Chronic Care Management for Community-Based Pharmacies
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Fee-For-Service (FFS): A system of health insurance payment in which a doctor or other health care provider is paid a fee for each particular service rendered. This is opposite of the quality payment models health care is moving toward.

Medicare Access and CHIP Reauthorization Act (MACRA) of 2015: Created the Quality Payment Program (QPP), which changes the way that Medicare, specifically part B, rewards clinicians for value over volume. MACRA created Merit Based Incentive Payments System (MIPS) and Advanced Alternative Payment Models (APMs).

Merit Based Incentive Payments System (MIPS): A payment approach that considers quality, resource use, clinical practice improvement activities, and advancing care information. MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.

Advanced Alternative Payment Models (APMs): A payment approach which incentivizes quality and value. Advanced APMs allow practices to earn more for taking on some risk related to patients’ outcomes. Examples of Advanced APMs are Accountable Care Organizations (ACOs) and Comprehensive Primary Care Plus (CPC+).

Accountable Care Organizations (ACOs): A group of doctors, hospitals, and other health care providers who come together voluntarily to provide coordinated high quality care to Medicare patients. The goal of coordinated care is to ensure patients, especially chronically ill patients, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

Patient-Center Medical Homes (PCMH): A care delivery model where patient treatment is coordinated through their primary care provider to ensure they receive the necessary care when and where needed. The objective is to have a centralized setting that facilitates partnerships between individual patients, and their personal providers, and the patient’s family when appropriate.

Comprehensive Primary Care Plus (CPC+): A national advanced primary care medical home (PCMH) model that seeks to improve quality, access, and efficiency of primary care. Additionally, CPC+ aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. The key functions of CPC+ focuses on 1) access and continuity; 2) care management; 3) comprehensiveness and coordination; 4) patient and caregiver engagement; and 5) planned care and population health. Pharmacists with a relationship with a CPC+ practice have the ability to contribute to these key functions.

Chronic Care Management (CCM): Non-face-to-face services primarily provided to Medicare beneficiaries who have two or more significant chronic conditions with the goal of providing care coordination and medication management based on an implemented patient-centered care plan. CCM is overseen by a qualified health care provider (QHP).

Qualified Health Care Professional (QHP): The only team members eligible to bill for CCM services. The patient’s primary care provider (i.e., physicians, nurse practitioners, physician assistants) is most often the QHP. The pharmacist partners with QHPs to provide CCM services under general supervision.

Evaluation and Management (E&M) Visit: A patient visit, which is the foundation of most providers’ practices. The visit is associated with a billable code that is based on three key components: patient history, physical exam, and medical decision making.
Pharmacy is familiar with medication management quality metrics for Medicare Part D Star Ratings Program, such as adherence measures, percent of comprehensive medication review completion, and high risk medications in the elderly. However, pharmacy as a whole, may be less familiar with quality payment reform that is occurring for Medicare Part B. Furthermore, pharmacy is well positioned to positively influence quality metrics for Quality Payment Programs (QPP) that the Centers for Medicare and Medicaid Services (CMS) have set forth which is a separate, new opportunity from the Medicare Part Star Ratings program metrics.

Fee-For-Service (FFS) payment models are focused on volume, growth, market share, and contract pricing; whereas, the new quality payment models are focused on quality, efficiency, partnerships, improving population health, per capita costs, and services.

FFS models focus on being paid for individual services performed and does not focus on what occurs prior to or after the service. Quality payment models are categorized as population management, which focuses on those individuals who are disengaged with the health care system in order to prevent or delay health complications. These models are displayed in the graphic below.

CMS has developed Alternative Payment Models (APMs) that have the following characteristics:

- Payment linked to effective management of a population or episode of care
- Opportunity for shared savings or 2-sided risk (shared risks)
- Payment for services
- Examples: Accountable Care Organizations (ACOs), Patient Centered Medical Homes (PCMH)

CCM offers a bridge between FFS and value-based reimbursement. CCM provides a FFS payment while still impacting population management with the goal of improving care.

We are moving from volume-based (i.e., FFS) to value-based health care

Ways for pharmacists to assist with value models:

- Improve payer and provider quality metrics
- Influence health outcomes for patients
- Conduct services, such as CCM

\[\text{Value} = \text{Health Outcomes Achieved Dollars Spent per Care Cycle}\]

Adapted from Harvard Business Review Webinar The Strategy that Will Fix Health care (20601)Featuring Harvard Business School
Quality Payment Reform

Understanding quality-based payment structures will allow you to be more familiar with the opportunities and challenges that practices face today. Many of the enhanced pharmacy services being offered by CPESN pharmacies can affect quality and patient outcomes.

Data is currently being collected and will affect payment structure based on quality of care provided beginning in 2019. Community-based pharmacy is in a prime position to help positively affect patient outcomes and decrease cost of care.

**CMS’ Quality Payment Program (QPP) provides practices the means and incentives to provide their patients high-value, high-quality, patient-centered care**

For practices who are not eligible or choose not to participate in Advanced Alternative Payment Models (APMs), CMS reimbursement rates will be determined by MIPS.

Many MIPS quality performance measure are impacted by medication management, which is a service component of CCM.

**Hint:** Ask providers what quality metrics they are trying to improve and educate them on how partnering with a pharmacy to provide CCM services may help improve the practice’s measured quality metrics.

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### Merit-based Incentive Payment System (MIPS)

**MIPS practices search tool**  

### Advanced Alternative Payment Models (APMs)

**Qualifying APM participant search tool**  
[https://data.cms.gov/qplookup](https://data.cms.gov/qplookup)

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### Sample 2017 MIPS Measures Impacted by Medication Management

<table>
<thead>
<tr>
<th>Quality Performance Measures</th>
<th>Clinical Practice Improvement Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Poor Control (&gt;9%)</td>
<td>Anticoagulant Management Improvements</td>
</tr>
<tr>
<td>Controlling High BP (&lt;140/90)</td>
<td>Implement Chronic Disease Self-Management Support Program</td>
</tr>
<tr>
<td>Medication Management in Patients with Asthma</td>
<td>Glycemic Management Services</td>
</tr>
<tr>
<td>IVD: Use of Aspirin or Other Antiplatelet Therapy</td>
<td>Medication Management Practice Improvements</td>
</tr>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
<td>Training and Waiver for Provision of Medication-Assisted Treatment of Opioid Dependence</td>
</tr>
<tr>
<td>Antidepressant Medication Management</td>
<td>Implementation of Antibiotic Stewardship Program</td>
</tr>
<tr>
<td>Falls: Screening for Future Falls Risk</td>
<td>Statin Therapy for the Prevention and Treatment of CV Disease</td>
</tr>
<tr>
<td>Medication Reconciliation Post-Discharge</td>
<td></td>
</tr>
</tbody>
</table>

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For practices who are not eligible or choose not to participate in Advanced Alternative Payment Models (APMs), CMS reimbursement rates will be determined by MIPS.
The Centers for Medicare and Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals. In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions.

