Is Chronic Care Management Chronically Impacting Your Employed Provider Productivity?

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As hospitals and health systems continue to increase reliance on nonphysician practitioners (including physician assistants, clinical nurse specialists, nurse practitioners, and certified nurse midwives), the collaborative nature of the physician and nonphysician practitioner (NPP) relationship remains a hot topic. As seen with other specialties and service offerings, depending upon the billing methodology used, a portion of a NPP's clinical productivity may be attributed to a physician due to payer billing conventions and limitations in the practical ability to isolate the NPP's services on a real-time, encounter-level basis. Leveraging NPPs for various Evaluation and Management (E/M) services may create a regulatory concern as physicians may be compensated based on work relative value units (wRVUs) for services that were not personally performed but rendered by the NPP through the billing practice traditionally known as "incident-to" billing.

Some services are rendered by clinical staff under the billing practitioner's (physician or NPP) direction and general supervision.[1] Chronic care management (CCM) services are an example of this type of billing. CCM and similar care management services may be rendered personally by a physician or NPP, but often, CCM models rely heavily upon clinical staff to assist with care coordination, communications, and other important care management functions. While published CPT[2] codes for CCM differentiate between services personally rendered by a physician or NPP and those rendered by clinical staff, Medicare billing guidelines require billing for CCM services using the supervising provider's National Provider Identifier (NPI). So, even when services are conducted by clinical staff, the billing for the CCM service is still reported under the physician or NPP. As such, the capture of wRVU credit for providers compensated based on productivity can be tricky.

CCM services are proven to reduce the total costs of care and improve patient outcomes. The Centers for Medicare & Medicaid Services (CMS) began reimbursing for CCM services in January 2015. Since that time, CMS continues to emphasize the value of CCM services and in 2022, increased the relative value units and wRVUs assigned to CCM services, resulting in an increase in reimbursement. While physicians and NPPs are billing for CCM services,[3] a significant opportunity to render these services to a greater number of Medicare beneficiaries remains.

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1 General supervision does not require the physician's physical presence and indicates the service is performed under the billing provider's overall direction and control. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf

2 Current Procedural Terminology (CPT® or CPT), a registered trademark of the American Medical Association (AMA).

3 See 84 Fed. Reg. 40,549 (Aug. 14, 2019).

Both physicians and NPPs may provide and are eligible to bill CCM services. To render CCM services, the billing provider must conduct a face-to-face initiating visit and discuss CCM services for new patients or patients the provider has not seen within the previous one year. (A separate initiating visit is not required for established patients seen within one year.) If an initiating visit is required, the visit is reported with the applicable CPT code, and wRVU credit is generated accordingly. The following types of visits may qualify as an initiating visit:

- "Comprehensive" E/M office visits (CPT codes 99212 through 99215)
- Annual wellness visit (HCPCS codes G0438 or G0439)
- Initial preventive physical exam (HCPCS G0402).

To be eligible to bill monthly for CCM services, patient consent is required. Documentation to support the patient/provider discussion of CCM initiation should also be present in the medical record for the initiating visit, along with the CCM care plan details. A care plan must address all health issues (not just chronic conditions) and be congruent with the beneficiary's choices and values. Care plans typically include:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and function assessment
- Symptom and medical management
- Planned interventions
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and/or providers.

Once CCM services are established, they are billed based on time spent per calendar month. The following table outlines the CPT codes used for ongoing CCM services. These codes are billed in addition to the initiating CCM visit service when applicable.

Table 1 - CCM CPT Codes and Medicare Payment Amounts

CPT Code	CPT Code Description	2024 Medicare Physician Fee Schedule National Payment Amount (Non-Facility)	2024 Medicare Physician Fee Schedule National Payment Amount (Facility)	2024 wRVU
Physician and NPP Performed CCM CPT Codes				
99491	Initial 30 minutes	$84.55	$74.56	1.5
99437	+30 minutes	$59.58	$49.93	1.0
Clinical Staff Performed CCM CPT Codes				
99490	Initial 20 minutes	$62.58	$49.60	1.0
99439	+20 minutes	$47.93	$34.62	0.7

The assigned wRVU values for CPT codes 99490 and 99439 are intended to capture the physician or NPP's time spent supervising the CCM services provided by clinical staff. The clinical staff primarily conduct the non-face-to-face activities associated with monthly CCM services with the physician or NPP providing general supervision.

The following example further demonstrates the potential impact of CCM services. (The examples presented in this article are for illustrative purposes only and are not intended to represent an opinion of fair market value compensation or CPT coding/billing guidance.)

Table 2 - Example wRVU Impact

Description	Value	Formula
Total CCM Patients for the Year	105	A
Months per Year	12	B
wRVUs[1]	1	C
Total wRVUs Attributed to CCM Services	**1,260**	**D = A*B*C**

[1] Assumes CPT code 99490 is billed each month.

Based on the above example, the physician has 1,260 CCM wRVUs, which are in addition to wRVUs generated for other non-CCM services (office visits, hospital rounding, etc.). Depending on the compensation model used by the hospital or health system, the compensation earned by the physician for CCM services has the potential to be significant.

