MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Understanding and Promoting the Value of Chronic Care Management Services Call
MLN Connects National Provider Call
Moderator: Nicole Cooney
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Nicole Cooney. Thank you. You may begin.

Announcements and Introduction

Nicole Cooney: Hello, everyone. Thank you for joining us today. I'm Nicole Cooney from the Provider Communications Group here at CMS. Welcome to this MLN Connects National Provider Call on the Understanding and Promoting the Value of Chronic Care Management Services. MLN Connects Calls are part of the Medicare Learning Network®.

On today's call, CMS experts will talk about the benefits of providing chronic care management or CCM services and changes for CCM as discussed in the Physician Fee Schedule final rule. A new outreach and education campaign from the CMS Office of Minority Health is designed to increase awareness about the value of CCM, encourage adoption, and provide an opportunity for health care professionals to ask questions. A question-and-answer session will follow today's presentation.

Before we begin, I have a few announcements. Today's call is via teleconference only. It is not a webinar or webcast. You will need the slides to follow along with the call. You should have received a link to the presentation in your registration and confirmation email. If you've not already done so, you can view or download the presentation from the CMS website at go.cms.gov/npc – that's go.cms.gov/npc – and select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website under Call Materials. We will put an announcement in the MLN Connects newsletter when these are available.

At this time, it's my pleasure to turn the call over to Michelle Oswald. Michelle?

Presentation

Michelle Oswald: Thank you, Nicole.

Hi, everyone. My name is Michelle Oswald, and I work in the CMS Office of Minority Health. And we are excited to talk to you today about chronic care management services.

So if you turn to slide number 4, you can see the agenda. So, we are here today to hopefully provide more in-depth information to you and answer some of your questions around chronic care management services.

Chronic Care Overview

So turning to slide number 5. Why do we need chronic care management? As you can see, according to the CDC, about half of all adults in the United States, around 117 million people, have one or more chronic health conditions and one in four adults have two or more chronic health conditions. Chronic diseases are prevalent among Medicare beneficiaries, with two-thirds of beneficiaries having two or more chronic conditions. And as we know, having multiple chronic conditions increases the risk for poor health outcomes and mortality and leads to increased health care spending. Chronic care management is a critical component of primary care. So we hope the information today will be beneficial to you and your practice.

So now I'm going to turn it over to my colleague Ann Marshall in the Center for Medicare to talk about the value of chronic care management and provide more details on the 2017 changes.

The Value of Chronic Care Management Services

Ann Marshall: Thank you, Michelle.

This is Ann Marshall in the Division of Practitioner Services. We're going to go over a new set of billing codes for 2017 and what the requirements are for chronic care management services. We have had a code that's been effective since 2015, but we made a significant amount of changes through rulemaking last year for this current payment year, and we want to highlight what those are.

Before I go into this section of the slides, I want to refer you on page 10 to a link that is there for detailed guidance regarding the CCM initiatives that we're going to talk about today. We have reorganized a section of the Physician Fee Schedule webpage to include a section for care management services. And we have there the fact sheets – two of

them – and a set of FAQs on chronic care management services and also some guidance on related services like transitional care management services. So, we just wanted to point you to that for additional information and frequently-asked questions by way of overview.

But jumping back to slide 7 – so for purposes of this call today, what we mean by chronic care management services are given the statistics that Michelle talked about. With the morbidity of multiple chronic conditions, in recent year CMS has been engaged in various efforts that you may be familiar with to improve payment for comprehensive care management for beneficiaries with multiple chronic conditions. They have a significant need for more centralized and coordinated management of their health care through care management services that are typically provided on a non-face-to-face basis across a more extended period of time as opposed to the traditional office visit. So, in addition to several demonstrations that are going on in the Innovation Center to test new primary care and care management care models, on the Fee-for-Service side under Medicare Part B we have been working to change the coding structure to better identify and separately pay for this kind of care.

