# GUIDANCE FOR USE OF TRANSITIONAL CARE AND CHRONIC CARE MANAGEMENT CPT CODES


Pharmacy Health Information Technology Collaborative

## Table of Contents



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## 1. PURPOSE

This resource provides guidance to assist pharmacists who contribute to care that may be billed under two sets of team-based Current Procedural Terminology® (CPT) codes.[1] The two code sets highlighted in this resource, Transitional Care Management (TCM) Services and Chronic Care Management (CCM) Services codes, support care coordination and care management. Components of the Pharmacy HIT Collaborative Guidance to Use SNOMED CT in Documenting Transitions of Care[2] are referenced to assist pharmacists in using TCM CPT® codes to bill for these team-based services.

## 2. OVERVIEW

As the health care system moves to coordinated, team-based care delivery models, CPT® codes have been created to reflect the work of a health care team and/or an episode of care. Two CPT® code sets that recognize a team-based approach to care are Transitional Care Management (TCM) Services and Chronic Care Management (CCM) Services. TCM[3] and CCM services are currently recognized services in the Medicare Part B program[4] and to a limited extent by other payers. Although there are other team-based CPT® codes, this guide focuses on TCM and CCM code sets because pharmacists are increasingly becoming involved in the delivery of TCM and CCM services.

With the expanding recognition of the value of pharmacists' patient care services, there is a concurrent need to have in place appropriate documentation and billing codes for those services. Various CPT® codes are currently being used for documenting and billing pharmacists' services, including Evaluation and Management (E/M) codes and Medication Therapy Management (MTM) codes. TCM and CCM fall under the Evaluation and Management section within the CPT® code set and are the primary focus of this guide.

### Pharmacists' Roles in Team-based Care

Pharmacists are increasingly being incorporated into various value-based programs that use a coordinated team-based approach to care. Pharmacists' roles in these programs can vary, but they generally focus on managing medications, including medication reconciliation; patient education; chronic condition management, especially those where medications are primary treatment modalities; prevention and wellness services; and from a population health perspective, promoting evidence-based approaches to care and appropriate prescribing.[5]

Services such as TCM and CCM are billed using a team-based CPT® code where the physician or eligible non-physician practitioner (NPP) bills under their respective National Provider Identifier (NPI). CMS requires that various team members involved in TCM and CCM deliver the services under the general supervision of the physician or NPP.[6] General supervision means that the physician or NPP must provide general oversight and be generally available but does not have to be located in the same office suite. The general supervision requirement provides opportunities for community pharmacists and consultant pharmacists, as well as pharmacists embedded in physician office practices, to deliver delegated portions of TCM and CCM services. Other services covered by Medicare require direct supervision, which means the pharmacist needs to be located in the same office suite as the physician, and the physician needs to be immediately available if needed by the pharmacist.

At this time, the TCM and CCM CPT® codes are emerging services. This style of team-based, patient-focused care has great potential to impact the lives of patients and greatly improve outcomes and quality measures. Pharmacists may want to start out by managing a small number of patients. Even at a small scale, notable advances in communication and delegation of care between pharmacists and other providers can be made.

### Pharmacists' Roles in Team-based Care

Pharmacists are often part of transition care teams and play an integral role in patients' successful transitions from one care setting to another. During health care visits, patients' medication regimens are often assessed to ensure appropriateness, effectiveness, safety, and adherence. Pharmacists are in the unique position to assist with the effective and safe use of indicated medications during transitions of care from the initial visit to subsequent follow up visits. With up to 67% of patients admitted to the hospital having unintended medication discrepancies,[7] it is clear that the occurrence of medication therapy problems during care transitions is a critical issue.

There are multiple definitions of transitions of care in the marketplace. Three definitions from the National Transitions of Care Coalition (NTOCC), CMS and the Joint Commission are outlined below, each with a slightly different focus and scope.

> *The term "transitions of care" connotes the scenario of a patient leaving one care setting (i.e. hospital, nursing home, assisted living facility, SNF, primary care physician, home health, or specialist) and moving to another. The care transition frequently involves multiple persons, including the patient, family or other caregiver, nurses, social workers, case manager, pharmacists, physicians, and other providers. An optimal transition should be well planned and adequately timed. More often, however, communication between settings fails to provide all of the information needed for optimum quality of care.*[8]

> *CMS: Transition of Care – The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.*[9] [10]

> *The Joint Commission: The Joint Commission has defined a "transition of care" as the movement of a patient from one health care provider or setting to another.*[11]

This guide focuses on the Transitional Care Management CPT® code using the CMS definition[12] for transitional care management. TCM according to CMS includes the transition of a patient FROM one of the following inpatient settings:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

TO one of the following settings in the patient's community:

- his or her home
- his or her domiciliary
- rest home
- assisted living

During care transitions, pharmacists working with members of the health care team, including the patient, family members, and other caregivers, use a patient-centered approach to help optimize medication and overall health outcomes. Providers, including pharmacists, and patients have a shared accountability during transitions to improve care and avoid re-hospitalizations. To do this, pharmacists follow a patient care process[13] that includes collecting, assessing, planning, implementing, and following up to ensure patients meet their individual goals. Pharmacists collaborate and communicate with others working on the care transitions team (including the patient and family) and document the care provided. Complete and accurate documentation that can be shared with all team members is critical in the on-going care of the patient.

