Chronic Care Management Services
CY 2015 Medicare Physician Fee Schedule

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Agenda

- Overview of chronic care management (CCM) services under the CY 2015 Medicare Physician Fee Schedule (PFS)

- Overlap with CMS demonstration and other initiatives

- Eligible population

- Scope of service

- Who can furnish CCM

- PFS Valuation

- Q&A

Overview

- Separate payment in CY 2015 under PFS for new CPT code 99490 for non face-to-face care management/coordination; about $43 (office) and standard coinsurance applies

- Beneficiaries with 2 or more chronic conditions

- Once per calendar month, if furnish a minimum of 20 min of qualifying care

- Only one practitioner can bill per month (per CPT and Medicare instructions)

- Transitional Care Management (TCM) and other overlapping care management services cannot be billed during the same service period

Overview

- Most requirements finalized in the CY 2014 PFS final rule, effective CY 2015

- CY 2015 PFS final rule addresses valuation, supervision and other incident to rules, scope of service element for electronic health record (EHR), and intersection with CMS' advanced primary care demonstrations

Overlap with CMS Demonstration and Other Initiatives

- Practitioners cannot bill CCM for patients attributed to their practices for participation in the Multi-payer Advanced Primary Care Practice Demonstration or the Comprehensive Primary Care Initiative since these initiatives pay for similar services

- Practices affiliated with Accountable Care Organizations may be eligible to bill

- Consult applicable CMS staff

Eligible Population

- Beneficiaries with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patients at significant risk of death, acute exacerbation/decompensation, or functional decline

Scope of Service

Summary Table 33 in 2015 PFS final rule

1. Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record, using a certified EHR

– This and other activities requiring certified EHR technology (CEHRT) must be completed using the edition(s) of certification criteria that is acceptable for the EHR Incentive Programs as of December 31st of each calendar year preceding each PFS payment year ("CCM certified technology", e.g., 2011 or 2014 edition for CY 2015 payment year)

Scope of Service

2. 24/7 access to care management services

– Providing the patient with means of timely contact with health care providers in the practice having access to the health record, to address urgent chronic care needs at all times

3. Continuity of care with a designated member of the care team

– Ability to obtain successive routine appointments with this individual

Scope of Service

4. Systematic assessment of health needs and receipt of preventive services
- – Systematic assessment of medical, functional and psychosocial needs

- – Systems based approaches to ensure timely receipt of all recommended preventive services

- – Medication reconciliation with review of adherence and potential interactions

- – Oversight of patient self-management of medications

Scope of Service

5. Electronic care plan

- Creation/maintenance of comprehensive plan of care for all health issues that is patient-centered, based on a physical, mental, cognitive, psychosocial, functional and environmental assessment or reassessment, etc.

- No CEHRT in 2015, but must at least electronically capture care plan information; make this information available 24/7 to all practitioners within the practice whose time counts towards the time requirement for the practice to bill the CCM code; and share care plan information electronically (other than by fax) as appropriate with other providers and practitioners

- Written/electronic copy to patient/caregiver, document its provision in the EHR using the CCM certified technology

Scope of Service

6. Management of care transitions - Managing transitions between and among health care providers and settings including referrals to other clinicians, follow-up after ER, and follow-up after discharge from hospital, skilled nursing facility or other health care facility

- – Create/format clinical summaries according to CCM certified technology

- – Transmission/exchange of summary care record using any electronic tool (other than fax)

Scope of Service

7. Coordination with home and community-based clinical service providers as appropriate

– Communication to and from these providers must be documented in the EHR using CCM certified technology

8. Enhanced communication opportunities for patient and caregiver

– Communication with the practitioner regarding the beneficiary's care through telephone, secure messaging, secure internet or other asynchronous non face-to-face consultation methods (subject to HIPAA)

Scope of Service

9. Informed consent - Document the beneficiary's written consent and authorization in the EHR using CCM certified technology.

- Inform beneficiaries in advance of their eligibility for CCM, documenting the explanation and offer

- Document written informed consent (or decline), including permission to electronically share relevant medical information with other providers

- Inform of the right to discontinue CCM, verbally or in writing, at any time (effective at the end of the service period) and the effect of revoking the agreement

- Inform that only one practitioner can furnish and be paid by Medicare for CCM within a service period

- Inform that cost sharing applies

Scope of Service

- Informed consent, cont'd
    - Billing practitioner must initiate the CCM service prior to furnishing or billing it, during a face-to-face visit (annual wellness visit, initial preventive physical exam, or comprehensive E&M visit billed separately)

Who Can Furnish CCM

- Physician, NP, PA, CNS or CNM subject to state licensure and scope of practice; clinical staff incident to these practitioners subject to PFS incident to rules

- Qualifying "clinical staff" defined by PFS incident to rules and CPT

- General supervision of clinical staff

- PFS incident to rules apply regarding employment/contractual arrangements (42 CFR 410.26)

- Non-clinical staff time excluded from the minimum 20 minute time required to bill

- May typically be furnished by primary care, but specialist could bill if all requirements are met

Valuation under the PFS

- Payment for CPT code 99490 based on the valuation of similar care management services (the non face-to-face portion of TCM services)

- CPT codes 99487 & 99489 (complex chronic care management) continue to be bundled under the PFS

Resources

- PFS Final Rules
  - 2014 PFS final rule (CMS-1600-FC) pages 74414-74427 and 2015 PFS final rule (CMS-1612-FC) pages 67715-67730, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html

- Fact Sheet
  - Medicare Learning Network® "Chronic Care Management Services" Fact Sheet http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- If you have questions following this call: Contact your Medicare Administrative Contractor

Question & Answer Session

Acronyms in this Presentation

- CCM   Chronic Care Management
- CEHRT   Certified Electronic Health Record Technology
- CFR   Code of Federal Regulations
- CMS   Centers for Medicare & Medicaid Services
- CNM   Certified Nurse Midwife
- CNS   Clinical Nurse Specialist
- CPT   Current Procedural Terminology
- CY   Calendar Year
- E&M   Evaluation and Management
- EHR   Electronic Health Record
- ER   Emergency Room
- HIPAA   Health Insurance Portability and Accountability Act
- MLN   Medicare Learning Network®
- NP   Nurse Practitioner
- PA   Physician Assistant
- PFS   Physician Fee Schedule
- TCM   Transitional Care Management

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