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Designing & Implementing CCM Services

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Agenda

1. Objectives
2. Foundational Planning & Infrastructure
3. Patient Identification & Enrollment
4. Care Plan Development
5. Monthly CCM Service Delivery
6. Billing & Compliance
7. Q&A
8. Next Steps

Objectives

- Identify the foundational elements required to successfully launch CCM services in a home-based palliative care setting
- Learn how to thoughtfully identify and enroll eligible patients while aligning care plans with palliative goals
- Understand how to deliver, document, and bill for monthly CCM services while ensuring quality and compliance

Introduction

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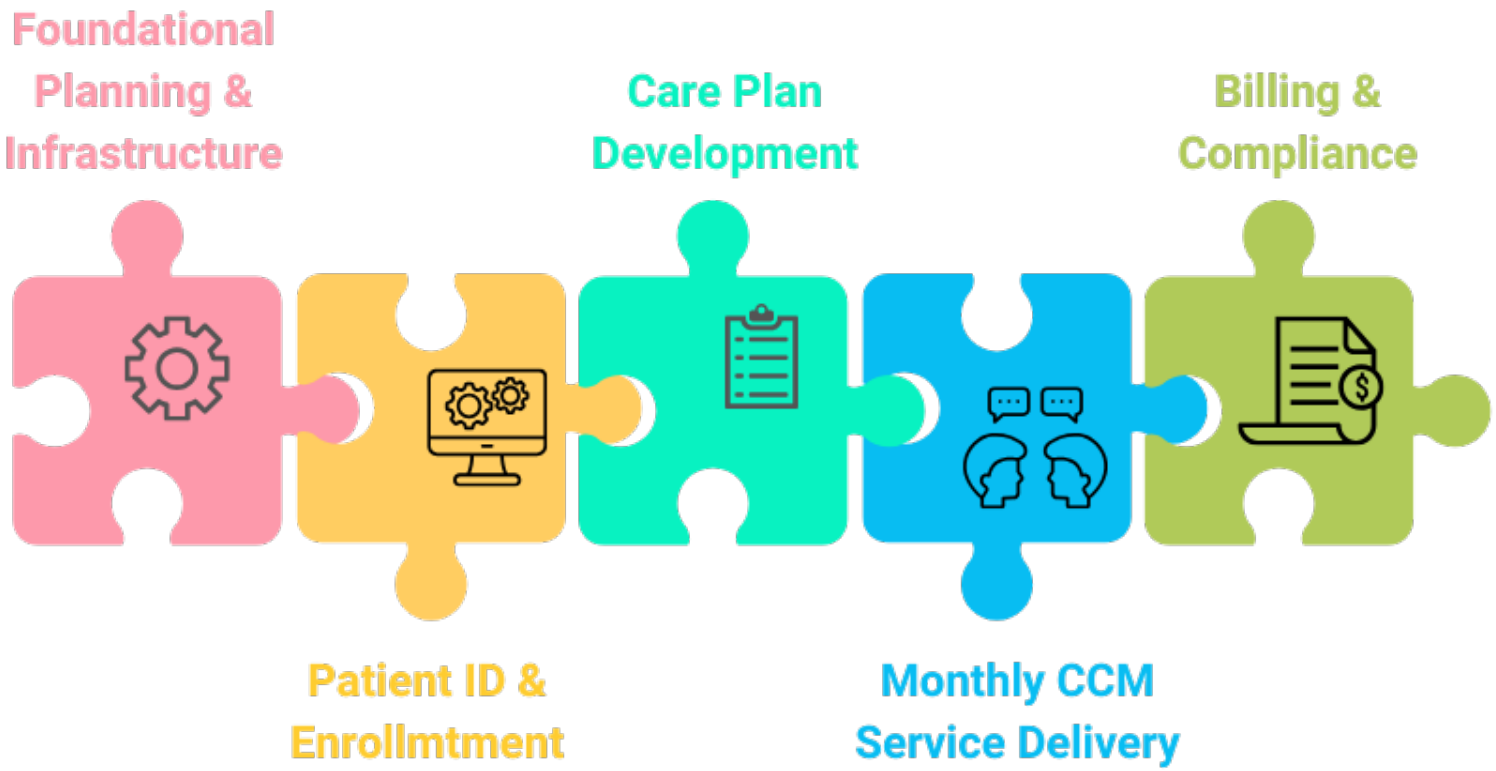
CCM Workflow Fundamentals