And so, beginning in 2015, as I mentioned, we adopted – began adopting a series of new Part B billing codes that describe and pay for chronic care management services by a physician or one of the advanced practitioners listed here on slide 7. So that would be a physician assistant, nurse practitioner, clinical nurse specialist, or a certified nurse midwife. These services are per calendar month for a month in which a qualifying amount of time is spent performing certain activities. So they are timed services. And in this section of the presentation we are going to go over what kinds of activities are included – so, what exactly is meant by chronic care management, what codes can be used to report these services – there are four of them in particular – who the eligible patients are, and who the eligible practitioners and providers are to bill.

So just to start at the bottom of page 7, the codes describe a threshold amount of clinical staff service time performing qualified activities per month under the direction and oversight of one of the types of – of a physician or one of the types of practitioners – advanced practitioners listed here. Clinical staff will be working under the usual incident-to relationship under general supervision of the billing practitioner, or the billing practitioner can perform the work themselves and count their own time. And as we'll see later in the presentation, for 2017 some of the codes, in addition to the clinical

staff time, also include moderate to highly complex medical decisionmaker, which is an activity of the billing practitioner themselves.

Moving to slide 8. Before we go over the individual code list, by way of overview, they all have sort of a core set of service elements that are listed here on this slide. They have been the same sort of core set of service elements since 2015 even though the coding has changed. We simplified these elements for this year compared to prior years in last year's regulation. The services listed here are characteristic of advanced primary care. For example, they include a comprehensive electronic care plan that addresses all health issues with a particular focus on the chronic conditions as well as a system to ensure receipt of all recommended preventive services.

The services include medication management and reconciliation as well as activities that are usually referred to as transitional care management. So that involves facilitating and coordinating referrals and followup care after emergency room visits or facility discharges. Of course, service elements include coordination with home- and community-based providers. It also includes timely sharing of relevant health information both within the billing practice and outside of it. There is a requirement to use a certified electronic health record, which we did limit this year and going forward to a structured recording of just a limited data set. So that would be demographics, medications, medication allergies, and a problem list.

There are several other elements here. I'm just going to highlight them. But you can find them – and more detailed discussion on them in the fact sheets and the FAQs that I referred earlier. There's 24/7 access to address urgent needs. There's also a requirement for advance patient consent because the usual Part B cost sharing does apply to these services. And because they're services that don't necessarily involve direct contact with the patient, we believe they need to be aware in advance that cost sharing may apply even though they may have wraparound or supplemental health insurance to help with that cost.

And also, the beneficiary needs to be informed in advance that only one practitioner can bill the services. This, we hope, will help to assist in preventing duplicate providers as only one professional claim and only one facility claim can be submitted per month per patient. The advanced consent should also include how to revoke or stop the services.

And even though that may sound like an extensive consent process, this year we did reduce it to a requirement to obtain consent verbally than written. And so this should be a facilitative process – piece of the process going forward.

And then on the last bullet on slide 8, the complex CCM codes, as we will see and as I mentioned, do include highly or moderately complex medical decisionmaking, which is defined by the traditional evaluation and management guidelines.

One more element that is not actually shown here because it is not actually considered part of the monthly services, but there is a requirement for an initiating visit, which is a face-to-face visit with a reporting practitioner. We did reduce that from being required in past years for all patients to only being required this year and going forward for new patients or those who have not been seen within a year prior to the commencement of CCM services. This is a face-to-face visit with the billing practitioner. It establishes the relationship with them since the majority of the services may be furnished incident to – on an incident-to basis. It enables them to collect information and conduct assessment that will inform the care plan. The initiating visit is separately reportable under the usual evaluation and management codes, or it can also be an annual wellness visit or IPPE.

So slide 9 just includes a few more notes about what is characteristic of chronic care management in this context. We do believe the included activities are a critical component of care that contributes to better outcomes as well as higher patient satisfaction. These are person-centered services, so they should be focused on the individual. And, again, they require centralized management of patient needs and extensive care coordination.