It is important at the time a care transition takes place that pharmacists receive and update a longitudinal, patient-centered care plan or create one in coordination with other providers if not available. Care plans should be goal-oriented, dynamic tools (not static documents). For the purpose of this resource, a pharmacist's patient-centered care plan[14] for TCM services addresses medication-related problems and optimizes medication therapy, sets goals of therapy for achieving clinical goals in collaboration with other care team members, engages the patient, and supports care continuity. The plan includes, at a minimum, a reconciled medication list, medication action plan, and patient-specific goals developed in collaboration with the patient and other health care providers. The care plan should be documented and shared with other members of the patient's health care team where appropriate.

## Required Elements of a TCM Service per the CPT® Code

Transitional Care Management Services are currently a covered benefit in the Medicare program and follow the CPT® code description:

> *TCM Services codes are designed to report transitional care management services for an established patient with medical and psychological care requiring moderate or high complexity medical decision making. These codes are intended to report services that occur when patients are making transitions from an inpatient setting (including acute hospital, rehabilitation hospital, long-term care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted-living institution). The services may initiate on the date of discharge and extend for 29 days from that date.*[15]
>
> *There are two TCM codes:*
>
> *CPT 99495: Transitional Care Management Services with the following required elements:*
>
> - *Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge.*
> - *Medical decision making of at least moderate complexity during the service period.*
> - *Face-to-face visit within 14 calendar days of discharge*

### SERVICES PROVIDED BY CLINICAL STAFF UNDER THE DIRECTION OF A PHYSICIAN OR NPP

Clinical staff under direction of a physician or NPP may provide these services, subject to the supervision, applicable State law, and other rules:

- Communicate with agencies and community services the beneficiary uses
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living
- Assess and support treatment regimen adherence and medication management
- Identify available community and health resources
- Assist the beneficiary and/or family in accessing needed care and services

*CPT 99496: Transitional Care Management Services with the following required elements:*

- *Communication (direct contact, telephone electronic) with the patient and/or caregiver within two business days of discharge.*
- *Medical decision making of high complexity during the service period.*
- *Face-to-face visit within seven calendar days of discharge.*[16]

TCM includes one face-to-face visit by a physician/qualified health care professional (QHP) within the timeframe outlined in the CPT® code and additional non–face-to-face service elements. The non-face-to-face visits may be performed by the physician/QHP or clinical staff working under the direction of the physician or QHP. In the Medicare program, pharmacists are considered "clinical staff" since they aren't recognized as providers.[17]

"The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days."[18] "TCM CPT® codes 99495 and 994960 cannot be billed during the same service period as the following:

- *CPT codes 99487, 99489, and 99490, (chronic care management and complex chronic care management)*
- *Care Plan Oversight Services, and Healthcare Common Procedure Coding System (HCPCS) codes G0181/ G0182 (home health care supervision/hospice care supervision)*
- *CPT codes 90951–90970 (certain End-Stage Renal Disease services)."*[19]

## Practical Points for TCM Codes

The two different TCM codes present an interesting challenge to the health care setting because of the need to know the patient's medical decision-making complexity in order to determine whether the patient needs to be seen in seven or 14 days by the PCP.[20] Coordination and a review of the patient's complexity may aid in deciding which code may be used for their care, as well as when the initial face-to-face service must be scheduled. Some clinics will aim to schedule all follow-up face-to-face visits within seven days of discharge, so that all potentially complex patient care can be eligible to be billed using the higher TCM Code, 99496. However, other clinics will work to schedule the patient within 14 days of discharge and will only bill CPT® Code 99495 for any patient initially seen face to face between seven and 14 days of discharge. Clinics should consider a workflow to assess the potential medical decision-making complexity for a discharged patient and schedule the face-to-face follow up appointment accordingly.

*Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering these factors:*

- *The number of possible diagnoses and/or the number of management options that must be considered*
- *The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed*
- *The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options*

*The table below depicts the elements for each level of medical decision making. Note that to qualify for a given type of medical decision-making, two of the three elements must either be met or exceeded.*

Elements for Each Level of Medical Decision Making Type of Decision Making

| Type or Decision Making | Number of Possible Diagnoses and/or Management Options | Amount and/or Complexity of Data to be Reviewed | Risk of Significant Complications, Morbidity, and/or Mortality |
|---|---|---|---|
| Straightforward | Minimal | Minimal or None | Minimal |
| Low Complexity | Limited | Limited | Low |
| Moderate Complexity | Multiple | Moderate | Moderate |
| High Complexity | Extensive | Extensive | High |

Reference CMS MLN Transitional Care Management Services

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf, and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

A TCM service under Medicare consists of the care coordination and management services provided to the patient in the 30 days post-discharge, starting with the day of discharge as Day 1. TCM services will not be covered if the patient has a readmission within the 30 days. There are three required components that must be delivered in the 30-day time period:[21]

- An interactive contact within two business days of discharge to the community setting (can be via telephone, email, or face-to-face). Note that an attempt to contact the patient within two business days is sufficient to satisfy this requirement, as long as the patient is eventually reached and the attempts are documented.
- A face-to-face visit with the physician or non-physician practitioner (NPP)[22] within seven (high medical decision complexity) or 14 days (moderate medical decision complexity) depending on the patient's medical complexity. Note that some practices will attempt to schedule all patients within seven days as medical complexity may not be verified until the physician sees the patient at the face-to-face visit.
- Certain non-face-to-face services delivered over the 30-day TCM period. Non-face-to-face services can be delivered by physicians and NPPs as well as clinical staff according to the following CMS guidelines. Pharmacists are considered clinical staff.
    - ◊ Non-face-to-face services that may be delivered by physicians or NPPs include:
        - Obtain and review discharge information (for example, discharge summary or continuity of care documents)
        - Review need for or follow-up on pending diagnostic tests and treatments;
        - Interact with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems;

- Provide education to the beneficiary, family, guardian, and/or caregiver;
- Establish or re-establish referrals and arrange for needed community resources; and
- Assist in scheduling required follow-up with community providers and services.