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Foundational Planning & Infrastructure

Program Goals & Scope

✓ Clarify Objectives

- Symptom management
- Care coordination
- Advanced care planning

✓ Define Eligible Population

- ≥2 chronic conditions expected to last ≥12 months

✓ Consider Inclusion Criteria

Goal Setting Categories:

- ❑ Enrollment targets (e.g., 100 patients in 90 days)
- ❑ Patient satisfaction scores
- ❑ ER visits/hospitalizations

Leadership & Care Team

Established Healthcare System

- Executive Leadership
- Lead Physician
- Clinical Lead
- Operational Lead
- Care Manager(s)
- IT Support
- Billing Specialist

Independent Practice w/ Solo Clinician

- Solo Clinician
- Part-Time Support (if available)
  - Virtual/medical assistant
  - Outsourced billing service
  - CCM software to template care plan & time

ADVANTAGES

- Multidisciplinary collaboration
- Dedicated staff for each function
- Easier to scale and evaluate outcomes

- Personalized care
- Flexibility in implementation
- Lower overhead

Patient Identification & Enrollment

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Enrollment Workflow Foundations

Patient Identification

- Review active palliative census
- Clinician referrals
- EHR filters
  - Medicare/Medicaid patients
  - 2+ chronic condition diagnoses
  - At-risk of functional decline/death
  - Prioritize by:
    - Recent hospitalization
    - high symptom burden
    - Polypharmacy
    - Multiple providers

Patient Outreach & Consent

- Develop patient education materials
- Staff training
  - CCM benefits
  - How to obtain consent
- Call eligible patients for written or verbal consent

Enrollment Workflow

- Assign care team roles for outreach & documentation
  - Who conducts monthly check-ins?
  - Who updates care plans?
  - Who handles documentation & billing?
- Standardized enrollment scripts & documentation templates

Key Deliverables

- ✓ Patient Eligibility List
- ✓ Enrollment Workflow & Documentation Templates
- ✓ Patient Consent Forms & Education Materials
- ✓ Staff Training Materials