CCM is reimbursed through the Medicare Fee-For-Service Program, which is also known as Original Medicare. Furthermore, pharmacists are able to provide CCM services under a formal partnership with a qualified health care professional (QHP) who is able to bill for the services.

CCM services consist of at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional (QHP), per calendar month, with meeting the following required elements:

1. Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
2. Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
3. Comprehensive care plan established, implemented, revised, or monitored

To qualify for CCM reimbursement, the patient must meet all of the required elements.

Medication / Pharmacy Spend

- CCM is reimbursed from the “Medical / Non-Pharmacy Spend,” not the 10% “Medication/Pharmacy Spend.”
- Most of community-based pharmacy is currently reimbursed from the Medication/Pharmacy Spend.
- Many of the efforts, such as the enhanced services that CPESN® pharmacies are offering, decrease spending on the medical spend.
- Community-based pharmacies are in a prime position to offer CCM services in collaborative efforts with a provider.

### 2 Types of CCM

1. Non-complex CCM
2. Complex CCM

**Similarities:**
- Common set of service elements

**Differences:**
- Amount of clinical staff service time
- Involvement and work of billing provider
- Extent of care planning performed
Non-Complex CCM and Complex CCM Common Service Set Elements

- Coordination with Home - and Community-Based Clinical Service Providers
- Comprehensive Care Management and Care Planning
- Continuity of Care with Designated Care Team Members
- Use of a Certified Electronic Health Record
- Enhanced Communication (e.g., e-mail)
- Transitional Care Management
- 24/7 Access to Address Urgent Needs
- Patient consent

Non-Complex CCM and Complex CCM Differences

**Non-Complex CCM:** 20 minutes must be spent in patient care. Reviewing the patient’s chart and coordinating care with other health care professionals can count toward documented clinical staff time. The monthly CCM payment anticipates that in addition to the 20 minutes in patient care, the billing provider spends approximately 15 minutes for ongoing oversight, direction and management.

**Complex CCM:** 60 minutes, minimally, must be spent in patient care. Reviewing the patient’s chart and coordinating care with other health care professionals can count toward documented clinical staff time. The monthly CCM payment anticipates that the billing practitioner spends approximately 26 minutes of work in ongoing oversight, direction and management and also, medical decision making of moderate to high complexity with establishment or substantial changes to the patient’s comprehensive care plan.
Chronic Care Management Background Codes

Non-Complex CCM
- Billing Code: CPT 99490
- At least 20 minutes of clinical staff time directed by a physician or other qualified health care provider (QHP), per calendar month
  Approximate CMS Payment Per Member Per Month: $43

Complex CCM
- Billing Code: CPT 99487
- At least 60 minutes of clinical staff time directed by a physician or other QHP, per calendar month
  - Establishment or substantial revision of a comprehensive care plan
  - Moderate or high complexity medical decision making
  Approximate CMS Payment Per Member Per Month: $94

Additional 30-minute CPT code for Complex CCM: 99489
- Complex CCM is eligible for 30 minutes of billable add-on time to the 60 minutes per month
- Each additional 30 minute of clinical staff time directed by a physician or other QHP per calendar month (list separately in addition to code for primary procedure)
- CPT 99489 cannot be reported for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM
  Approximate CMS Payment Per Member: $47

G0506
- The billing practitioner (i.e., the QHP) who furnishes a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code G0506 (Comprehensive assessment of and care planning by the physician or other QHP for patients requiring CCM services)
  Approximate One-Time CMS Payment Per Member: $64

*Approximate CMS Payment is dependent on geographical location. For exact payment, please refer to https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/
Additional Information for CCM Codes

- CCM codes (CPT 99487, 99489, and 99490) are assigned in the general supervision category under Medicare Physician Fee for Service (PFS).
  - General supervision means that the service is furnished under the physician’s overall direction and control, but the physician’s presence is not required.
- CCM codes are not billed by the pharmacist. They are billed by the physician or other QHP who is supervising the work of the pharmacist.
- The QHP cannot bill for the 30-minute add-on to Complex CCM (CPT 99489) for care management services of less than 30 minutes in addition to the first 60 minutes of complex CCM services during a calendar month.
  - CCM services that are more than 20 minutes but less than 60 minutes in duration within a calendar month are considered non-complex CCM.

**CCM codes cannot be billed by the QHP during the same month as the following codes:**

- Transitional Care Management (TCM): CPT 99495, 99496
- Home Healthcare Supervision: HCPCS G0181
- Hospice Care Supervision: HCPCS G9182
- Certain ESRD services: CPT 90951 - 90970

- 90 minutes of CCM services that are provided in a calendar month that meet the requirements of Complex CCM:
  - The QHP should bill 2 codes: CPT 99487 (60 minutes for Complex CCM) and CPT 99489 (30-minute add-on to Complex CCM).
- CCM services provided by the care team within a federally qualified health center or a rural health clinic can only billed by the provider for 20 minutes of non-complex CCM (CPT 99490) per month.
CCM for Rural Health Centers and Federally Qualified Health Centers

- QHPs may bill CCM services at Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC).
- Beginning January 1, 2017 through December 31, 2017, the non-complex CCM code (CPT code 99490) could be billed for 20 minutes of CCM services under general supervision, instead of direct supervision.
- Effective January 1, 2018, RHCs and FQHCs are to bill CCM using a General Care Management code (G0511) instead of the CPT code 99490.
- RHC or FQHC claims submitted using CPT 99490 for dates of service on or after January 1, 2018, will be denied.

**RHC and FQHC Code for CCM Billing**

- Billing Code: G0511
- At least 20 minutes of clinical staff time directed by a physician or other qualified health care provider (QHP), per calendar month
- Must meet all requirements that the standard CCM code (CPT 99490) must meet
- RHC and FQHC face-to-face requirements are waived for the purposes of CCM.

2018 CMS Payment Per Member Per Month: $62.28

- The payment amount is set at the average of 3 national non-facility physician fee schedule (PFS) payment rates. The rate is updated annually based on the PFS amounts and does not have geographic adjustment.
- Similar to the other CCM codes, G0511 can only be billed once per month per beneficiary.
- G0511 may be used alone or with other payable services with RHC and FQHC claim.
- G0511 may not be billed by the QHP during the same month as other care management services are billed, which are the TCM, home healthcare or hospice care supervision, or certain ESRD codes, which are listed on Page 9.
Where is CCM performed?

- CCM services are being overseen and coordinated from the medical office but may be largely provided elsewhere (i.e., community-based pharmacy). An agreement must be established between the pharmacy and the billing provider.
  - Performing CCM services remotely from a community-based pharmacy may make more economical sense from the community-based pharmacy perspective.
- CCM can be performed in a clinic with a pharmacist working in the practice.
  - If performing in a practice, you are more likely to be more involved with services in addition to CCM, such as annual wellness visits, diabetes care, weight loss programs, etc.
- EHR access to patient information in the provider practice makes delivery of CCM services much easier for community-based pharmacies but is not required.
- Even though not required, having EHR access makes CCM services more efficient and thorough.
  - A benefit of having access to an EHR gives the pharmacy more information about the patient and the pharmacy can better coincide efforts with the practice.