◊ Non-face-to-face services that may be provided by clinical staff (according to state law) under the general supervision of a physician or NPP include:

- Communicate with agencies and community services the beneficiary uses;
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living;
- Assess and support treatment regimen adherence and medication management;
- Identify available community and health resources; and
- Assist the beneficiary and/or family in accessing needed care and services.

*The required face-to-face visit must be furnished under a minimum of direct supervision and is subject to applicable state law, scope of practice, and the Medicare Physician Fee Schedule (PFS) "incident to" rules and regulations. The non-face-to-face services may be provided under general supervision. These services are also subject to applicable state law, scope of practice, and the PFS "incident to" rules and regulations. The practitioner must order services, maintain contact with auxiliary personnel, and retain professional responsibility for the service*

## TCM Use Cases

The following TCM use cases highlight the stepwise approach used to document and bill the required elements of TCM services for a Medicare beneficiary who has been discharged from the hospital to home. Guidance on the clinical documentation for this case can be found in the Guidance for Use of SNOMED CT in Transitions of Care Documentation document.[23]

### *Use Case 1: TCM Delivered by a Primary Care Practice that Includes a Pharmacist*

RB is a 74-year-old Hispanic female with DM type 2, HTN, hyperlipidemia, and osteoporosis who was admitted to the hospital with a diagnosis of severe hypoglycemia and falls. Prior to hospital admission, RB was living at home. This is her third hospital admission in the past nine months, with her most recent hospitalization occurring three months ago. On May 5, after a three-day hospital stay, RB is discharged to her home and the care of her primary care physician who has agreed to take responsibility for providing transitional care management TCM services post-discharge. The hospital discharge team transmits the discharge care plan to the primary care practice.

*The 30-day TCM period begins on the date the beneficiary is discharged from the inpatient hospital setting and continues for the next 29 days.*[24]

RB's primary care physician is part of a group medical practice recognized as a patient-centered medical home that includes five physicians, a nurse, a nurse practitioner, a primary care pharmacist,

and three medical assistants. The primary care physician's team will be responsible for delivering the required elements of TCM. Each member of the team has defined roles and responsibilities, and the primary care pharmacist is responsible for coordinating and managing patients' medications. The primary care pharmacist is a salaried employee of the practice and is responsible for reaching out to RB within two days and on an ongoing basis to initially discuss and reconcile her medications and coordinate scheduling of her face-to-face visit, and then manage RB's medications, provide education, and coordinate medication-related communication between the primary care practice, RB's other physicians and the community pharmacy.

Upon receipt of the discharge summary, the nurse records May 5 (Day 1) as the date of discharge in the practice's EHR, reviews the summary and estimates that RB's case is of moderate decision-making complexity based on the discharge summary and targeting criteria established by the practice. A face-to-face visit is scheduled with RB 10 days post-discharge. RB is considered to require moderate medical decision-making, and therefore, her visit must be scheduled within 14 days of discharge. (As discussed above, practices may have a policy to attempt to schedule the face-to-face visit within a week regardless of complexity).

Because RB has a challenging medication regimen, the nurse requests that the primary care pharmacist make the initial two-day contact with RB. The primary care pharmacist reaches RB by phone the day after discharge (Day 2) to see how she's doing, discuss her health status, and review her medications to identify any medication-related problems and to make sure she understands how to use them. After review and discussion with RB, the pharmacist updates the medication list in the EMR and identifies and recommends necessary medication changes. The pharmacist documents the discussion and the date of the initial contact call as May 6 in the EHR. A social worker is engaged to work with a local social services agency to arrange transportation for RB to and from the visit 10 days after discharge.

The primary care physician sees RB 10 days after discharge. Prior to RB's face-to-face visit, the primary care pharmacist calls RB to discuss how she is taking her medications, how her medications are working, and any problems she is having. RB is having dizziness from her new hypertension medication. The primary care pharmacist documents the review and recommendations in the EHR. At the visit, the primary care physician evaluates RB's status, verifies her level of medical decision-making complexity for TCM billing and decides to change her hypertension medication and discontinue her benzodiazepine. The primary care physician also decides to have RB see the pharmacist for diabetes management and refers RB to home health services for a home safety evaluation visit.

The primary care pharmacist completes weekly follow-up calls with RB at 18 and 25 days post discharge to check on her health status and address concerns. The pharmacist documents the discussions in RB's medical record. The pharmacist also verifies that home health will be visiting RB in two weeks (more than 30 days post-discharge). At the 30-day point, RB is progressing well and has not been readmitted to the hospital.