Obtaining Consent for CCM

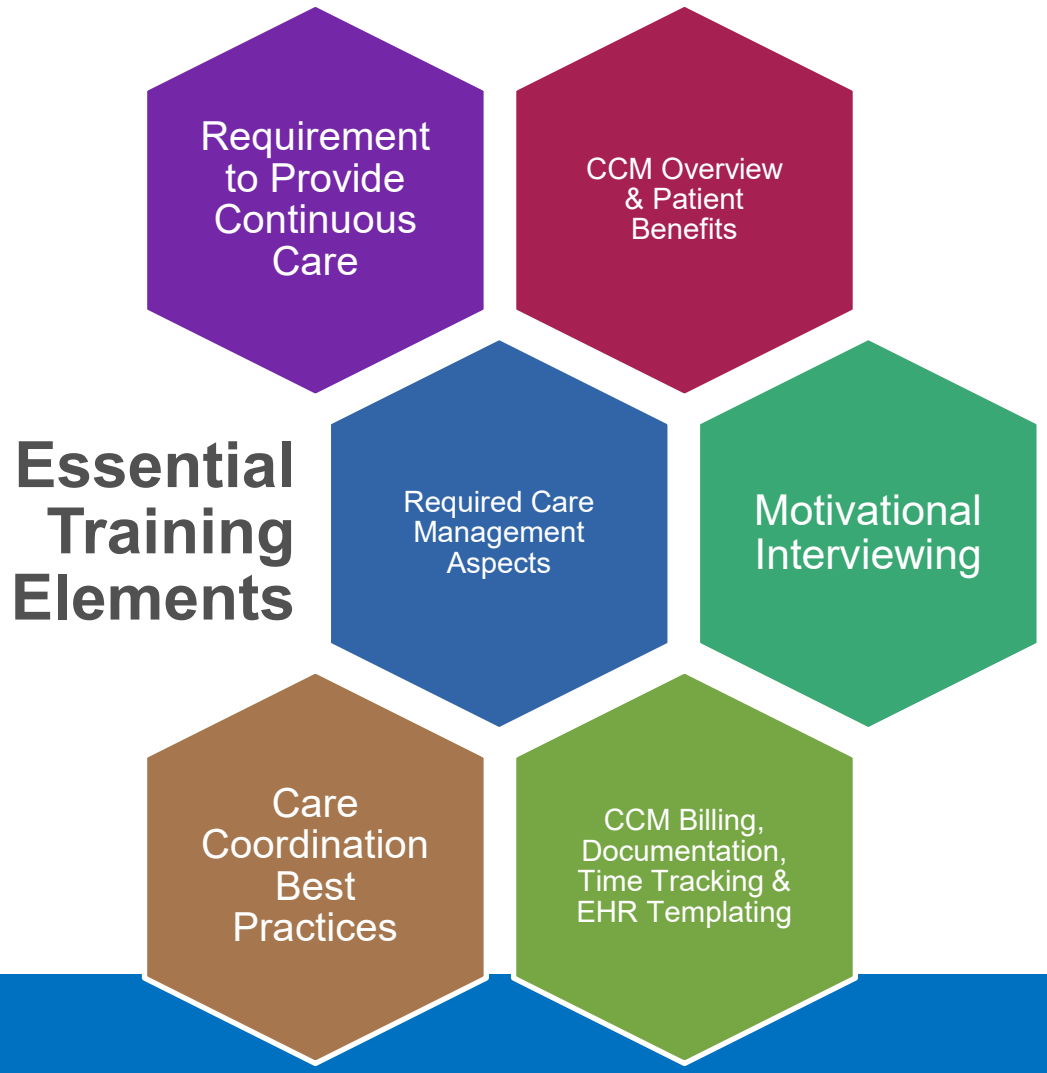
✅ What to Do

- ✓ Clearly Explain CCM Services
- ✓ Prepare With a Script
- ✓ Disclose Costs and Copays
- ✓ Obtain Consent BEFORE Starting Services
- ✓ Document Consent Properly
- ✓ Empower & Train Staff
- ✓ Start Small & Scale

❌ What to Avoid

- X Don’t Skip the Cost Discussion
- X Don’t Use Vague or Technical Language
- X Don’t Assume Consent is Ongoing
- X Don’t Forget to Document
- X Don’t Pressure Patients
- X Don’t Overlook Staff Involvement

Care Team Training



Training Methods:

- Instructor-led Workshop
- Training Manual
- Shadowing
- Team Huddles & Case Reviews
- Technology Training
- Staff Feedback & Evaluation

Care Plan Development

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Care Plan Requirements

- Problem List
- Expected Outcome & Prognosis
- Measurable Treatment Goals
- Cognitive & Functional Assessment
- Symptom Management
- Planned Interventions
- Medical Management
- Environmental Evaluation
- Caregiver Assessment
- Interaction & Coordination w/ Outside Resources
- Requirements for Periodic Review
- Care Plan Revisions, When Applicable