Questions to consider before beginning CCM

- Is your pharmacy staff ready to start CCM?
- Are services that you are already providing aligning with the goals of CCM? Do those services benefit the patient directly and the provider practice and/or pharmacy practice indirectly?
- Do you have a good relationship with a provider in the area?
- Do you have an established medication adherence program in which you are following-up with the patient monthly and asking clinical health condition questions to ensure the patients aren’t just taking their medications, but they are actually showing improved outcomes?
- Are you talking with patients monthly that assists with coordination of care (i.e., initiating the prior authorization process, discussing screenings due, immunizations)
- Do you provide Medication Therapy Management services and comprehensive medication reviews to your patients?
When partnering with a qualified health care professional (QHP) to provide CCM to patients, productivity-based revenue should be considered for the services that the pharmacy and the practice are providing. After a working relationship has been established, discuss the contributions of each party involved while developing the provider agreement. Within the agreement, decide upon the extent of services that the pharmacy and the practice will be providing. Then develop a productivity-based revenue stream, so that the pharmacy is reimbursed for services being provided. In the chart below, an example is provided based on the varying percentages each team member is contributing. Actual total revenue will depend on the percentage of services provided by each team member and the CCM reimbursement amount for the practice because quality performance taken into account and the region of the practice’s location.

### Chart

<table>
<thead>
<tr>
<th>QHP Practice %</th>
<th>Clinical Staff %</th>
<th>QHP Practice</th>
<th>Clinical Staff (i.e., pharmacist)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10%</td>
<td>90%</td>
<td>$5,112</td>
<td>$46,008</td>
</tr>
<tr>
<td>20%</td>
<td>80%</td>
<td>$10,224</td>
<td>$40,896</td>
</tr>
<tr>
<td>30%</td>
<td>70%</td>
<td>$15,336</td>
<td>$35,784</td>
</tr>
<tr>
<td>40%</td>
<td>60%</td>
<td>$20,448</td>
<td>$30,672</td>
</tr>
<tr>
<td>50%</td>
<td>50%</td>
<td>$25,560</td>
<td>$25,560</td>
</tr>
<tr>
<td>60%</td>
<td>40%</td>
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</tr>
</tbody>
</table>

Assumes 100 patients receiving Non-Complex CCM services at $42 per patient per month for a total revenue per year of $51,120.

If a pharmacy provides 20 minutes per month for these 100 patients, this is equal to 33.33 hours per month that should be dedicated to CCM.
Structured Recording of Patient Health Information

- Patient’s demographics, full list of problems, medications, and medication allergies must be utilized in the care plan, care coordination, and ongoing clinical care.
- Certified Electronic Health Record (EHR) acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year. Additional information may be found at: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms
- Required for core clinical information (demographics, problems, medications, medication allergies), but certified technology no longer required for other CCM documentation.
- Fax can be used to communicate care plan information as long as it is available timely (meaning promptly at an opportune, suitable, favorable, useful time).

Comprehensive Care Plan

- A person-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources.
- This plan should be comprehensive for all health issues with a particular focus on chronic conditions.
- Patient and/or caregiver must be provided a copy of the care plan.
- Ensure the electronic care plan is available and shared in a timely manner within and outside the billing practice to individuals involved in the patient’s care.
- Care planning tools and resources are publicly available.

See example template on Pages 37 - 39

Comprehensive care plans typically include, but not limited to:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Medication management
- Planned interventions and identification of individuals responsible for each intervention
- Community/social services ordered

These 2 CCM service components are the ones that a QHP must have in place to oversee the delivery of CCM.
CCM Service Components

Access to Care and Care Continuity
- Provide 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other QHPs or clinical staff. Also, ensure patients and/or caregivers with a means to contact health care professionals in the practice to address urgent needs regardless of the time of day or day of week.
- Ensure continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient’s care by telephone and also through secure messaging, secure internet, and/or other asynchronous non-face-to-face consultation methods (e.g., email, secure electronic patient portal).

Comprehensive Care Management
- 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
- Oversight of patient self-management of medications
- Coordinating care with home- and community-based clinical service providers

Transitional Care Management
- Manage transitions between and among health care providers and settings, including referrals to other clinicians, follow-up after an emergency department visit, or facility discharge
- Timely create and exchange/transmit continuity of care document(s) with other practitioners and providers
### CCM Implementation Steps

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify provider partnership</td>
</tr>
<tr>
<td>2</td>
<td>Initiate provider agreement discussions that lead to a signed agreement</td>
</tr>
<tr>
<td>3</td>
<td>Ensure compliance</td>
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<tr>
<td>4</td>
<td>Determine ability to access practice’s electronic health record</td>
</tr>
<tr>
<td>5</td>
<td>Analyze pharmacy management system for CCM compatibility</td>
</tr>
<tr>
<td>6</td>
<td>Identify pharmacy employees and provider office staff</td>
</tr>
<tr>
<td>7</td>
<td>Establish patient referral and follow-up</td>
</tr>
<tr>
<td>8</td>
<td>Identify patients to target for CCM</td>
</tr>
<tr>
<td>9</td>
<td>Obtain patient consent</td>
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<tr>
<td>10</td>
<td>Create a patient-specific comprehensive care plan</td>
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<tr>
<td>11</td>
<td>Conduct CCM services and Document CCM time</td>
</tr>
<tr>
<td>12</td>
<td>Provide CCM time documentation to billing provider’s office</td>
</tr>
</tbody>
</table>
1. **Identify provider partnership**
   - Must be providers who accept Medicare
   - Avoid providers whose main population is pediatrics—they are not Medicare recipients.
   - Approach a LOCAL provider with whom you have an established good relationship. Approaching a provider with the most mutual patients may be beneficial in providing CCM within the pharmacy. Patients do not need to receive prescriptions at the pharmacy in order to provide CCM on behalf of the local provider.
   - Reach out to providers who share a common goal with you.

2. **Initiate provider agreement discussions that lead to a signed agreement**
   - Be prepared to answer questions about your specific purpose for the agreement (e.g., what services you will be providing, how this can improve outcomes for patients).
   - Inquire about quality performance measures the practice needs to improve. Offer services that you can provide to address those measures, while meeting the CCM criteria.
   - A provider agreement is **not** a collaborative practice agreement and does not expand the pharmacist’s scope of practice. Pharmacists are already doing many of the care coordination efforts that CCM requires. The agreement outlines shared responsibilities between the provider and the pharmacy.
   - A provider agreement is necessary for CCM to be delivered through a community pharmacy on behalf of a physician or QHP.