For billing purposes in addition to the care notes, the following information is documented in RB's medical record in order to bill CPT Code 99495:

- Date RB was discharged: May 5
- Date of interactive contact with RB: May 6
- Date of RB's face-to-face visit: May 15
- The complexity of RB's medical decision making: Moderate

The date of service for the claim is the date of the face-to-face visit, in this case May 15. The TCM 30-day period of service spans May 5 – June 3.

### *Use Case 2: TCM Delivered by a Primary Care Practice that is contracted with a Community Pharmacy to deliver TCM Services*

RB is a 74-year-old Hispanic female with DM type 2, HTN, hyperlipidemia, and osteoporosis who was admitted to the hospital with a diagnosis of severe hypoglycemia and falls. Prior to hospital admission, RB was living at home. This is her third hospital admission in the past nine months, with her most recent hospitalization occurring three months ago. On May 5, after a three-day hospital stay, RB is discharged to her home and the care of her primary care physician who has agreed to take responsibility for providing TCM services post-discharge. The hospital discharge team transmits the discharge care plan to the primary care practice.

RB's primary care physician runs a practice with one other physician, a nurse, an MA (medical assistant), and one office manager. There is a contract between ABC Pharmacy and RB's primary care physician practice to deliver care as part of the TCM service. The physician delegates the medication-related and some of the care coordination services to the community pharmacist under the general supervision requirements of TCM. The primary care physician bills Medicare for the TCM service and pays the community pharmacy a contracted rate for the services delivered. The primary care practice and community pharmacy have agreed to exchange needed clinical information including patients' care plans through a secure network.

The primary care physician's team, including the community pharmacist, will be responsible for delivering the required elements of TCM. Each member of the team has defined roles and responsibilities, and the community pharmacist is responsible for coordinating and managing patients' medications. The community pharmacist is also responsible for reaching out to RB within two business days after discharge and an ongoing weekly basis over the 30-day period to initially discuss and reconcile her medications and coordinate scheduling of her face-to-face visit, and then manage RB's medications, provide education, and coordinate medication-related communication between the primary care practice, RB's other physicians, and the community pharmacy.

Upon receipt of the discharge summary, the nurse records May 5 as the date of discharge in the practice's EHR (Day 1), reviews the summary and estimates that RB's case is of moderate decision-making complexity based on the discharge summary and targeting criteria established by the practice. A face-to-face visit is scheduled with RB 10 days post-discharge. Because RB is considered to require moderate medical decision-making, her visit must be scheduled within 14 days of discharge.

Since RB has a challenging medication regimen, the nurse contacts the community pharmacist via secure network to let her know of RB's discharge and transmits the discharge summary to the community pharmacist via secure network. The community pharmacist reaches RB by phone the day after discharge to discuss her health status and reviews her medications to identify any medication-related problems and to make sure she understands how to use them. After reviewing and discussing with RB, the pharmacist identifies and recommends necessary medication changes. The pharmacist documents the discussion and the date of the initial contact call as May 6 (post discharge Day 2) in the pharmacy's software system and sends a summary to the primary care physician via a secure network. The community pharmacist also alerts the MA that RB is going to need assistance with transportation to the face-to-face visit, and the MA works with a local social services agency to arrange transportation for RB to and from the visit 10 days post discharge.

Two days prior to the face-to-face visit, the community pharmacist calls RB for an in-depth review of her medications using information in the discharge summary, RB's care plan received from the primary care physician, and RB's medication records in the pharmacy. The community pharmacist discusses with RB how she is taking her medications, how her medications are working, and any

problems she is having. RB is having dizziness due to her new hypertension medication and has not been taking it as prescribed. The community pharmacist sends a recommendation to the primary care physician to change RB's hypertension medication and discontinue her benzodiazepine dose. The primary care physician sees RB 10 days post discharge and verifies her level of medical decision-making complexity for TCM billing. The primary care physician evaluates RB's status, and after reviewing the recommendation from the community pharmacist, decides to change RB's hypertension medication and discontinue her benzodiazepine dose. The primary care physician also decides to have RB see the community pharmacist for diabetes management and refers RB to home health services for a home safety evaluation visit.

The community pharmacist completes weekly follow-up calls 18 and 25 days post-discharge with RB to check on her health status and address concerns. The pharmacist documents the discussions in the pharmacy software system and sends a summary to the physician via secure email. The pharmacist also verifies that home health will be visiting RB in two weeks (more than 30 days post-discharge). At the 30-day point, RB is progressing well and has not been readmitted to the hospital.

For billing purposes, in addition to the care notes, the following information is documented in RB's medical record in order to bill CPT code 99495:

- Date RB was discharged: May 5
- Date of interactive contact with RB: May 6
- Date of RB's face-to-face visit: May 15
- The complexity of RB's medical decision making: Moderate

The date of service for the claim is the date of the face-to-face visit, in this case May 15. The TCM 30-day period of service spans May 5 – June 3.

## TCM Summary

Transitional Care Management Services, as described by CPT codes 99495 and 99496, support practitioners as patients transition between being hospitalized, in a skilled nursing facility or home. These transitions can be difficult and disorienting to patients, who will benefit from a team-based approach to care. Pharmacists are essential members of this care team for their ability to help patients with medication understanding, side effects, simplification and concerns. TCM services in the Medicare program can be delivered using team members either in the clinic or contracted outside of the clinic setting. TCM services provide opportunities for pharmacist involvement in patient care in a variety of practice settings. These opportunities also serve as important bridges between fee-for-service and quality-based care.