Additional Care Plan Requirements

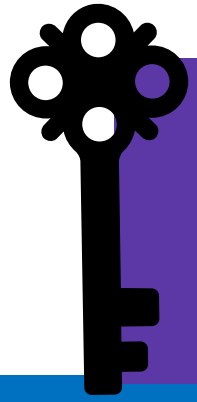
A Care Plan Must Be…

- ✓ Accessible in the EHR
- ✓ Shared with the patient
- ✓ Established, implemented, monitored, and revised, as appropriate
- ✓ Aligned with patient's goals of care and advanced directives
- ✓ Accessible to relevant healthcare providers, as needed

Technology & Infrastructure

Implement or Integrate:

- CCM documentation & billing capability within EHR
- Secure messaging & telehealth tools
- Remote Patient Monitoring (if applicable)



Key Deliverables

✓ EHR & Workflow Customization

✓ Standardized Care Plan Templates

Monthly CCM Service Delivery

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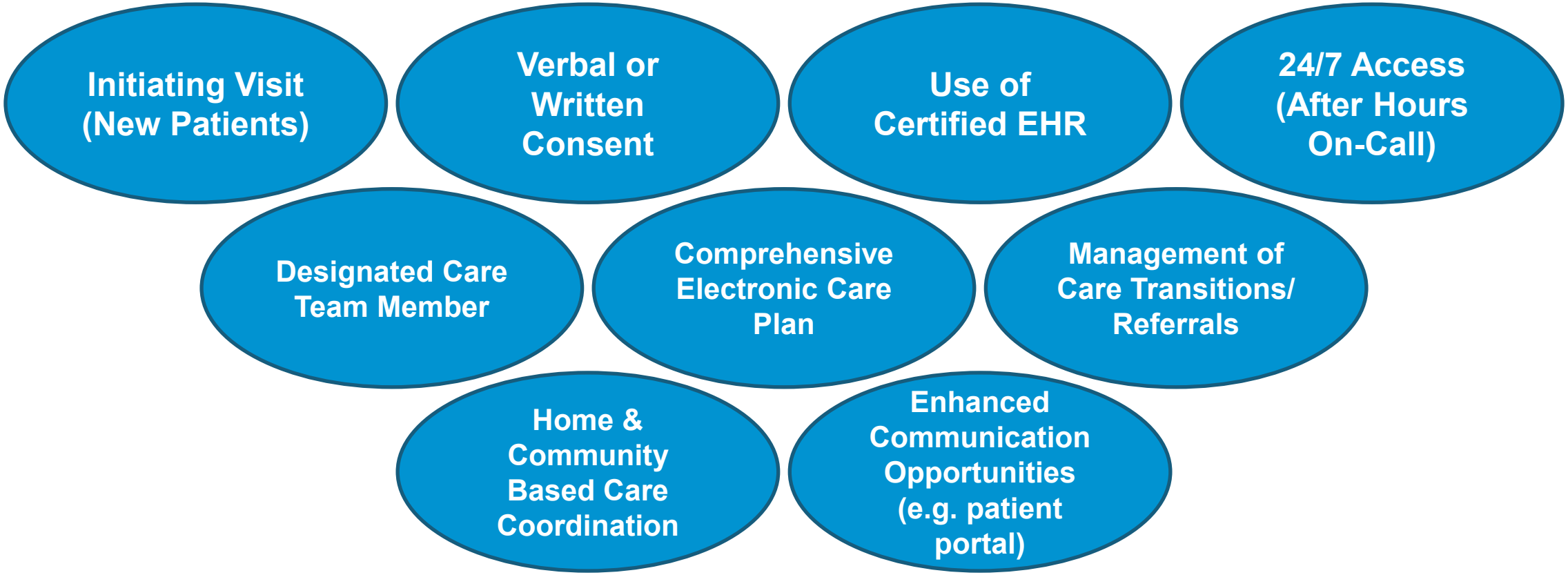
CCM Requirements



Non-Face-to-Face Activities Eligible for CCM

📞 Care Coordination & Communication

- Patient/Caregiver communication via phone, email, secure messaging
- Coordination with specialists, pharmacies, or community services
- Arranging follow-up appointments/referrals