   See Pages 21 - 25: “Guidance for Establishing a Provider Agreement for CCM”

3. **Ensure compliance**
   - Centers for Medicare and Medicaid Services’ CCM regulations
   - State regulations for provider ability to delegate/supervise pharmacists (i.e., some states may allow a nurse practitioner to delegate/supervise a pharmacist and others may not)
   - CPC+ regulations: CPC+ participating practices cannot bill for the same services using the CCM code under the Physician Fee Schedule. If the Medicare beneficiary is not attributed to the practice for purposes of the CPC+ model, the CPC+ practice may bill for CCM.
     - Determine if practice is CPC+:
       - [https://data.cms.gov/Special-Programs-Initiatives-Speed-Adoption-of-Bes/Comprehensive-Primary-Care-Plus/eevd-hiep](https://data.cms.gov/Special-Programs-Initiatives-Speed-Adoption-of-Bes/Comprehensive-Primary-Care-Plus/eevd-hiep)
   - HIPAA regulations: Information can be shared between the pharmacy and provider for treatment of an individual patient. Ensure all privacy rules are reviewed and obtain signed consent when applicable before sharing patient information with any entities that are uncovered.

4. **Determine ability to access practice’s electronic health record**
   - Need to know if the EHR is a cloud-based or server-based EHR.
   - Server-based EHRs will require you to be in the clinic to work-up patients.
   - If no EHR access is granted, you may continue to perform CCM activities but a method of communicating information will need to be established.

   See table on Pages 30 - 34 for implementation based on accessibility of information.
5. Analyze pharmacy management system for CCM compatibility
- Identify a third party CCM platform to assist with time tracking and documentation, if needed.
- Check with your pharmacy management system to see if they offer the service.
- CPESN USA will regularly inform CPESN pharmacies with a list of current vendors who offer CCM capabilities. CPESN pharmacies with immediate questions, please contact Cody Clifton (cclifton@cpesn.com).

6. Identify pharmacy and provider office staff
- In order for any program to be successful, the appropriate staff members must be identified.
- Define personnel roles
  - Pharmacists: provide at least 20 minutes of CCM in collaboration with provider
  - Student Pharmacists: Assist pharmacist in providing CCM services with pharmacist’s supervision.
  - Pharmacy Technicians: Technicians can do technical work to set up the encounter, but technicians’ time cannot count toward the contracted CCM time
  - Provider office: provider, medical assistants, nurses, case managers, billing manager

See Page 26 for ideas with identifying the right staff.

7. Establish patient referral and follow-up
- Discuss with the provider how patient referrals to receive CCM services will be administered
- Utilize a list or a CCM vendor’s software to ensure patients receive follow-up each month

8. Identify patients to target for CCM
- Focus on patients with multiple chronic conditions at an increased risk for hospitalization. This assists in providing the minimum 20 minutes for the billable CCM code as these patients are likely to be more complex patients.
- Start by focusing on certain diagnoses for patients (e.g., diabetes, heart failure, COPD). This can help streamline patients who are enrolled.
- Patients must meet the following:
  1. 2 or more chronic conditions that are expected to last ≥ 12 months or until death
  2. Places patient at significant risk of death, acute exacerbation/decompensation, or functional decline
9 **Obtain patient consent**
- Patients can provide verbal or written consent.
- Consent must be documented within the patient’s medical record at the billing provider’s location.

See “Patient Enrollment Process” on Pages 27 - 28 to understand required.

10 **Create a patient-specific comprehensive care plan**
- The patient-specific care plan should be 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, with particular focus on the chronic conditions being managed).
- The QHP must create the initial care plan.
- A pharmacist may make updates to the care plan and communicate to the provider in a timely manner in order for the updated care plan to be reviewed and signed by the provider.

11 **Conduct CCM Services and Document CCM Time**
- Document non-face-to-face time with patient
  - Phone calls; secure email; coordinating care with other clinicians, facilities, community resources, and caregivers; medication management & reconciliation
  - The minimum time for CCM billing does not have to be completed in one patient encounter and may be collected over a 30-day period. Add up all documented time at the end of the month before sending to billing provider by utilizing a spreadsheet or CCM software vendor
    - Example - Reviewed labs: 5 min.; counseled on new drug: 7 min.; provided diabetes education: 10 min.; CCM billing period time: 23 min.
- Time is just one component for meeting CCM requirements. If 60 minutes are achieved for a patient per month, ensure that all complex CCM requirements are met.

12 **Provide CCM time documentation to billing provider’s office**
- Determine with the provider an agreed upon time for the billing provider’s office to receive documented CCM time for billing purposes (i.e., at the end of the calendar month or when the time requirement for a non-complex CCM or complex CCM has been met).
## Types of Practitioners

<table>
<thead>
<tr>
<th>Direct Supervision: physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. Does not mean the physician must be in the room</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>General Supervision: procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required</th>
</tr>
</thead>
</table>

- Community-based pharmacy—physician partnerships for providing CCM services can be performed under general supervision.

### Eligible Practitioners

- Medical Doctors
- Nurse Practitioners
- Physician Assistants
- Clinical Nurse Specialists
- Certified Nurse Midwives

- Only one practitioner may be paid for CCM services for a given calendar month and must only report either complex or non-complex CCM.

- CCM services are typically billed by primary care practitioners. However, under certain circumstances, specialty practitioners may bill for CCM.

### Ineligible Practitioners

- Clinical Psychologists
- Podiatrists
- Dentists

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CCM is not within the scope of practice of limited license physicians and practitioners. Please refer or consult with eligible practitioner.
Getting In the Door

- **Start with the practitioners you and your patients know.** Talk first with practitioners with which you share mutual patients.

- **Befriend the gatekeeper.** Building positive rapport with the clinical coordinator and nursing staff by bringing in lunch or snacks for the office staff to show your appreciation is valuable.

- **Send providers material to review on their own schedule.** If an in-person meeting is not conducive, send material via e-mail and mail for the clinical team to review.
  - Follow up and provide responses to questions and inquiries.
  - Keep material simple and compatible on all devices (if electronic).

- **Socialize and build relationships.** Look for shared interests (golf, tennis, sports, cookouts, etc.) and invite the practitioner to a social activity. This will give you the opportunity to get to know one another and understand each practice’s needs.

Making the Pitch

- **Know and state your purpose of the visit.** There are many reasons why you would visit local prescribers in your area—increase CCM program referrals, expedite the short fill and refill request process, look for collaborative opportunities, etc. Be clear with your message and focus on takeaways.

- **Educate on Chronic Care Management and pharmacy enhanced services.** Mention the importance of CCM to quality metrics. Mention all the services that your pharmacy offers and what makes you different (e.g., delivery, adherence packaging, comprehensive medication reviews, and other services) that may help improve the patient’s health. Another good point is that the pharmacy will be proactively contacting patients once a month, at the very minimum, to provide coordination of care services. This may likely decrease phone calls from patients to the provider’s office.

  - **Highlight provider benefits.** Focus on the improved workflow with more streamlined communications from the pharmacy. Improving quality and patient outcomes is just as important for providers as pharmacists.

  - **Identify ways to partner together.** Ask if there are any other ways your pharmacy could help care for their chronically ill patients.