## Chronic Care Management Services

In addition to TCM, pharmacists can also participate in the provision of Chronic Care Management (CCM) Services. The Centers for Medicare & Medicaid Services (CMS) estimates that approximately two-thirds of Medicare patients have two or more chronic conditions.[25] CCM aims to better coordinate the care patients receive. Payment for CCM is billed using a team-based code that can be applied on a monthly calendar basis to reflect the work of the team in managing patients' chronic conditions. Whether in the pharmacy or in the physician's office, pharmacists are often positioned as the most trusted health care provider and have strong patient relationships. CCM provides an opportunity to leverage the pharmacist's accessibility to improve patient outcomes.

CMS currently recognizes two levels of CCM services – chronic care management (sometimes referred to as non-complex CCM) and complex chronic care management. CCM and complex CCM services share a common set of service elements. They differ in the amount of clinical staff service

time provided, the billing practitioner work, and the extent of care planning performed.

## Summary of 2017 CCM Coding Changes

| Billing Code | Payment (Non-Facility Rate) | Clinical Staff Time | Care Planning | Billing Practitioner Work |
|---|---|---|---|---|
| CCM (CPT 99490) | $43 | 20 Minutes or more of clinical staff time in qualifying services | Established, implemented, revised, or monitored | Ongoing oversight, direction, and management Assumes 15 minutes of work |
| Complex CCM (CPT 99487) | $94 | 60 minutes | Established or substantially revised | Ongoing oversight, direction, and management +Medical decision-making of moderate-high complexity Assumes 26 minutes of work |
| Complex CCM Add-on (CPT 99489 use with 99487) | $47 | Each additional 30 minutes of clinical staff time | Established or substantially revised | Ongoing oversight, direction, and management +Medical decision-making of moderate-high complexity Assumes 13 minutes of work |
| CCM Initiating Visit | $44-$209 | -- | -- | Usual face-to-face work required by the billed initiating a visit code |
| Add-On to CCM Initiating Visit (G0506) | $64 | N/A | Established | Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit |

**(Annual Wellness Visit (AWV) Initial Preventative Physical Examination(IPPE), Transitional Care Management (TCM), or Other Qualifying Face-to-Face Evaluation and Management (E/M))*

Through CCM (and complex CCM), pharmacists provide coordination services to Medicare beneficiaries residing in a community setting. CMS provides guidance that these services be delivered primarily in a non-face-to-face format to provide care coordination in between office visits.[26]

*CCM includes, in large part, activities that are not typically or ordinarily furnished face-to-face with the beneficiary and others, such as telephone communication, review of medical records and test results, and coordination and exchange of health information with other practitioners and providers.*

As of publication, CMS' required elements of CCM[27] for billing practitioners are:

- Use of a Certified Electronic Health Record (EHR)
- Continuity of Care with Designated Care Team Member
- Comprehensive Care Management and Care Planning
- Transitional Care Management
- Coordination with Home- and Community-Based Clinical Service Providers
- 24/7 Access to Address Urgent Needs
- Enhanced Communication (for example, email)
- Advance Consent

Community pharmacists working with a physician office practice can communicate with the practice via fax, secure email or other secure electronic transmissions, and, in some situations, through access to the practice's EHR. Many community pharmacies are also beginning to implement EHRs in the pharmacy that allow for clinical documentation and information sharing with the practice.

Pharmacists, as medication experts, can ensure the appropriateness, safety, effectiveness, and adherence to medication regimens associated with the patient's chronic conditions. Care is provided using a patient-centered approach and follows a patient care process that includes collecting, assessing, planning, implementing, and following up to ensure patients meet their individual goals.

As with TCM, pharmacists providing CCM collaborate and communicate with the patient and other members of the care team and document the care provided. Similarly, pharmacists should create or update a longitudinal, patient-specific, care plan using patient specific goals developed in collaboration with the patient and other members of the care team.

*The 15 minutes of work by the billing practitioner are assumed times, established through physician survey by the American Medical Association when the codes were created and valued, for how much time the billing practitioner spends himself or herself each month, but are not exact times.*[28]

Required Elements of a CCM Service per the CPT® Code.[29]

CPT 99490 (CCM): Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, 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.

CPT 99487 (Complex CCM): Complex 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.
- Establishment or substantial revision of a comprehensive care plan.
- Moderate or high complexity medical decision making.
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.*

CPT 99489 (Complex CCM): Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).*

*CPT code 99490 for Chronic Care Management is used for reporting CCM services of 20 minutes or more per month. Pharmacists have noted the initial month(s) of CCM often require substantially more than 20 minutes to get the patient onboarded. Complex CCM services require at least 60 minutes of clinical staff service time and moderate to high complexity medical decision making.

*Add-on CPT code 99489 can be used with CPT code 99487 when 30 minutes of time are spent in addition to the first 60 minutes of complex CCM.*[30]

The billing practitioner cannot report both complex CCM and non-complex CCM for a patient in a calendar month, and only one practitioner can bill CCM for a patient in a given month. CCM cannot be billed during the same service period as the following:[31]

- HCPCS codes G0181/G0182 (home health care supervision/hospice care supervision)
- CPT codes 90951–90970 (certain End-Stage Renal Disease services)
- CPT 99495, 99496 (transitional care management)

## Use Case 1: CCM Delivered by a Primary Care Practice that Includes a Pharmacist

LG is a 68-year-old male with COPD, hyperlipidemia, and Type 2 diabetes mellitus who was seen by his primary care physician on April 26 for his annual wellness visit (AWV) where he was identified as a candidate for CCM. LG currently lives at home with his wife who assists him with managing the medications for his chronic diseases. Both LG and his wife, acting as the primary caregiver, gave verbal consent for being in the CCM program, including the cost share associated with it and verified that he is not enrolled in a CCM program with another provider. This consent is documented in LG's medical record.