📋 Care Plan Management

- Creating, updating, or reviewing patient's care plan
- Documenting changes in patient's condition or treatment goals
- Sharing the care plan with other providers involved in patient's care

💊 Medication Management

- Reviewing & reconciling medications
- Patient education on adherence and side effects
- Pharmacy coordination for refills/changes

🧠 Patient Support & Monitoring

- Self-management support & education
- Remote patient monitoring
- Addressing SDOH (e.g., transportation, housing)

📜 Administrative Tasks

- Reviewing test results & communicating findings
- Updating patient's medical record
- Documenting time spent on services provided for billing

Tips for Success

- **Schedule and document 20+ minutes of monthly non-face-to-face interactions**
  - Use time-tracking tools integrated with EHR
  - Update care plan, as needed
- **Assign care team member to:**
  - Coordinate patient care
  - Schedule appointments
  - Provide ongoing support in managing chronic conditions
- **Coordinate with:**
  - Primary care providers
  - Specialists
  - Hospice (if applicable)
  - Home health
- **Use shared care plans and regularly meet with care team**
- **Ensure CCM and TCM are not billed during the same month**

Monthly CCM Checklist

1. Patient Eligibility & Consent

- ❑ Confirm 2+ chronic conditions expected to last 12+ months or until death
- ❑ Initial face-to-face visit (E/M or AWV) occurred w/in past year
- ❑ Obtain & document consent

2. Care Plan Management

- ❑ Create or update electronic care plan
- ❑ Share care plan with involved providers
- ❑ Make care plan accessible to patient and/or caregivers

3. Care Coordination & Communication

- ❑ Provide 24/7 access to care
- ❑ Coordinate with home/community-based services, specialists, and other providers

4. Medication Management

- ❑ Review and reconcile medications & allergies
- ❑ Support medication self-management & adherence

5. Time Tracking & Documentation

- ❑ Track 20+ minutes of non-face-to-face care per patient per month
- ❑ Document the following:
  - ❑ Time spent
  - ❑ Services provided
  - ❑ Communication with patient & care team

6. Billing & Compliance

- ❑ Use appropriate CPT codes
- ❑ Ensure only 1 provider bills for CCM per patient per month
- ❑ Maintain audit-ready documentation

Billing & Compliance

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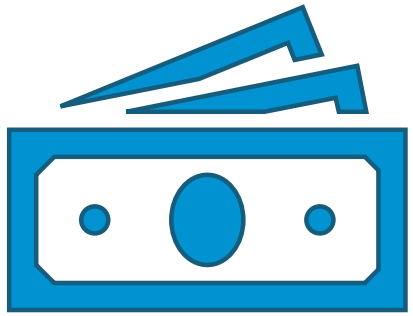
Who Can Bill For CCM?



- Only 1 eligible practitioner can furnish and be paid for CCM services during a calendar month.
- Physicians and certain Non-Physician Practitioners (Physician Assistants, Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Hospitals, including Critical Access Hospitals

CCM Coding Summary

CPT Code	2025 CMS National Non-Facility Payment	Description
99490	$61.49	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month
99439	$45.93	Add-on code, can only be billed in conjunction with traditional CCM (99490). CCM each additional 20 minutes of clinical staff time directed by a provider per calendar month.
99491	$82.16	Provider CCM, 30 minutes per calendar month by the billing provider
99437 (add on for 99491)	$57.58	Provider CCM Add-on Code: Each additional 30 minutes of CCM time personally spent by the billing practitioner.
99487	$131.65	Complex chronic care management services, at least 60 minutes of clinical staff time as directed by a physician or qualified health care professional per calendar month.
99489 (add on for 99487)	$70.52	Complex CCM Add-on Code; Each additional 30 minutes of clinical staff time as directed by the physician or other qualified health care professional
G0506 CCM Initiating Visit	$60.81	Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services. Billed separately from monthly care management services. * This is only used for new patients or patients not seen within the past 12 months that require an initiating visit to enroll in CCM services

Questions or Thoughts?