Derived from National Community Pharmacists Association
Guidance for Developing a Provider Agreement for CCM

Framework for a Successful Provider Partnership

**Purpose:** This is a guide for pharmacists within CPESN networks who want to initiate and/or formalize relationships surrounding provider partnership with local providers.

**Background:** Published evidence supports the role of pharmacists as essential members of the interdisciplinary health care team and emphasizes that pharmacists are well positioned to perform medication- and wellness-related interventions that improve patient outcomes.

### Common Goals

- **For patients:** A product, service, experience, or added value that motivates the patient to take action that will improve health.
- **For health care providers:** Appropriate compensation for products and services provided.
- **For payers:** Minimizing total health care expenditures while providing high quality, necessary services.

### Provider Partnership and Agreement

#### Improved Patient Care

- As pharmacists, patients, and other health care team members work together, patient health outcomes improve.
- Combined efforts of tracking progress and reporting outcomes ensures all members of the health care team are aware of the patient impact.

#### Reduced Health Care Costs

- The aligned incentive for the health care system is similar to that for payers: control overall health care costs.
- Improved health status ultimately decreases health care costs.

### KEY COMPONENTS TO A SUCCESSFUL PROVIDER PARTNERSHIP

- Use consistent terminology and language that is readily understandable by all potential audiences.
- Ensure each involved party understands their responsibility for the critical components of the agreement.
- Incentivize and facilitate the adoption of electronic health records and the use of technology in pharmacists’ patient care services.
- Encourage pharmacists to maintain strong, trusting, and mutually beneficial relationships with patients, physicians, and other providers; encourage those individuals to promote pharmacists’ patient care services.
- Properly align incentives based on meaningful process and outcome measures for patients, payers, providers, and the health care system.
What are the necessary components for a legal document outlining a provider agreement?

- Introduction to a Provider Agreement
  - Provide a short description of the purpose of the relationship/agreement.

- Detailed Information of Involved Parties
  - Include detailed contact information and licensure information of each party involved.
    - Example: name, license number, work telephone, mobile telephone, fax number, emergency contact information, etc.

- Description of Specifically Agreed Upon Roles and Responsibilities
  - This should be one of the more robust areas of the agreement and include granular detail of the roles and responsibilities of each party.
  - Critical responsibilities include:
    - Training / Education
      - All responsible parties will remain up-to-date on competencies, knowledge, and regulations for the agreed upon service offering(s).
    - Documentation
      - Documentation may include record keeping in both the Pharmacist eCare plan and the electronic health record (EHR). Typically, documentation includes accurate and timely note taking describing interactions with patients.
      - As part of any agreement, include where the documentation must be kept and by what method documentation must be performed and communicated (e.g., within the EHR, utilizing a vendor, or faxing).
    - Communication
      - Describe what is expected of both parties to communicate, by what means communication occurs, and how often participating parties will interact (e.g., HIPAA compliant communication methods for patient data, etc.).
Description of Specifically Agreed Upon Roles and Responsibilities (continued)

- Clearly describe the services of the pharmacist and other members in the partnership.
  - Reference appropriate practice guidelines and regulations.
  - Example:

<table>
<thead>
<tr>
<th>Patient Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mutual Agreement</strong></td>
</tr>
<tr>
<td>1. Prepare patient for collaborative care management by explaining the relationship between primary care and community-based pharmacy</td>
</tr>
<tr>
<td>2. Consider patient/family choices in care management, diagnostic testing and treatment plan</td>
</tr>
<tr>
<td>3. Provide to and obtain informed consent from patient according to community standards</td>
</tr>
<tr>
<td>4. Explores patient issues on quality of life in regards to their specific medical condition and shares the information with the care team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Practice</strong></td>
</tr>
<tr>
<td>☐ Explain to community-based pharmacy results and care plan to patient, as necessary</td>
</tr>
<tr>
<td>☐ Identify the patient’s care team and communicate to community-based pharmacy</td>
</tr>
<tr>
<td><strong>Community-Based Pharmacy</strong></td>
</tr>
<tr>
<td>☐ Further educate patient on disease state management</td>
</tr>
<tr>
<td>☐ Identify and recommend appropriate follow-up with PCP, as necessary</td>
</tr>
<tr>
<td>☐ Participate with patient care team</td>
</tr>
<tr>
<td>☐ Screen for care management needs and make referral to care manager as identified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Structured Recording of Patient’s Health Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mutual Agreement</strong></td>
</tr>
<tr>
<td>☐ Ensure patient’s information is being recorded and communicated between settings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Practice</strong></td>
</tr>
<tr>
<td>☐ Record updates provided by community-based pharmacy into patient’s chart</td>
</tr>
<tr>
<td>☐ Share updated care plan information with community-based pharmacy in a timely manner</td>
</tr>
<tr>
<td><strong>Community-Based Pharmacy</strong></td>
</tr>
<tr>
<td>☐ Receive care plan in a timely manner via EHR access or fax</td>
</tr>
<tr>
<td>☐ Communicate via secure messaging (e.g., EHR, fax, phone) about care plan objectives achieved or any questions surrounding care plan objectives</td>
</tr>
</tbody>
</table>
Billing for services and Compensation
- Discuss the codes that the responsible party (i.e., practice) will bill.
- Discuss the pharmacy’s responsibility in providing documentation for billing purposes.
- Determine services for which pharmacy will be reimbursed as well as what rates.
- Determine how services and payments will be tracked and billed.
  - Determine if the payment will be fee-for-service or fee-for-performance.
  - Outline when the practice is obligated to pay the pharmacy.

Indemnification
- Understand the scope of indemnification. Make sure the risk is appropriately balanced for each party.

Insurance
- Outline the minimum liability insurance necessary to maintain for each party.

Termination
- Discuss that the agreement will begin on the effective date and continue for a 12-month period.
  The agreement will automatically renew after 12 months unless terminated earlier.
- Discuss under which circumstances the agreement will be terminated via a written notice.
- Discuss termination due to a breach of contract.

Record Retention
- Provide a statement that addresses each signatory must keep a copy of the agreement always.
- Determine the necessary documentation of care for each party.
- Determine the party responsible for record retention and the amount of time records should be retained.

Independent Contractor
- Discuss that the pharmacy is working as an independent contractor of services.

Confidentiality of Information: HIPAA Compliance
- Each party agrees not to disclose information outlined within the agreement to an outside entity without approval from the other party.
Business Associates Agreement (BAA)

- The Privacy Rule allows covered providers and health plans to disclose protected health information to these “business associates” if the providers or plans obtain satisfactory assurances that the business associate will use the information only for the purposes for which it was engaged by the covered entity, will safeguard the information from misuse, and will help the covered entity comply with some of the covered entity’s duties under the Privacy Rule. Covered entities may disclose protected health information to an entity in its role as a business associate only to help the covered entity carry out its health care functions – not for the business associate’s independent use or purposes, except as needed for the proper management and administration of the business associate.

Governing Laws and Regulations

- Understand state and federal laws and regulations surrounding scope of pharmacy practice and abide by the laws outlined.