*A practitioner must obtain patient consent before furnishing or billing CCM. Consent may be verbal or written but must be documented in the medical record and include informing them about:*

- *The availability of CCM services and applicable cost-sharing.*
- *That only one practitioner 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).*[32]

LG's primary care physician (PCP) is part of a group medical practice recognized as a patient-centered medical home that includes five physicians, one nurse, one nurse practitioner, one pharmacist, and three medical assistants (MA). The primary care physician's team will be responsible for delivering the required elements of CCM, and each member of the team has defined roles and responsibilities. The physician is responsible for oversight and continuing assessment of the patient, which includes medical decision-making assessment, documenting the diagnoses, and establishing the initial care plan in the electronic health record. There is a rotating on-call provider on the team for 24/7 access for patients with urgent needs. The MA will communicate the best times for phone appointments with the patient on a monthly basis, coordinate additional needs from LG or his wife, and track when to bill for the care.

The pharmacist is a salaried employee of the practice and is responsible for patient education, coordinating and managing medications, as well as assisting with managing chronic disease states. Specifically, the pharmacist will monitor and coach LG on his COPD, hyperlipidemia, and diabetes, assess medication appropriateness and adherence, update the care plan, manage care transitions, identify preventative care and quality interventions, and assist with coordinating care and communications between LG's other physicians and his community pharmacy.

During the AVW on April 26, the primary care physician develops the CCM care plan and decides to refer LG to the pharmacist in the practice for assistance with managing his chronic conditions. Subsequently, the physician enters a referral in LG's medical record for CCM management with the pharmacist and assesses the patient as non-complex (CPT Code 99490). Also, G0506 is added to the AWV bill since the CCM care plan was developed. Prior to LG leaving the physician's office, the MA schedules LG for a telephone visit with the pharmacist on May 3.

LG qualifies for non-complex CCM because he has two or more longstanding chronic conditions, is at risk of acute exacerbation and functional decline, and the physician determines that LG does not need moderate or high medical decision making.[33]

On the day of the call, the pharmacist spends 15 minutes preparing for her initial telephone visit with LG and his wife. This includes a chart review of the AVW, review of LG's care plan and specific treatment goals, other provider notes, as well as evaluation for preventative care services. The pharmacist calls LG at the scheduled time. The pharmacist uses open-ended questions and patient interviewing skills during the phone conversation to collect information from LG regarding his ability to self-manage his disease states and medications. LG admits he receives assistance from his wife, who manages his medications.

LG expresses concern about managing his COPD and has a desire to improve on his nutrition and exercise. These goals are added to the care plan by the pharmacist. The pharmacist verifies all of LG's medications with his wife and has LG describe his administration technique for his inhalers to assure proper technique. As typical of CCM visits, the initial call takes longer than average, and the pharmacist spends 20 minutes on the phone and documents in the EHR.

Immediately following the call, the pharmacist consults with the physician about proposed changes to LG's COPD regimen and requests a referral to a Diabetes Self-Management Education (DSME) program. Once agreed upon, the pharmacist updates LG's care plan accordingly and documents five minutes of consultation time with the physician in the EHR.

On a follow-up call two days later (May 5), the pharmacist informs LG of the referral to the DSME pro-

gram that will help him with his nutrition, exercise and diabetes goals, and educates LG and his wife about the changes to his medication regimen. At the end of the follow-up call, which lasts 10 minutes, the pharmacist asks LG to schedule the next phone call for the following month, establishes a plan for monthly phone calls with LG to manage his conditions, and documents 15 minutes in the EHR to account for the care coordination time also. LG and his wife agree to this plan and schedule an appointment for June 4 for another phone call with the pharmacist.

In addition to the care notes, the pharmacist (and any other clinical staff) must document the following information in order to bill for CPT Code 99490:

- Total time (65 minutes):
  - ◊ May 3: 40 minutes (includes chart review, telephone visit with LG, consultation with physician)
  - ◊ May 5: 15 minutes (follow-up telephone visit and care coordination for LG).
  - ◊ Documentation time: (non-billable) 10 minutes
- Dates of CCM care delivery: May 3, May 5
- Period of CCM billable care: May 1- May 31 (the billing date could be May 3, since the time requirement for CCM was met for the month on this day or any day, thereafter, up to and including May 31)
- Complexity of LG's medical decision making: Low*

* The changes in the patient's COPD regimen were simple, but if the change was significant, that may constitute complex medical decision-making, and if more time was spent with the patient over the month billing, a complex CCM could be considered.

*Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month in order to bill CCM services. Non-clinical staff time cannot be counted toward the threshold.*[34]

Non-Complex CCM assumes 20 minutes or more of clinical staff time in qualifying services and 15 minutes of work by the billing practitioner within a month and cannot be combined with CPT 99489 for reimbursement of additional time.

