practice, as required for "incident to" guidelines. Billable services by clinical staff usually require direct physician supervision (implying that the physician is in the office suite and immediately available) under the guidelines for activities "incident to" the physician service. However, for chronic care coordination, the CMS has provided an exception such that general supervision is allowable for clinical staff who are direct employees of the practice.[9] The services typically include the establishment and monitoring of a plan of care, coordination of care with other professionals or agencies, and education of the patient and caregivers. A comprehensive plan of care must be documented and shared with the patient and caregivers, with assessment of all health problems, and including physical, psychosocial, functional, and environmental factors. Care management activities by the clinical staff may include the following: communication with patient, family, and caregivers; communication with home health agencies; collection of outcomes data (included in CPT but not specified by the CMS); support for independent living; medication reconciliation; assessment of adherence to treatment; assistance with access to care; management of transitions of care not separately coded (CPT 99495-99496); and maintenance of the comprehensive plan of care. Services may be provided by different staff members but time should not be counted more than once for multiple individuals providing services simultaneously.

The physician or other qualified practitioner must explain and obtain consent for chronic care coordination at a face-to-face encounter, the sole purpose of which should not be the initiation of the chronic care services. The plan of care should be developed by the physician or other qualified provider, while the ongoing care management services can be provided by clinical staff.

The care plan is expected to include features such as a clinical problem list, treatment goals, planned interventions and patient response, expected outcomes, prognosis, and medication and symptom management. There is also expectation for identification and coordination of community and social services, coordination with other agencies and specialists, periodic review, and revision of the plan as needed.

Practice Expectations

The clinical practice providing chronic care coordination is expected to provide continuous (24/7) access and means to contact physicians, other qualified health-care professionals, or clinical staff; continuity of care with a designated team member; timely access and management after emergency visit or hospitalization; a certified electronic health record (EHR); an internal process that consistently identifies eligible patients; standardized forms within the medical record; and engagement and education of patient and caregivers.

The CMS has specified some of the certified EHR features expected.[9] The structured recording of demographics, problems, medications, allergies, and creation of structured clinical summary records should use certified technology. Communication among home-based and community-based providers regarding the patient's psychosocial needs and functional deficits should also be documented in the medical record using certified technology. The CMS has allowed that the certified EHR can meet the criteria of the incentive programs for the calendar year preceding the date of the care coordination service. For the patient-centered care plan, the practice must at least electronically capture the care plan information, make this available in a centralized location of the EHR on a 24/7 basis to all practitioners whose time counts toward the time requirement for the practice to bill the chronic care management code, and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers. The care plan must also be shared with the patient in written or electronic form, and the provision of the plan must be documented in the EHR. Clinical summaries for care transitions do not require a specific technology, but should be transmitted electronically (other than by fax). The beneficiary's written consent and authorization for information sharing should also be documented in the certified EHR.

CPT Coding for Chronic Care Coordination

CPT code 99490 became effective January 1, 2015, with the following descriptor:

99490. Chronic care management services, at least 20 min of clinical staff time directed by a physician or other