Acknowledgement/Signature

- All key participants must acknowledge and sign the agreement.

*If your CPESN pharmacy needs additional resources for developing a provider agreement for CCM, please contact Cody Clifton (cclifton@cpesn.com).
Identify Pharmacy and Provider Office Staff

**Ideal Pharmacy and Provider Office Staff to Assist in CCM**

- Pharmacists trained and comfortable in delivering Medication Therapy Management
- Pharmacists who have clinical interests and willing to help with care coordination within patient care teams
- Pharmacists who stay up-to-date on continuing education surrounding chronic conditions
- Pharmacy staff who already assist with medication synchronization and/or medication adherence programs (e.g., appointment-based models)

- Pharmacy technicians who are willing to assist pharmacists in collecting socioeconomical and clinical data
- Team members who understand the changes in our current pharmacy and health care industry and are willing to learn and adopt the new payment models
- Pharmacy staff who are not intimidated with learning new technology platforms
- Pharmacy clerks and pharmacy technicians may assist with scheduling patients for CCM calls.
- Student pharmacists can be leveraged to assist with efficiently providing CCM services to patients under the supervision of a pharmacist
Patient Enrollment Process

**Initiating Visit**

- New patients or patients not seen within one year prior to commencement of CCM, Medicare requires initiation of CCM services during a face-to-face visit with the billing provider (Annual Wellness Visit [AWV] or Initial Preventive Physical Exam [IPPE], or other face-to-face visit with the billing practitioner). This initiating visit is not part of the CCM service and is separately billed.

- Providers who furnish CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code also can bill HCPCS code G0506, which is reportable once per CCM billing provider, in conjunction with CCM initiation.

**Patient Consent**

- Advance consent ensures the patient is engaged and aware of the service and applicable cost sharing. The patient knowing that he/she is receiving CCM with a specific provider, may also help prevent duplicative provider billing.

- Patient consent must be documented prior to providing CCM services or prior to CCM billing.

- Consent may be verbal or written, but must be documented in the provider’s medical record.

- Verbal and written consent must include the following information:
  - The availability of CCM services and applicable cost-sharing
  - Only one provider can furnish and be paid for CCM services during a calendar month
  - The right to stop CCM services at any time (effective at the end of the calendar month)

- Informed patient consent needs to only be obtained one time prior to furnishing CCM, or if the patient chooses to change providers who will furnish and bill CCM

- Cost-sharing (i.e., the 20% copayment for Medicare) applies to the CCM service, but many patients may have supplemental insurance or are dual eligible to cover the costs of the copayment.
The text below outlines ways that provider offices can discuss the CCM enrollment process with patients.

- Identify patients who have 2+ chronic conditions through appointments and workflow
- State the purpose of CCM
  - Improve patient care, reduce hospitalizations, improve control of chronic conditions, coordinate care, and promote appropriate use of medications
- Explain how CCM will benefit the patient
  - Patient-centered care plans for difficult-to-manage chronic diseases
  - At least 20 minutes per month of CCM services
  - Coordination of care between your pharmacy and physician appointments
  - 24/7 emergency access to a healthcare professional
  - Assistance with setting and meeting goals
- Explain that CCM is covered by Medicare
  - Copays are usually covered by Medicare supplements or those patients who also have Medicaid
  - 20% copay for Medicare only (approximately $8)
- State the four requirements for consent (obtain verbal consent and document in the EHR)
  - Overview of how to access the services
  - Costs will be shared between insurance provider and patient (80/20)
  - Only one practitioner can provide at a time
  - Patient can opt out at any time and services will cease at the end of the month that they opt out

Examples of ways to begin the conversation:

“I’d like to discuss a program that may help you better control your [insert conditions]. The program will aim to improve control of your condition(s), reduce your risk of being hospitalized and optimize your medication regimen.”

“You will have more direct access to the health care team with at least 20 minutes of chronic care management services being dedicated to improving your health each month. [Insert pharmacy name] will be assisting our office in offering these services to you. This will be helpful for the time in between office visits, which aims to make sure you are receiving the best care outside of the time that you’re visiting us at the medical office.”
Create a Patient-Specific Care Plan

Chronic Care Management Components:

- Patient Consent
- Collect Structured Data
- Care Plan
- Manage Care
- Provide 24/7 Access to Care
- Bill for CCM Services

Care Plan Components:

- 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

The QHP should establish the care plan which may involve pharmacists or other health care professionals on the team. For each chronic condition, there should be a plan of care and each should be matched with the patient’s goals. Each condition should be addressed throughout the course of time the patient is enrolled in CCM services, but every condition may not be addressed at each CCM encounter.

Patient needs and/or challenges (i.e., assess functional, psychosocial, and medical needs) should be associated with solutions or a plan of action.

<table>
<thead>
<tr>
<th>Example conditions in</th>
<th>Status (stable/unstable)</th>
<th>Plan of Action / Symptom Management</th>
<th>Associated Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2 Diabetes</td>
<td>Unstable—A1c &gt; 7%</td>
<td>May be filled in by provider initially and pharmacist when revising/updating</td>
<td>May be filled in by provider initially and pharmacist when revising/updating</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Stable</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>
The table below is an overview of the tables on Pages 31 - 34. The charts on the following pages outline each CCM component, the CCM component detail, ideas on how to implement the service based on whether the pharmacy has access to the EHR, and who can provide the service.

**Definitions:**

**Qualified Health Care Professional (QHP):** The only team member eligible to bill for CCM services. The patient’s primary care provider (i.e., physicians, nurse practitioners, physician assistants) is most often the QHP.

**Clinical Staff:** The terminology used by CPT for the licensed practitioner who can assist in the delivery of services, under general supervision by a QHP. A pharmacist is considered clinical staff.

**Non-clinical Staff:** Any personnel who are not QHPs or clinical staff. Time cannot be counted toward CCM time. These individuals may help facilitate service delivery to help maximize the clinical staff’s time with the patient.

<table>
<thead>
<tr>
<th>CCM Component</th>
<th>Qualified Health Care Professional (Provider)</th>
<th>Clinical Staff (Pharmacist)</th>
<th>Non-clinical Staff (Pharmacy Technician)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Consent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collect Structured Data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop Comprehensive Care Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manage Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide 24/7 Access to Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bill for CCM Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide Support Services to Facilitate CCM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The boxes that are blue colored reflect the team member(s) able to provide the respective CCM component.
## Practical Implementation of CCM Service Components