LG continues to receive monthly CCM from his primary care team over the next few months including care coordination and coaching calls. The care team documented their interventions and updated LG's care plan. The PCP bills the non-complex CCM code during the months that CCM was provided. The pharmacist has noticed improvement in LG's chronic conditions and overall health during this time.

## Use Case 1: CCM Delivered by a Primary Care Practice that Includes a Pharmacist

Over the next nine months, LG's COPD and hyperlipidemia management improved significantly. LG also experienced an improvement in his HBA1c and blood sugar levels since CCM began. The care team had been making gradual adjustments to LG's medications since October to better control his DM, and LG and his wife report his being adherent to medications and diet throughout this time. In January, the care team noted that LG's HBA1c has been rising, and LG reported an increasing number of above goal glucose readings during his CCM call on January 3 with the pharmacist. The

primary care team decided to add insulin to LG's regimen on January 10 during a clinic visit with LG to improve his blood sugar control.

On a follow up call on January 12 with the pharmacist, it is noted that LG and his wife are having a hard time with the change to insulin and need more coaching on administration and timing of doses. On January 15, LG reports a low reading and continued confusion about dosing. The PCP is engaged to make adjustments to LG's regimen, blood sugar control goals, and care plan. With calls and coaching, LG is better able to manage insulin but continues to require multiple times a week calls by the nurse to remind him to measure his blood sugar and support his dosing. The pharmacist has been making routine calls each week to consult on whether insulin dose changes may be necessary for LG. The PCP evaluates LG and determines that he requires moderate medical decision making, which makes the patient care eligible for billing complex CCM this month (if he receives at least 60 minutes of CCM services in addition to complex decision making).

In February, LG is scheduled to have weekly calls with the nurse and every other week calls with the pharmacist to discuss his medications. The nurse focuses her calls on blood sugar measurements and goals, and the pharmacist discusses his insulin regimen. LG and his wife also notify the care team that they can no longer drive, and the MA on the care team works with LG and his wife to schedule transportation to his clinic visits as part of the complex CCM service.

*CCM may help avoid more costly services in the future by proactively managing patient health, rather than only treating severe or acute disease and illness.*[35]

For the month of February, the nurse dockets 30 minutes of calls with LG, the pharmacist spends 25 minutes working with LG and the PCP on insulin regimen, and the MA spends 15 minutes coordinating care, including transportation for LG.

In addition to the care notes, the pharmacist (and other members of the care team) document the following information in LG's medical record to bill for complex CCM - CPT Code 99487:

- Total time (70 minutes):
  - ◊ February 7: 10 minutes –chart review and call with nurse to discuss blood glucose readings
  - ◊ February 10: 15 minutes –chart review and call with pharmacist to discuss insulin dosing
  - ◊ February 15: 5-minute call with nurse to discuss symptoms and blood glucose readings
  - ◊ February 21: 5-minute call with nurse to discuss symptoms and blood glucose readings
  - ◊ February 24: 10-minute call with pharmacist to discuss insulin dose changes and administrations
  - ◊ February 26: 15 minutes – call with MA and MA coordination with social services for transportation to the next appointment
  - ◊ February 27: 10-minute call with nurse to discuss blood glucose readings and problems with COPD
  - ◊ Documentation time: (non-billable) 15 minutes

- Dates of CCM care delivery: February 7, 10, 15, 21, 24, 26, 27
- Period of CCM billable care: February 1- February 28. The billing date for Complex CCM should be February 28, (reported at the conclusion of the service period) because the code includes clinical staff service time and moderate or high complexity medical decision-making by the PCP during the month.
- Note that because an additional 30 minutes was not spent on Complex CCM over and above the 60 minutes, the add-on code 99489 cannot be billed for LG.
- Complexity of LG's medical decision making: Moderate

*Complex CCM assumes 60 minutes or more of clinical staff time in qualifying services and 26 minutes of work by the billing practitioner within a month. The Complex CCM CPT code (99487) can be combined with add-on CPT code 99489 for reimbursement of additional 30-minute time increments.*[36]

## Use Case 2: CCM Delivered by a Primary Care Practice that Contracts with a Community Pharmacy to Deliver CCM Services

LG is a 68-year-old male with COPD, hyperlipidemia and Type 2 Diabetes Mellitus. LG currently lives at home with his wife who assists him in medication management for his chronic diseases. LG was seen by his primary care physician (PCP) on April 26 for his annual wellness visit (AWV). The PCP determines that LG is eligible for CCM and discusses the benefits of LG participating in the CCM program administered through the clinic. Both LG and his wife, acting as the primary caregiver, give verbal consent to the PCP to be coached by a pharmacist for assistance in managing his chronic disease states as part of CCM services. This consent was documented in LG's medical record.

LG's PCP runs a practice with one other physician, one nurse, two medical assistants, and an office manager. There is a contract between ABC Pharmacy and LG's physician practice to deliver care as part of the CCM service. The physician delegates the chronic disease management services to the community pharmacist under the general supervision requirements of CCM. The primary care physician bills Medicare for the CCM service and pays the community pharmacy a contracted rate for the services delivered. Both physicians in the practice rotate to provide on-call 24/7 access for patients with urgent needs. The primary care practice and community pharmacy have agreed to exchange needed clinical information including patients' care plans through secure email.

