# CHRONIC CARE MANAGEMENT PROGRAM
# FREQUENTLY ASKED QUESTIONS (FAQS)

**WHAT IS CCM?** Chronic care management is a specific care management service that provides coverage for patients with two or more chronic conditions for a continuous relationship with their care team. This includes formulating a comprehensive care plan, interactive remote communication and management (usually over the phone), medication management, and coordination of care between providers.

**What are the benefits of CCM?** Chronic care management is beneficial for patients in terms of ongoing health and wellness support, increased access to appropriate medical resources, enhanced communication with members of their care team, reduction in emergency room visits and hospitalization or readmissions, and increased engagement in their own healthcare.

**Who Qualifies for CCM?** Any patient having two or more qualifying chronic health conditions that are expected to last at least 12 months or until their death, or if the patient's chronic health conditions put them at significant risk of death, acute exacerbation, or functional decline are eligible for Chronic Care Management services.

**What CCM services does GIA/Brand provide?** CCM for patients with chronic GI Disease such as: IBD, IBS, PEI and esophageal disorders. ADHs focus currently is on IBD, with other diagnosis being a supportive diagnosis. CCM for chronic Liver Disease such as: NAFLD, obesity, metabolic syndrome and related conditions.

**Who administers CCM?** Anyone on the Patient's medical team (MDs, RNs, MAs, etc) can administer CCM services. GIA Providers who offer CCM services have met CCM requirements as outlined by Medicare and are qualified to provide CCM services.

**Do I need a referral to receive CCM services? - No**

**What does CCM cost?** There is normally a 20% copay for Medicare patients. Commercial insurance rates vary and may be subject to deductible, flat rate for service or a % of billed amount. GIA recommends patients to check with their insurance providers prior to enrolling in CCM services to verify eligibility and associated costs.

**How long can I receive CCM services?** The minimum chronic care management service period is one calendar month and is available for as long as the patient meets the requirements of: having two or more qualifying chronic health conditions that are expected to last at least 12 months or until their death, or if the patient's chronic health conditions put them at significant risk of death, acute exacerbation, or functional decline.

**How do I enroll in GIA CCM services?** Explicit written consent must be received from patients and documented in the patient chart to be enrolled in the GIA CCM program. Eligible patients must have: two or more chronic conditions that are expected to last at least 12 months or until death; the chronic condition must place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

**What happens if I don't experience any improvement with CCM services**? – Patients can "unenroll" from CCM services at any time.

**Can I switch CCM service providers?** – Patients cannot switch providers within the organization, however they can unenroll from services entirely and can choose a different provider from a different organization. However, they will not be eligible to receive services until the following calendar month, as only one provider can provide and bill for services within a calendar month.

**Can I have more than one CCM provider**? – No. Insurance/Medicare will only allow one Provider to provide CCM services and bill for said services in the calendar month.

**Can my GIA Provider treat chronic ailments other than GI related diseases?** No. A GIA provider can recommend and encourage patients to follow-up with your PCP or other specialists as appropriate, but cannot treat conditions outside of the gastroenterology scope of practice

**How do I find a CCM provider near me?** Visit www.gialliance.com/conditions-procedures/ccm