<table>
<thead>
<tr>
<th>CCM Component</th>
<th>CCM Component Detail</th>
<th>Pharmacist/Provider Activities</th>
<th>Accessibility of Information</th>
<th>Main Team Member</th>
</tr>
</thead>
</table>
| **Patient Consent** | Ensure patient has had a visit in past year: AWV, comprehensive E/M, IPPE, or TCM visit where CCM was discussed | *New patients or patients not seen in the past year:* obtain verbal or written consent at a face-to-face initiating visit (AWV, comprehensive E/M, IPPE, TCM)  
*Patients who have been seen in the past year:* obtain consent via phone or email  
Page 28 lists required information which should be discussed with the patient. You may want to share the requirements with the provider and/or create a CCM patient handout for the provider to give to the patients. | Provider documents consent in EHR | Provider |
| **Collect Structured Data** | Demographics  
Problems  
Medications  
Allergies | Access the EHR to locate this information. Additionally, collect from the patient and other sources.  
As the pharmacy offers CCM services to the patient, ensure that structure data is being updated within the patient’s EHR | *EHR access:* update structured data as needed within the patient’s EHR and care plan.  
*No EHR access:* If structured data updates are collected during a CCM encounter and differs from the information in the care plan, communicate to the provider the updated data on a regular basis using established communication methods. | Provider, Pharmacist or Pharmacy Staff |
### Practical Implementation of CCM Service Components

<table>
<thead>
<tr>
<th>CCM Component</th>
<th>CCM Component Detail</th>
<th>Pharmacist/Provider Activities</th>
<th>Accessibility of Information</th>
<th>Main Team Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical, mental, cognitive, psychosocial, functional and environmental assessment</td>
<td>Problem List</td>
<td>The provider establishes the care plan. The pharmacist reviews the care plan and makes revisions based on management/monitoring of the patient.</td>
<td>Document updates/revisions to the care plan established during CCM services</td>
<td>Provider for the development of the care plan</td>
</tr>
<tr>
<td>Expected outcome and prognosis</td>
<td>Expected outcome</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measurable treatment goals</td>
<td>Measurable treatment goals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptom management</td>
<td>Symptom management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned interventions and identification of individuals responsible for each intervention</td>
<td>Planned interventions and identification of individuals responsible for each intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication management</td>
<td>Medication management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/social services ordered</td>
<td>Community/social services ordered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of how services of agencies and specialists will be directed/coordinated</td>
<td>Description of how services of agencies and specialists will be directed/coordinated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule for periodic review and revision of care plan</td>
<td>Schedule for periodic review and revision of care plan</td>
<td>As the care plan is updated, communicate any updates with the provider on a scheduled basis (e.g., at the end of the month)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide patient with copy</td>
<td>Provide patient with copy</td>
<td>Send to patient portal or print a copy at check out. Pharmacist can print care plan and provide patient with a copy. Document when mailed or delivered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure care plan available electronically to healthcare team</td>
<td>Ensure care plan available electronically to healthcare team</td>
<td>Develop a process for sending and receiving the care plan</td>
<td>EHR access: Input updates to the care plan in the EHR. No EHR access: Communicate updates to the care plan to the provider using established communication mechanisms</td>
<td></td>
</tr>
<tr>
<td>Revise/update care plan</td>
<td>Revise/update care plan</td>
<td>If a pharmacist makes changes to care plan, provider must sign</td>
<td>Update care plan and share with the provider on a scheduled basis.</td>
<td></td>
</tr>
</tbody>
</table>

**Care Plan**

The provider establishes the care plan. The pharmacist reviews the care plan and makes revisions based on management/monitoring of the patient.
# Practical Implementation of CCM Service Components

<table>
<thead>
<tr>
<th>CCM Component</th>
<th>CCM Component Detail</th>
<th>Pharmacist/Provider Activities</th>
<th>Accessibility of Information</th>
<th>Main Team Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Ensure timely receipt of preventative care | Ensure patient is aware of age-related and disease-related screenings and immunizations needed; utilize notification ticklers to automatically send notifications to patients and/or providers when screenings are needed. Document within the care plan. | EHR access: Review recent screenings and immunizations and any scheduled that the patient has received. 
No EHR access: Discuss patient-specific screenings and immunizations with the patient and document any recent screenings and immunizations and communicate to the provider. | Pharmacist or Provider |
| Medication reconciliation | Ensure patient’s medication list is updated and therapy matches conditions. Assess medications for appropriateness, effectiveness, and adherence. Educate the patient about their medications to make sure they know how to use them. Use motivational interviewing to engage patients in self-management of their medication. | EHR access: After performing medication reconciliation ensure medication list is updated in EHR. 
No EHR access: Communicate reconciled medication list to the provider on a scheduled basis |                  |
| Oversee self-management of medications | | | |
| Access to urgent care management services | Provider usually provides access via telephone and messaging. Ensure provider has systems for after hours access to care when practice is closed. Educate patient about the practice’s availability outside of business hours. Optional: the pharmacist may offer 24/7 access to care on behalf of the provider (Some CPESN pharmacies offer these services already for patients). | If the pharmacy offers 24/7 access, a mechanism to access the current care plan will be needed. | Pharmacist or Provider |
| Continuity with regular provider | Ensure patient knows when their next follow-up appointment is and what routine screenings and procedures need to be performed | EHR access: Check to see when follow-up is scheduled and inform patient. 
No EHR access: Ask patient about next scheduled appointment(s). Document in order to follow-up with the patient. | |
| Provide 24/7 Access to Care | Enhanced opportunities for asynchronous, non face-to-face methods | Some EHR systems have 2-way communication methods through the patient portal, some practices may have other means of communication other than the phone. Mainly achieved by calling the patient to follow-up with CCM services each month. | Not applicable |
## Practical Implementation of CCM Service Components

<table>
<thead>
<tr>
<th>CCM Component</th>
<th>CCM Component Detail</th>
<th>Pharmacist/Provider Activities</th>
<th>Accessibility of Information</th>
<th>Main Team Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record time</td>
<td>Time must be tracked for billing purposes.</td>
<td><strong>EHR Access:</strong> Some EHR systems have the ability to track CCM time</td>
<td><strong>No EHR Access:</strong> A list of software vendors that help with CCM time tracking will be provided by CPESN USA. Time may be recorded manually with each time increment associated with an activity (i.e., keeping track of time via excel document) and securely communicated to practice on a scheduled basis for billing purposes.</td>
<td>Pharmacist or Provider</td>
</tr>
<tr>
<td>Trigger monthly billing report</td>
<td>If utilizing a software vendor, send a monthly charge statement to the provider which tracks time and level of CCM</td>
<td></td>
<td></td>
<td>Provider</td>
</tr>
<tr>
<td>Ensure not billed in the same month: Transitional Care Management (TCM), Home Health Care Supervision, Hospice Care Supervision, Certain ESRD Services, Patient Monitoring Services</td>
<td>Work with the practice to ensure that the provider has a system in place to avoid overlapping billing from occurring. Discuss with practice about how the pharmacist would know that the provider performed one of the specified services for the month, such as TCM. If this occurs, the worst case scenario is the pharmacy may not be paid for the CCM as the TCM will be approved and CCM reversed.</td>
<td></td>
<td></td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Modify billing for E/M services</td>
<td>Provider’s billing department performs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collect patient co-pay</td>
<td>If patient is not dual eligible or does not have a supplement, the patient’s copay is 20% of CCM service performed that month. Ensure provider/patient is aware of a potential copay. The provider is responsible for collecting the copay. If the patient is not dual eligible or does not have a supplement, obtain guidance from the medical practice about how to proceed with patients unable to pay for CCM copay.</td>
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<td>Provider</td>
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• If a pharmacist calls a CCM enrolled patient and the patient does not answer, but the pharmacist has completed the required amount of time for the month. Can CCM be billed for the month? Yes

• If the pharmacy staff performs automatic refills for a patient, can I count time toward CCM? No

• If the pharmacy staff performs dispel or strip packaging can I count time toward CCM? No

• Upon a pharmacist deciding a patient will benefit from an adherence packaging service, the pharmacist informs the technician what medications can be dispensed together or separate and the timing of each. Can this scenario be counted toward CCM?
  • No, none of these activities can be contributed for CCM at this time. This scenario does not coordinate care between the care team and patient.

