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Providing and Billing Medicare for Chronic Care Management

PYA

VISION BEYOND THE NUMBERS

Research studies have demonstrated time and again that care management reduces total costs of care for chronic disease patients while improving their overall health. Despite these impressive results, patients receiving care management services remain the exception, not the rule.

Historically, payers have taken the position that payment for non-face-to-face care management services (*e.g.*, medication reconciliation, coordination among providers, arrangements for social services, remote patient monitoring) is bundled into the payment for face-to-face evaluation and management (E&M) services. But these payments do not cover the significant staffing and technology investments required for chronic care management, and thus practitioners do not usually furnish these services.

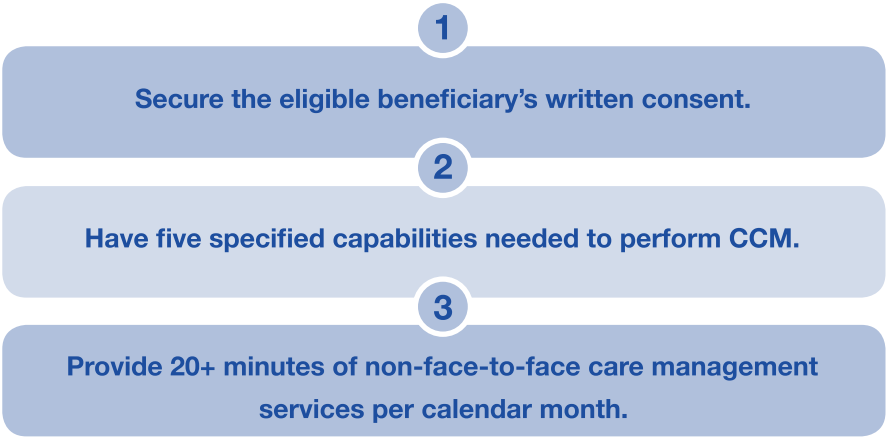
As a result, chronic disease patients are too often left to manage for themselves between episodes of care. That pattern of sporadic care translates into higher complication rates which, in turn, means more suffering and costly care.

New Medicare Payment for CCM

Beginning January 1, 2015, Medicare now pays for chronic care management, or CCM. As detailed below, CCM payments will reimburse practitioners for furnishing specified non-face-to-face services to qualified beneficiaries over a calendar month.

Specifically, CMS has adopted CPT[1] 99490 for Medicare CCM services, which is defined in the CPT Professional Codebook as follows: "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."

CMS developed the requirements for providing and billing for CCM over a three-year period. To fully understand those requirements, one must review the three different proposed and three different final rules CMS published during that period. We have analyzed those rules carefully and condensed them down to three core requirements a provider must meet to bill for CCM:



You will find a complete discussion of each core requirement in the tables below. The tables also provide an explanation of potential revenue; address which providers can bill for CCM; outline which Medicare beneficiaries are eligible for the service; and offer next steps for providers interested in furnishing CCM.

[1] Current Procedural Terminology (CPT) a registered trademark of the American Medical Association.

Potential Revenue

What is the Medicare reimbursement for CCM?

As of January 1, 2015, the national average reimbursement is $40.39 per beneficiary per calendar month. This amount (and all other payments under the Medicare Physician Fee Schedule) will increase by 0.5% on June 1, 2015, per the Medicare Access and CHIP Reauthorization Act of 2015.

Does CCM qualify as a preventive service exempt from beneficiary cost sharing?

No. CMS determined it does not have the statutory authority to exempt CCM from cost-sharing requirements. A beneficiary will be responsible for any co-payments or deductible amounts. If a beneficiary has a Medicare Supplemental Insurance (MediGap) policy, these amounts will be covered in the same manner as co-payments and deductibles for regular office visits.

What is the potential revenue associated with providing CCM?