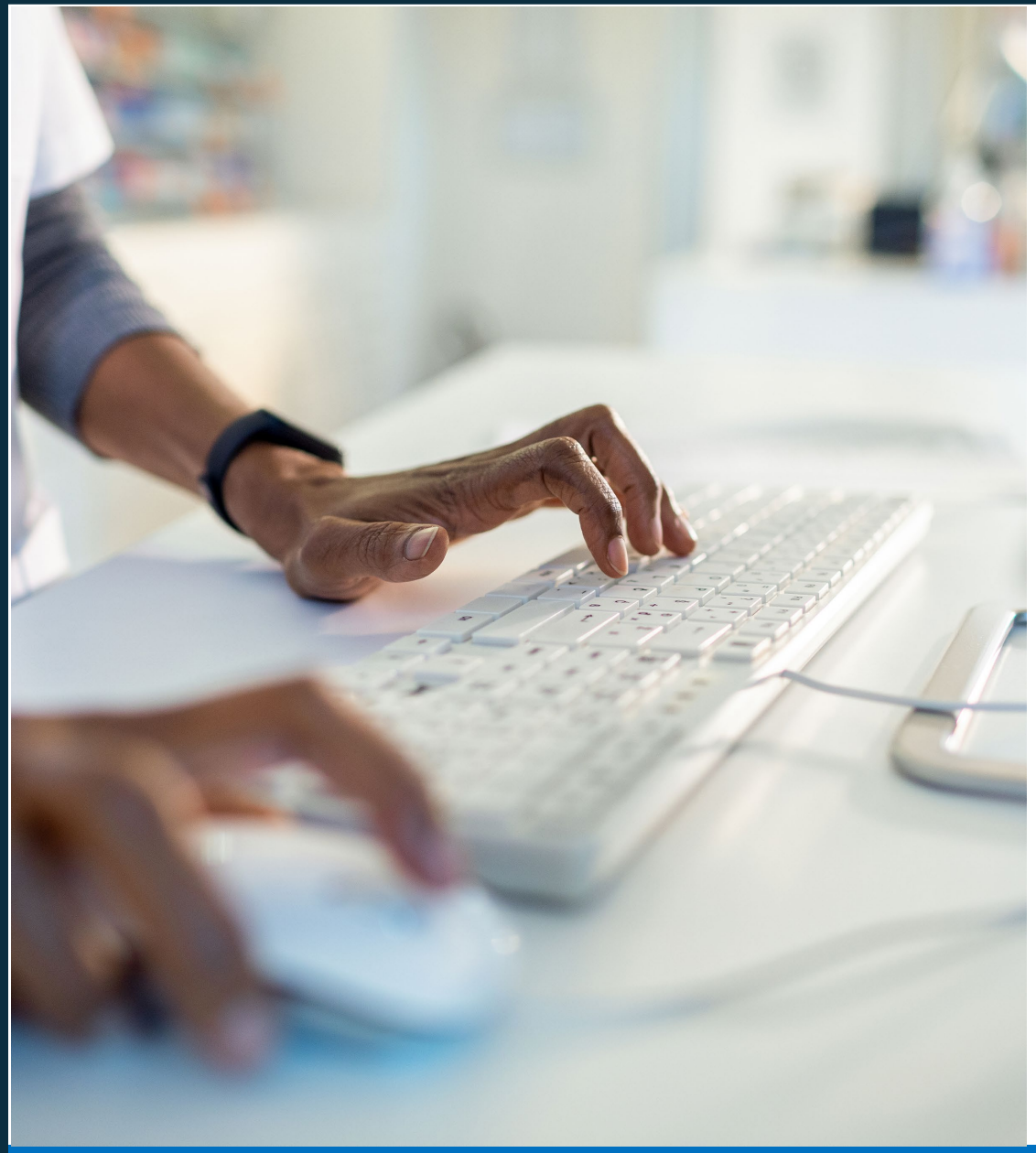
How Did We Do?