• What technician time can be counted toward CCM services?
  • No pharmacy technician time can count toward CCM billing because pharmacy technicians are not considered clinical staff. Furthermore, administration time performed by pharmacy technicians cannot be documented as billable time.

• What if a pharmacy technician delivers a message to the pharmacist about the patient’s chronic conditions and the pharmacist must make a clinical decision?
  • The time the pharmacist takes to make a clinical decision related to chronic care management services, including understanding the background of the patient by talking with the patient or reviewing the patient’s profile, may count toward CCM time.

• Why does medical assistant’s time count toward CCM but pharmacy technicians do not?
  • Pharmacy technicians are not considered clinical staff. Medical assistants are considered clinical staff because they are supervised by a qualified healthcare provider (QHP). Pharmacy technicians are not considered clinical staff because a pharmacist is not considered a QHP who can bill for CCM services. Pharmacists are considered clinical staff because pharmacists provide CCM under general supervision of a CMS-recognized QHP.

• Patient SM received 60 minutes of documented CCM time during this month, can this be automatically be billed as complex CCM using CPT 99487?
  • Complex CCM does not just consider time, but also considers complexity of medical decision making. Just because 60 minutes were spent on CCM with the patient, it does not mean that the patient met all requirements to qualify for complex CCM. In this case, if the patient did not require moderate or high complexity medical decision making by the QHP, only the non-complex CCM code (CPT 99490) can be billed.
Slippery Slopes (FAQs)

- **Who can develop the care plan?**
  - Physicians or QHPs must at this current time. Pharmacists can be a part of a care team that is involved in the development/revision of the care plan but a physician or QHP has to be involved.

- **Can CCM codes be billed on the same date of service as other Evaluation & Management (E&M) services (i.e., medical office visit or other procedures)?**
  - Time or effort that is spent providing services within the scope of the CCM service, on the same day as an E&M visit or other E&M service that Medicare and CPT allow to be reported during the CCM service period, can be counted towards CCM codes, as long as it is not counted towards other reported E&M code(s). Note that time and effort cannot be counted twice, whether face-to-face or non-face-to-face.
  - Example: CCM time started on January 3 and additional CCM services were provided and aggregated to 20 minutes by January 31 (the end of the calendar month). The billing date for CCM should either be the date when the time allotment has been met or at the end of the service period. This is the same date of service that will be transmitted during billing for CCM. If it happens that on January 31, the patient also had an office visit or medical procedure—this code may reject. If this code rejects, it is due to technical billing of 2 similar service dates.

- **If a phone call to the patient leads to a medical office visit that results in an E&M charge, can the time (phone call time) be documented toward the monthly CCM time?**
  - If the time was spent discussing the patient’s chronic health conditions and an acute condition was presented to the pharmacist which required an office visit, the time discussing chronic health conditions may count toward documented CCM time. However, any time spent discussing the acute condition should not be documented as CCM time.

- **Can pharmacy technician time be counted in the following scenario? A pharmacy technician calls the patient monthly and asks a series of yes or no clinical medication synchronization questions. After collecting the information, the technician provides the answers to the pharmacist.**
  - The pharmacy technician time does not count toward CCM time. Once the pharmacists reviews the information from the technician, this time counts toward CCM contracted time.
  - Medicare regulations for counting CCM time needs to be clinical contact time; not non-clinical contact time. Look at the pharmacist’s clinical activities to assess and develop a professional opinion of what is considered clinical contact time, specifically related to the patient’s chronic conditions. Pharmacy technicians who are facilitating these questions are not wasting time doing these tasks as it makes the process more efficient.
Can all of the Medicare patients at my pharmacy be offered CCM services while partnering with a remote physician to bill for these Medicare patients?

- No. CCM is meant to establish coordination of care services among a patient’s providers, in which a remote billing provider with no established patient relationship would be unable to serve in this integral role.
- Patients must receive a comprehensive E/M, IPPE, or TCM visit within 1 year prior to the commencement of CCM services in order for CCM to be billed by a qualified healthcare provider (QHP). Furthermore, this is a minimum requirement to bill for CCM services. One of these defined visits must have occurred in the past year for any provider, including telehealth providers. Any providers who may offer to partner with you without an established patient relationship and a defined visit are not considered the patient’s QHP.
- If a patient has not had one of the defined visits 1 year prior, patients must have an initiating visit in order to establish an initial care plan. If partnering with a remote physician, this cannot be ensured because the remote physician does not know this information as the patient is not his/her patient.
## Patient-Centered Care Plan

### Patient Information

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<thead>
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<th>Care Plan Date:</th>
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<tr>
<td>Name:</td>
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<td>Date of birth:</td>
<td>Phone number:</td>
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<td>Current address:</td>
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<td>City:</td>
<td>State:</td>
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### Caregiver Information

| Name:           |  |
| Phone:          | E-mail: |
| Address:        |  |
| City:           | State: | ZIP Code: |

### Emergency Contact

| Name:           |  |
| Address:        | Phone: |
| City:           | State: | ZIP Code: |
| Relationship:   |  |

### Allergies

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<th>□ Check Box if No Allergies</th>
<th>Reaction</th>
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### Current Health Conditions

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<td>Provider Name</td>
<td>Practice Type</td>
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<tr>
<th>Health Condition</th>
<th>Status</th>
<th>Plan of Action / Symptom Management</th>
<th>Associated Goal</th>
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**Patient-Centered Care Plan**

**Other Healthcare Provider Information**

**Provider Name**

**Practice Type**

**Upcoming Appointments**

**Practice Address**

**Practice Phone Number**

**Health Condition**

**Status**

**Plan of Action / Symptom Management**

**Associated Goal**
## Patient-Centered Care Plan

<table>
<thead>
<tr>
<th>Patient Needs / Challenges</th>
<th>Type of Need/Challenge (functional, psychosocial, medical)</th>
<th>Solution</th>
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Items to be completed (tests, routine procedures, planned office visits, medication concerns to be discussed with provider)

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Lifestyle Modifications (diet, exercise, stress management, etc)

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Playbook Resources


Care Plan. Managing Care Solutions, Inc. [CCM care plan template provided on pages 37-39 was derived from Managing Care Solutions, Inc.]