The following analysis assumes a family medicine physician with an average size patient panel, an average percentage of Medicare beneficiaries in that panel, and the average number of Medicare beneficiaries with two or more chronic diseases:

Potential CCM Gross Annual Revenue

Description	Average	Formula
Annual Number of Unique Patients[1]	3,279	A
Percent of Patients Covered by Medicare[1]	21.85%	B
Annual Number of Unique Medicare Patients	716	C = A*B, Rounded
Percent with 2+ Chronic Conditions[2]	68.60%	D
Annual Number of Unique CCM Patients	491	E = D*C, Rounded
CCM Monthly Payment[3]	$40.39	F
Estimated Annual Gross Revenue for Family Medicine Physician	**$237,978**	**G = (F*12)*E**

[1] Per the MGMA *Cost Survey for Single Specialty Practices: 2013 Report Based on 2012 Data* specific to the specialty of family medicine. Includes Medicare A/B and Medicare Advantage.
[2] CMS.gov - *County Level Multiple Chronic Conditions (MCC) Table: 2012 Prevalence, National Average*
[3] Reimbursement amount from the *CY 2015 Physician Fee Service Final Rule;* assumes 100% of unique patients are covered by Medicare A/B. Medicare Advantage reimbursement may vary.

Of course, the incremental economic benefit a practitioner may realize depends on costs incurred in providing the service. The following detailed discussion of CCM requirements should assist a practitioner in estimating those costs.

Will Medicare Advantage (MA) plans reimburse for CCM? Commercial payers?

An MA plan must offer its enrollees at least traditional Medicare benefits, which now will include CCM. Presumably, an MA plan will pay for CCM in the same manner as it now pays for other physician services. Whether commercial payers will pay for CCM remains to be seen, although the fact CMS is paying for this service makes it more likely.

Are there other financial benefits associated with developing a CCM program?

In addition to the potential for more than $200,000 in new incremental revenue per physician (or other qualified practitioner), CCM offers practitioners a bridge over the chasm between fee-for-service and value-based reimbursement. By developing and implementing a CCM program, a practitioner will grow skill sets and internal processes critical to population health management, all the while receiving fee-for-service payment to support those activities.

Eligible Practitioners

Which practitioners are eligible to bill Medicare for CCM?	Physicians (regardless of specialty), advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse midwives (or the provider to which such individual has reassigned his/her billing rights) are eligible to bill Medicare for CCM. Other non-physician practitioners and limited-license practitioners (*e.g.*, clinical psychologists, social workers) are not eligible.
Can more than one practitioner bill for CCM for the same beneficiary for the same calendar month?	No. CMS will pay only one claim for CCM per beneficiary per calendar month. CMS has not stated how competing claims will be resolved, but presumably the practitioner with the most recent valid written consent will receive payment.
Must a practice be recognized as a patient-centered medical home (PCMH) to provide CCM?	At one point, CMS proposed PCMH recognition as a condition to provide CCM, but the Final Rule does not include this requirement. That said, the transformation to PCMH should position a practice to successfully provide CCM. Also, many commercial payers offer financial incentives for PCMH-recognized practices. There are at least four accreditation organizations that have established specific standards and are offering formal recognition for PCMH practices: National Committee on Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAHC), Joint Commission, and URAC (formerly known as the Utilization Review Accreditation Commission).
Are there specific services the billing practitioner must furnish to a beneficiary as a prerequisite to providing CCM for that beneficiary?	According to CMS' most recent guidance,[2] the billing practitioner must discuss CCM with the beneficiary as part of a separately billable face-to-face visit (i.e., comprehensive evaluation & management (E/M) visit, annual wellness visit, or initial preventive physical exam) prior to billing for CCM for that beneficiary.
Are there services for which the same practitioner cannot bill during the same calendar month as CCM for the same beneficiary?	The same practitioner cannot bill Medicare for CCM and any of the following four services for the same beneficiary in the same calendar month (with one exception noted below): (1) transitional care management (TCM) (CPT 99495 and 99496), (2) home healthcare supervision (HCPCS G0181), (3) hospice care supervision (HCPCS G0182), and (4) certain end-stage renal disease (ESRD) services (CPT 90951-90970). In the case of TCM, that service and CCM may be billed by the same practitioner in the same calendar month for the same beneficiary if the 30-day post-discharge service period for TCM concludes prior to the end of that calendar month, and at least 20 minutes of CCM services are furnished between that time and the end of that month.

[2] Centers for Medicare & Medicaid Services, "Frequently Asked Questions about Billing Medicare for Chronic Care Management Services" at 5 (May 7, 2015), available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf.