Scan the QR Code

to complete a short evaluation.

Takes 1–2 minutes

Thank you for your time and insights!

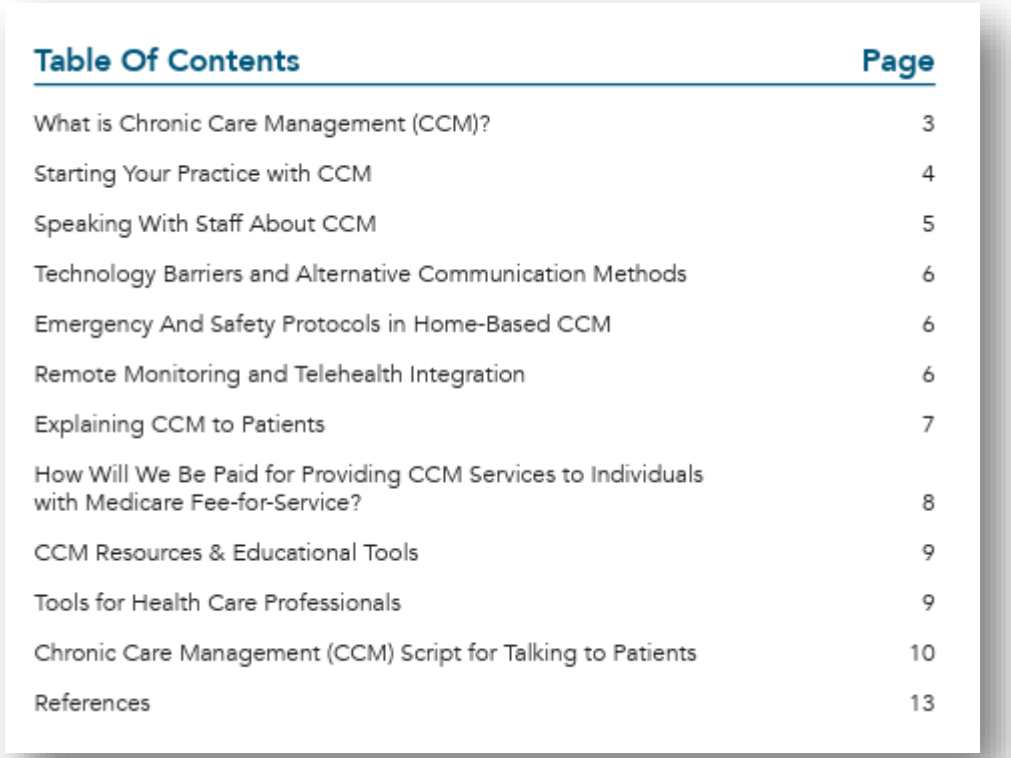


Next Steps

- ❑ **Watch *Crossroads of Care: Managing Serious Illness in the Home***
  - **Session 3:** Optimizing Efficiency in House Call Operations
  - **Session 4:** Contracting with Payers to Demonstrate the Value of Home-Centered Care
- ❑ **Attend Monthly Consult Meeting**
- ❑ **Register & Attend Webinar #3**

New Resources!