While the wRVUs assigned for CCM services are intended to account for the billing (supervising) practitioner's involvement in CCM services, some organizations are concerned that the wRVU assigned is not weighted commiserate with the true allocation of work personally performed by the provider versus the clinical staff. Additionally, organizations may face situations where expenses paid per CCM service (clinical support costs, provider wRVU compensation, etc.) exceed reimbursement, creating an unintentional deficit.

To address these concerns, two potential scenarios are presented below. In Option 1, the employer hospital or health system could remove all the wRVUs generated from CPT codes 99490 and 99439 from the physician's productivity and instead pay a CCM oversight stipend. Under this model, the physician's duties need to be clearly defined, and a range of stipend amounts may be subject to annual review based upon the number of annual CCM wRVUs for these codes.

An illustrative example of Option 1 is included in the following table. The option includes a CCM oversight stipend based on the number of CCM wRVUs.

Table 3 - Option 1

Description[1]	Option 1	Formula
CCM Supervision Compensation per wRVU	NA	A
All Other Compensation per wRVU	$50	B
CCM wRVUs	1,260	C
All Other wRVUs	5,740	D
Total wRVUs Attributed to Physician	7,000	E = C+D
Total Clinical Compensation, excluding CCM Supervision	$287,000	F = B*D
CCM Oversight Stipend	$20,000	G
Total Compensation	$307,000	H = F+G

[1] Amounts presented are for illustrative purposes only. The options presented are not intended to represent fair market value compensation.

As mentioned previously, the CCM oversight stipend may change based on the annual CCM wRVUs. The following table provides an illustrative example of ranges for CCM oversight compensation. The CCM wRVU range was determined by estimating the wRVUs associated with various CCM patient panel sizes. The value of the CCM oversight stipend was estimated using an approximate $12.50 per wRVU[4] for the high end of each range.

Table 4 - Oversight Stipend Illustrative Ranges

CCM wRVU Range	Value of CCM Oversight Stipend[1,2]
150 to 250	$2,500
251 to 400	$5,000
401 to 600	$7,500
601 to 800	$10,000
801 to 1,200	$15,000
1,201 to 1,600	$20,000

[1] Estimated using an approximate value of $12.50 per wRVU.

[2] A CCM wRVU range greater than 1,600 annually would require a review of the compensation model in this illustration.

Another option would be to include wRVUs generated from CPT codes 99490 and 99439 in the physician's productivity but pay a reduced conversion factor for the CCM wRVUs (Option 2). An illustrative example of this option is included in the following table. Option 2 includes a 75% reduction in the conversion factor for wRVUs associated with the CCM services. PYA used the 15% differential between physician and NPP reimbursement under the Medicare Physician Fee Schedule (assuming the difference in reimbursement approximates the value of supervision by a physician) plus 10% as a potential illustrative incentive/ engagement component to support this type of service by a hospital or health system.

Table 5 - Option 2

Description[1]	Option 2	Formula
CCM Supervision Compensation per wRVU	$12.50	A = B*25%
All Other Compensation per wRVU	$50	B
CCM wRVUs	1,260	C
All Other wRVUs	5,740	D
Total wRVUs Attributed to Physician	7,000	E = C+D
Total Clinical Compensation, excluding CCM Supervision	$287,000	F = B*D
CCM Oversight Stipend	$15,750	G = A*C
Total Compensation	$302,750	H = F + G

[1] Amounts presented are for illustrative purposes only. The options presented are not intended to represent fair market value compensation.

4 $12.50 determined by multiplying $50 per wRVU by 25% (i.e., the 15% differential between physician and NPP reimbursement under the Medicare Physician Fee Schedule plus 10% as a potential illustrative incentive/engagement component).

As demonstrated in the following table, Option 1 and Option 2 allow 75% and 80%, respectively, of estimated professional collections for the CCM services to cover operating and NPP costs. The potential current model leaves only 20% of estimated professional collections for the CCM services to cover operating and NPP costs.

Table 6 - Professional Collections Analysis

Description	Potential Current Model	Formula	Option 1	Formula	Option 2	Formula
Estimated Professional Collections for CCM Services[1]	$78,851	A	$78,851	A	$78,851	A
CCM Oversight Compensation per wRVU	$50	B	NA	B	$12.50	B
Total CCM Oversight wRVUs	1,260	C	1,260	C	1,260	C
Compensation for CCM Oversight	$63,000	D = B*C	$20,000	D	$15,750	D = B*C
Amount Remaining for CCM Administration and Overhead	$15,851	E = A-D	$58,851	E = A-D	$63,101	E = A-D
As a % of Professional Collections	20%	H = E/A	75%	H = E/A	80%	H = E/A

[1] Calculated by multiplying 1,260 wRVUs by $62.58, which represents the reimbursement specific to CPT code 99490.

While the requirements continue to evolve, and CCM and other similar care management services become more prevalent, understanding the impact of these services on physician compensation models, operating margins, and patient outcomes is essential. The options shared in this article provide alternatives that allow you to assign value based on the services physically provided by the physician or NPP via a CCM compensation methodology that is simple to administer, easy to explain, and does not create unintended consequences.