Is CCM recognized as a rural health clinic (RHC) service and/or a federally qualified health center (FQHC) service?	For now, CMS has not recognized CCM as an RHC or FQHC service; thus, these providers will not be reimbursed at their all-inclusive rate for CCM services. An RHC or FQHC may have the opportunity to bill for CCM on the Medicare Physician Fee Schedule, provided it satisfies the applicable requirements to bill for non-RHC/non-FQHC services.
Can Medicare Shared Savings Program (MSSP) participants bill for CCM?	Participants in CMS' Multi-Payer Advanced Primary Care Practice Demonstration and the Comprehensive Primary Care Initiative cannot bill CCM for those beneficiaries who have been attributed to them for purposes of these programs. Otherwise, participation in other CMS' initiatives – including the MSSP – does not disqualify a practitioner from billing CCM for any beneficiary.

Eligible Beneficiaries

Who is an eligible beneficiary?	A beneficiary is eligible to receive CCM if he or she has been diagnosed with 2 or more chronic conditions expected to persist at least 12 months (or until death) that place the individual at significant risk of death, acute exacerbation/decompensation, or functional decline. CMS has not provided a definition or definitive list of "chronic conditions" for purposes of CCM. Nor has the agency offered guidance on how to determine or document the specified acuity level. However, CMS has stated it intends for CCM services to be broadly available.
Is there a list of chronic conditions on which a practitioner can rely?	CMS maintains a Chronic Condition Warehouse (CCW) to provide researchers with beneficiary, claims, and assessment data linked by beneficiary across the continuum of care. The CCW includes information on 22 specified chronic conditions.[3] However, the CCW list is not an exclusive list of chronic conditions; CMS may recognize other conditions for purposes of providing CCM.

Requirement No. 1: Beneficiary's Written Consent

What type of consent is required?	A practitioner cannot bill for CCM unless and until the practitioner secures the beneficiary's written consent. Specifically, the beneficiary must acknowledge in writing that the practitioner has explained the following: (1) the nature of CCM; (2) how CCM may be accessed; (3) that only one practitioner at a time can furnish CCM for the beneficiary; (4) the beneficiary's health information will be shared with other practitioners for care coordination purposes; (5) the beneficiary may stop CCM at any time by revoking consent, effective at end of then-current calendar month; and (6) the beneficiary will be responsible for any associated co-payment or deductible.

[3] The CCW includes data on the following chronic conditions: Acquired Hypothyroidism; Acute Myocardial Infarction; Alzheimer's Disease Related Disorders, or Senile Dementia; Anemia; Asthma; Atrial Fibrillation; Benign Prostatic Hyperplasia; Cancer (Colorectal, Endometrial, Breast, Lung, and Prostate); Cataract; Chronic Kidney Disease; Chronic Obstructive Pulmonary Disease; Depression; Diabetes; Glaucoma; Heart Failure; Hip/Pelvic Fracture; Hyperlipidemia; Hypertension; Ischemic Heart Disease; Osteoporosis; Rheumatoid Arthritis/Osteoarthritis; and Stroke/Transient Ischemic Attack.

When and how must the consent be obtained from the beneficiary?	While CMS requires the billing practitioner to discuss CCM with the beneficiary during a face-to-face visit prior to initiating the service, CMS does not require written consent be obtained during this visit. In obtaining written consent for CCM, the billing practitioner should follow existing policies regarding consent for treatment. If the beneficiary is not competent to give his or her consent to receive CCM, the consent form should be signed by an individual with legal authority under applicable state law to consent to treatment on behalf of the beneficiary. It is not necessary to obtain a new written consent from the beneficiary each month. Once signed, the consent remains effective unless and until it is revoked by the beneficiary. The manner and impact of revocation is discussed below.
What should a practitioner do with the consent form once it is signed?	A copy of the signed consent form must be maintained in the beneficiary's medical record. See discussion below regarding the required use of a certified electronic health record (EHR) in providing CCM.
What happens if a beneficiary revokes his or her consent?	Once a beneficiary revokes his or her consent to receive CCM from a specific practitioner, that practitioner cannot bill for CCM after the then-current calendar month. The practitioner may bill for CCM for the month in which the revocation is made, if the practitioner has furnished 20+ minutes of non-face-to-face care management services for the beneficiary.
How does a beneficiary revoke consent?	CMS does not specify the manner in which a beneficiary must revoke consent. Presumably, if a beneficiary gives written consent to a second practitioner to furnish CCM, that will revoke the consent given to the first practitioner. However, this can create confusion (and billing issues) if the first practitioner is unaware of the consent given to the second practitioner.
Can a practitioner require a beneficiary to revoke consent in a certain manner?	In an effort to avoid confusion, a practitioner should specify on the CCM consent form the manner in which the beneficiary should revoke consent (*e.g.*, in writing delivered to the practitioner). Such an attempt to limit the manner of revocation, however, may or may not be recognized by CMS; CMS may deny payment based on the beneficiary's revocation in a manner other than specified on the practitioner's consent form.