CCM Toolkit



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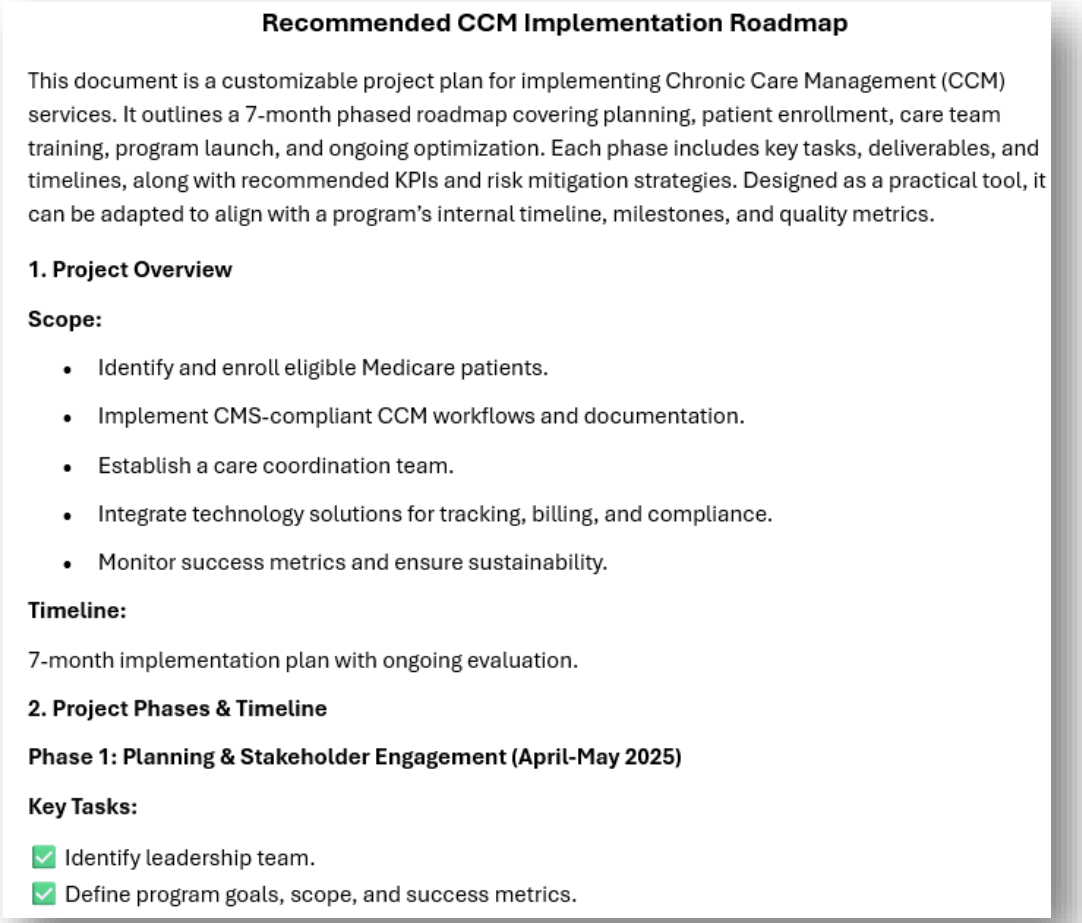
Recommended CCM Implementation Roadmap



Recommended CCM Implementation Roadmap

This document is a customizable project plan for implementing Chronic Care Management (CCM) services. It outlines a 7-month phased roadmap covering planning, patient enrollment, care team training, program launch, and ongoing optimization. Each phase includes key tasks, deliverables, and timelines, along with recommended KPIs and risk mitigation strategies. Designed as a practical tool, it can be adapted to align with a program's internal timeline, milestones, and quality metrics.

1. Project Overview

Scope:

- Identify and enroll eligible Medicare patients.
- Implement CMS-compliant CCM workflows and documentation.
- Establish a care coordination team.
- Integrate technology solutions for tracking, billing, and compliance.
- Monitor success metrics and ensure sustainability.

Timeline:

7-month implementation plan with ongoing evaluation.

2. Project Phases & Timeline

Phase 1: Planning & Stakeholder Engagement (April-May 2025)

Key Tasks:

✅ Identify leadership team.
✅ Define program goals, scope, and success metrics.

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Innovation Award: Webinar #3

Monitoring, Evaluating, and Measuring Success in CCM Implementation

Tuesday, July 22, 2025
10 – 11AM CST

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