The care team, including the community pharmacist, will be responsible for delivering the required elements of CCM. Each member of the team has defined roles and responsibilities. The PCP will oversee LG's care, and the community pharmacist is responsible for patient education, coordinating and managing medications, as well as assisting with managing the chronic disease states for which the patient is already diagnosed. Specifically, the community pharmacist will monitor and coach LG on his COPD, hyperlipidemia, and diabetes, assess medication appropriateness and adherence, update the care plan, manage care transitions, and assist with coordinating care and communications between LG's other physicians and his community pharmacy.

During the AWV on April 26, the PCP develops the CCM care plan and enters a referral into LG's medical record for non-complex CCM management (CPT Code 99490) with the community pharmacist. The MA contacts the community pharmacist via secure email to notify him of the referral. The MA also transmits the care plan to the community pharmacist via secure email. The community phar-

macist calls LG and schedules a telephone appointment on May 3.

On May 3, the community pharmacist spends 15 minutes preparing for his telephone visit with LG and his wife. This includes a chart review of the recent AWV, review of LG's care plan and specific treatment goals, as well as evaluation for preventative care services. The community pharmacist calls LG at the scheduled time. The community pharmacist uses open-ended questions and patient interviewing skills during the phone conversation to collect information from LG regarding his ability to self-manage his disease states and medications. LG admits he receives assistance from his wife, who manages his medications.

LG expresses concern about managing his COPD and has a desire to improve his nutrition and exercise. The pharmacist adds these new goals to the care plan. The pharmacist verifies all of LG's medications with his wife and has LG describe his administration technique for his inhalers to assure proper technique. The pharmacist spends 20 minutes on the phone with LG and documents this encounter.

Following the call, the pharmacist spends 5 minutes consulting with LG's primary care physician about proposed changes to LG's COPD regimen and requests a referral to a Diabetes Self-Management Education program. Once agreed upon, the pharmacist updates LG's care plan accordingly and sends it to the PCP via secure email.

On a follow-up call on May 5, the pharmacist informs LG of the referral to the DSME program that will help him with his nutrition, exercise and diabetes goals, and educates LG and his wife about the changes to his medication regimen. At the end of the follow-up call, which lasts 10 minutes, the pharmacist asks LG to schedule the next phone call for the following month and establishes a plan for monthly phone calls with LG to manage his conditions. LG and his wife agree to this plan and schedule an appointment for June 4 for another telephone call with the pharmacist. The pharmacist documents each call, including time spent in the pharmacy's clinical documentation system.

In addition to the care notes, the community pharmacist must document the following information in the pharmacy's clinical documentation system and transmit this information to the PCP for billing CPT Code 99490:

- Total time (50 minutes)
  - ◊ May 3: 40 minutes (includes review of chart, telephone visit with LG, consultation with the physician)
  - ◊ May 5: 10 minutes (follow-up telephone visit with LG)
  - ◊ Documentation time: (non-billable)10 minutes
- Dates of CCM care delivery: May 3, May 5
- Period of CCM billable care: May 1- May 31 (the billing date could be May 3 since the time requirement for CCM was met for the month on this day or any day thereafter up to and including May 31)
- Complexity of LG's medical decision making: Low

The PCP bills for CCM, and the community pharmacist bills the PCP for the contracted per patient rate each month.

*CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the direction of the billing practitioner on an "incident to" basis (as an integral part of services provided by the billing practitioner), subject to applicable State law, licensure, and scope of practice. The clinical staff are either employees or working under contract to the billing practitioner whom Medicare directly pays for CCM.*[37]

Non-complex CCM assumes 20 minutes or more of clinical staff time in qualifying services and 15 minutes of work by the billing practitioner within a month and cannot be combined with CPT 99489 for reimbursement of additional time.

LG continues to receive monthly CCM from his PCP and community pharmacist, including care coordination and coaching calls. The care team documents their interventions, updates LG's care plan, and the PCP bills the non-complex CCM code during the months that CCM is provided. If LG requires moderate to high complexity medical decision making, then consent for complex CCM could be solicited, and the requirements would be similar to the above case on page 17.

## CCM Summary

Chronic Care Management, as described by CPT codes 99487, 99489, and 99490, can be effective services for helping patients better control their chronic illness and receive the supportive team care they need. Providers benefit from a novel delivery and payment mechanism that facilitates ongoing team-based care both within the clinic, as well as outside the clinic with contracted providers. Pharmacists have a role in CCM as part of the care team to improve patients' use of medications and achieve quality outcomes. There are complexities in delivering CCM services, but when properly implemented, CCM is a useful service in improving patients' health and supporting a practice's transition to quality-focused team-based care.

## Additional Resources

The following resources describing pharmacists' roles in transition of care and chronic care management should be reviewed: (1) American Medical Directors Association, Transitions of Care in the Long-Term Care Continuum Clinical Practice Guideline (2010); (2) American College of Clinical Pharmacy, Improving Care Transitions: Current Practice and Future Opportunities for Pharmacists (2012); and (3) American Pharmacists Association and American Society of Health-System Pharmacists, Improving Care Transitions: Optimizing Medication Reconciliation (2012). In addition, the Pharmacy HIT Collaborative has developed the following resources to assist pharmacists in documenting and billing care: (1) Pharmacy HIT Collaborative's Guidance to Use SNOMED CT in Documenting Transitions of Care.

## 6. ACKNOWLEDGEMENTS

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