Requirement No. 2: Five Specified Capabilities

What are the five capabilities CMS requires a practitioner to have to bill for CCM?	The five capabilities include: (1) use a certified EHR for specified purposes; (2) maintain an electronic care plan; (3) ensure beneficiary access to care; (4) facilitate transitions of care; and (5) coordinate care. When a practitioner submits a claim for CCM, the practitioner is, in effect, attesting to the fact the practitioner has each of these capabilities for providing CCM. Each of these capabilities is discussed in the following sections.

For what purposes must a practitioner use a certified EHR in furnishing CCM (1st capability)?	A practitioner is not required to be a meaningful user of a certified EHR technology, but is required to use "CCM certified technology" (*i.e.*, for 2015, an EHR that satisfies either the 2011 or 2014 edition of the certification criteria for the EHR Incentive Programs) to meet the following core technology capabilities: • Structured recording of demographics, problems, medications, and medication allergies, all consistent with 45 CFR 170.314(a)(3)-(7) • Creation of summary care record consistent with 45 CFR 170.314(e)(2) The practitioner must be able to transmit the summary care record electronically for purposes of care coordination. CMS does not specify acceptable methods of transmission, but does state that facsimile transmission is not acceptable. Additionally, a practitioner must use CCM certified technology to fulfill any CCM requirement that references a health or medical record. Specifically, the following must be documented in the beneficiary's record using CCM certified technology: • Beneficiary consent • Provision of care plan to beneficiary • Communication to and from home and community-based practitioners regarding beneficiary's psychosocial needs and functional deficits (care coordination)
What is the requirement for an electronic care plan (2nd capability)?	The practitioner must develop and regularly update (at least annually) an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment of the beneficiary's needs. The plan should include a list of current practitioners and suppliers that are regularly involved in providing medical care to the beneficiary, the assessment of the beneficiary's functional status related to chronic health conditions, the assessment of whether the beneficiary suffers from any cognitive limitations or mental health conditions that could impair self-management, and an assessment of the beneficiary's preventive healthcare needs. The plan should address all health issues (not just chronic conditions) and be congruent with the beneficiary's choices and values. While required to bill for CCM, the preparation and updating of the care plan is not part of the reimbursable service. Instead, these activities may be billed separately as an evaluation and management service (*e.g.*, an AWV, an IPPE, or regular office visit), provided the applicable requirements are satisfied.

What items are typically included in a care plan?	CMS has identified the following as items typically included in a care plan (although the agency does not specifically require a care plan to include each): • Problem list; expected outcome and prognosis; measurable treatment goals • Symptom management and planned interventions (including all recommended preventive care services) • Community/social services to be accessed • Plan for care coordination with other providers • Medication management (including list of current medications and allergies; reconciliation with review of adherence and potential interactions; oversight of patient self-management) • Responsible individual for each intervention • Requirements for periodic review/revision
Does the care plan have to be created, maintained, and updated using a certified EHR?	CMS requires a practitioner to "use some form of electronic technology tool or services in fulfilling the care plan element," but acknowledges that "certified EHR technology is limited in its ability to support electronic care planning at this time." Accordingly, practitioners "must have flexibility to use a wide range of tools and services beyond EHR technology now available in the market to support electronic care planning."
Who must have access to electronic care plan?	CMS imposes three requirements with respect to electronic access to the beneficiary's care plan: 1. The care plan must be electronically accessible on a 24/7 basis to all care team members furnishing CCM services billed by the practitioner. • *E.g.*, remote access to EHR, web-based access to care management application, web-based access to an electronic health information exchange (HIE) (facsimile is not sufficient) 2. The practitioner "must electronically share care plan information as appropriate with other providers" caring for the beneficiary. • *E.g.*, secure messaging, participation in HIE (facsimile not sufficient) 3. The practitioner must make available a paper or electronic copy of the care plan to the beneficiary. • Must be documented in CCM certified technology

What is required with respect to beneficiary access to care (3rd capability)?	A practitioner furnishing CCM must: 1. Provide a means for the beneficiary to access a member of the care team on a 24/7 basis to address acute/urgent needs in a timely manner (who constitutes a member of the care team is discussed below). 2. Ensure the beneficiary is able to get successive routine appointments with a designated practitioner or member of care team. 3. Provide enhanced opportunities for beneficiary-practitioner (or caregiver-provider) communication by telephone and asynchronous consultation methods (*e.g.*, secure messaging, internet), although the beneficiary is not required to use these methods.
What is required with respect to transitions of care (4th capability)?	A practitioner must have the capability to do the following: 1. Follow-up with the beneficiary after an ER visit. 2. Provide post-discharge transitional care management (TCM) services as necessary (although the practitioner cannot bill for TCM and CCM during the same month). 3. Coordinate referrals to other clinicians. 4. Share information electronically with other clinicians as appropriate (see prior discussion of summary care record and electronic care plan).
What is required with respect to coordination of care (5th capability)?	The practitioner must have the capability to coordinate with home and community-based clinical service providers to meet beneficiary's psychosocial needs and functional deficits (including providers of home health and hospice, outpatient therapies, durable medical equipment, transportation services, and nutrition services). The practitioner's communication with these service providers must be documented in CCM certified technology.

Requirement No. 3:
20+ Minutes of Non-Face-to-Face Care Management Services

What types of services constitute non-face-to-face care management services?	In the context of CCM, CMS identifies the following types of services performed on a beneficiary's behalf as counting toward the 20-minute requirement: (1) performing medication reconciliation and overseeing the beneficiary's self-management of medications; (2) ensuring receipt of all recommended preventive services; and (3) monitoring the beneficiary's condition (physical, mental, social). This list, however, is not exclusive; other types of services may count toward the 20-minute requirement. In the context of TCM, for example, CMS identified the following additional services as non-face-to-face care management services: provide education and address questions from patient, family, guardian, and/or caregiver; identify and arrange for needed community resources; and communicate with home health agencies and other community service providers utilized by the beneficiary.
Who may perform non-face-to-face care management services?	CMS anticipates "clinical staff will provide CCM services incident to the services of the billing physician" or non-physician practitioner.[4] However, if the billing practitioner provides these services directly, that time also counts toward the 20-minute minimum. The agency references the CPT definition of "clinical staff": "a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service."[5] CMS clarifies that "time spent by clinical staff may only be counted if Medicare's 'incident to' rules are met such as supervision, applicable State law, licensure and scope of practice."[6] It is the responsibility of the billing practitioner to determine a clinical staff member is competent and capable of performing a specific service under appropriate supervision. CMS also notes that "other staff may help facilitate CCM services, but only time spent by clinical staff may be counted towards the 20 minute minimum time." The agency also explains that a billing practitioner may arrange to have clinical staff external to the practice (*e.g.*, a case management company) provide the non-face-to-face care management services for his or her patients, but only if all requirements for "incident to" billing are satisfied, including general supervision (see following section). However, Medicare rules prohibit billing for services furnished by individuals located outside the U.S.

[4] See footnote 2 at 1
[5] American Medical Association, *2015 CPT Handbook*.
[6] See footnote 2 at 1.

What level of supervision is required for clinical staff providing non-face-to-face management services?	Initially, CMS proposed to require direct supervision of clinical staff (*i.e.*, physician or other practitioner present in the same suite of offices and immediately available to provide assistance while non-face-to-face care management services were being provided), with a limited exception for services furnished outside normal business hours. However, the Final Rule requires only general supervision (*i.e.*, physician or other practitioner available by telephone to provide assistance as required). The physician or other practitioner does not have to be the same person under whose name CCM is billed. Thus, a practitioner could contract with a third party to provide non-face-to-face care management services (including after-hours availability to address the beneficiary's urgent care needs), provided the third party has electronic access to the beneficiary's care plan. This "subscription service" approach would allow a smaller practitioner that could not otherwise afford necessary staffing to provide CCM.
What documentation is required?	CMS does not list explicit documentation requirements for non-face-to-face care management services. In the event of an audit, a practitioner would be well-served to have the following documentation available in the beneficiary's record: • Date and amount of time spent providing non-face- to face services (preferably start/stop time) • Clinical staff furnishing services (with credentials) • Brief description of services
What time counts toward the 20-minute minimum requirement?	Time spent providing services on different days or by different clinical staff members in the same calendar month may be aggregated to total 20 minutes. However, if two staff members are furnishing services at the same time, only the time spent by one individual may be counted. Time of less than 20 minutes during a calendar month cannot be rounded up to meet this requirement; nor may time be carried over from a prior month.
Can face-to-face activities be counted toward the 20-minute minimum requirement?	According to CMS, CCM involves activities not typically or ordinarily furnished face-to-face. If these activities occasionally are provided by clinical staff face-to-face with a beneficiary, the time may be counted toward the 20-minute minimum requirement.
Can CCM services furnished on the same day as an office visit be counted toward the 20-minute minimum requirement?	CMS has stated that "[f]ace-to-face time that would otherwise be considered part of the E/M service that was furnished cannot be counted toward [CCM]. Time spent by clinical staff providing non-face-to-face services within the scope of the CCM service can be counted . . . . If both an E/M and the CCM code are billed on the same day, modifier -25 must be reported on the CCM claim."[7]

[7] See footnote 2 at 4-5.

Can CCM services furnished while the beneficiary is an inpatient be counted toward the 20-minute minimum requirement?	CCM cannot be billed for services furnished to an inpatient at a hospital or skilled nursing facility, or a resident at a facility that receives Medicare payment for that individual. However, if the beneficiary is not an inpatient or resident for the entire month, time spent furnishing CCM services while he or she is not an inpatient or resident can be counted toward the 20-minute minimum requirement for that month.
Can a practitioner practicing in a hospital outpatient department bill for CCM? Can the hospital bill for CCM?	CMS has clarified that a practitioner who bills for CCM while practicing in a hospital outpatient department will be paid at the facility rate, which is approximately $9.00 less than the non-facility rate (i.e., the payment made to a practitioner practicing in an outpatient office setting). This payment compensates the practitioner for providing direction to hospital staff furnishing non-face-to-face care management services for the beneficiary (who is considered a hospital outpatient for this purpose). CMS also has clarified a hospital outpatient department is eligible to bill CPT 99490 under OPPS in these circumstances. This payment compensates the hospital for the costs associated with the clinical staff furnishing the non-face-to-face care management services and related expenses.
Can remote monitoring be counted as part of the 20-minute minimum requirement?	According to CMS, "[p]ractitioners who engage in remote monitoring of patient physiological data of eligible beneficiaries may count the time they spend reviewing the reported data towards the monthly minimum time for billing the CCM code, but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device." CMS has clarified that "in order to bill CPT 99490, such activity cannot be the only work that is done – all other requirements for billing CPT 99490 must be met in order to bill the code . . . ."[8]

Billing for CCM

When filing a claim for CCM, what should be listed as the date of service?	The billing practitioner may list as the date of service the day on which the 20-minute minimum requirement is satisfied or any day thereafter through the end of the calendar month. If the beneficiary dies during the month, the claim for CCM will be paid only if the date of service is prior to the date of death.
What should be listed as the place of service?	The billing practitioner must list as the place of service the location at which he or she would furnish a face-to-face office visit with the beneficiary. Thus, a practitioner who practices in a hospital outpatient department must list "22" as the place of service on the CCM claim form, triggering payment at the facility rate.

[8] See footnote 2 at 3-4.

So What's Next?

Who can help your organization design and implement a CCM program?	PYA has the experience and know-how to assist your organization in developing an effective and efficient chronic care management program. We pride ourselves on our ability to transition complicated rules and regulations into practical, straightforward strategies.
Who are the members of PYA's team?	Our integrated delivery team includes experienced clinicians, certified case managers, regulatory specialists, data analysts, process improvement professionals, and IT specialists.
What specific services does PYA provide?	Our CCM-related services include: • Gap analysis (current capabilities and resources vs. CCM requirements) • Business plan development and ROI analysis • Staffing plans • Staff training • Identification and stratification of eligible beneficiaries • Development and implementation of beneficiary enrollment process • Work flow design • Electronic care plan development • Documentation tools • Internal/patient communication strategies • Selection of supportive technology • Strategies to achieve PCMH recognition • Coding and billing processes • Compliance reviews

PYA can help you devise a sound strategy for providing and billing Medicare for CCM. To learn more, please contact one of the following:

Lori Foley
Principal - Atlanta
lfoley@pyapc.com
(888) 420-9876

Martie Ross
Principal - Kansas City
mross@pyapc.com
(800) 270-9629

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