Moving on to slide 10. We're going to – this slide lists the specific codes for 2017. So, just briefly, the first code, CPT code 99490, is for a minimum of 20 minutes of clinical staff time. And that has been in effect since January 1, 2015. Starting this year, we've adopted three additional billing codes. CPT codes 99487 and 99489 are a base and add-on code pair that describe patients with greater complexity, which is defined by the amount of clinical staff time and some other parameters that we'll look at in more detail in a minute. G0506 is an add-on code for patients who do get an initiating visit. When that is performed, this code can be added on to the codes for the initiating visit itself to account for time with the billing practitioner when they personally perform an extensive assessment and personally perform care planning in preparation for chronic care

management services. And it is only to account for billing practitioner time, and it does not involve any clinical staff piece.

Moving on to page 11. Before we get into the details of those codes, the eligible beneficiaries have two or more chronic conditions that are expected to last at least 12 months or until death that place them at significant risk. This is the – included in the code descriptors, and there are no other diagnostic limitations. They can be mental health conditions. They can be physical conditions. We have not limited the eligible conditions to any specific list. There may be certain lists out there, such as the Chronic Conditions Warehouse that CMS maintains that you may want to reference and that we referenced in developing these codes. But there's not a set list of diagnoses as long as they meet these criteria, which are included within the code descriptors themselves.

We did provide through rulemaking that a given beneficiary will receive either a non-complex CCM – that is the regular base code 99490 – or complex CCM for a given month. They would not be receiving both. So you would not be stacking the 99490 – or the 99487 or 9 on top of 99490. It would be one or other within a given month.

In terms of eligible reporting practitioners, providers, and suppliers, the folks who can submit claims are, for professional claims, the providers that we mentioned earlier, the physicians or the advanced practitioners listed here on slide 11. Rural health centers and federally qualified health centers can also report these services. And we'll have a separate section on the requirements for them in a few minutes.

Hospital outpatient departments, including critical access hospitals, can report these services. And we do allow a facility and a professional claim within the same month, which is a traditional dual billing that would apply, for example, in a provider-based setting. However, only one practitioner, in other words, only one professional claim can be submitted per month and only one hospital can report CCM per month.

Changes for Calendar Year 2017

Moving on to page 12, we will start looking at the codes themselves in a little bit of detail. Again, CPT code 99490 is still effective for regular or what we sometimes refer to as non-complex CCM, which is the $43 code. That is the facility – the office rate.

Excuse me. And, then, we have the other three codes. And for all of the codes, we simplified and reduced that core set of service elements, which we will look at in a minute.

On page 13, there is a table that shows all of the CCM-related codes – so what the new coding schema looks like. The top two rows are the actual CCM service codes – so, the regular or non-complex CCM and then the complex CCM codes below that. You can see in the columns here the differences between them in terms of clinical staff service time, the complexity of the medical decisionmaking, and the extent and nature of the care planning. And then the bottom two rows in this table show the initiating visit codes and the potential add-on code G0506.

So moving on to slide 14. In terms of those core service elements, we just wanted to have a separate section here that highlights what some of the changes were from last year so that you can see that more easily. There is also a fact sheet on the page – the webpage that I referred to earlier that specifically highlights these and other changes for 2017. But, first, the complex CCM service codes do provide higher payment for complex patients, which is those for whom the billing practitioner is addressing problems of moderate or high complexity during the month and for patients who also require 60 or more minutes of clinical staff time and substantial care revision or, of course, it might be care plan establishment in the first month.

I think I already went through some of the changes in the patient consent process for this year. We did reduce the technology requirement significantly. We retained the requirement to use a certified EHR, but there's a limited data set. And we changed the focus in terms of how information has to be exchanged to exchanging information timely rather than using specific electronic technology for these pieces. We do discourage the use of fax, but it can count for electronic exchange where we are still specifying that as long as it is timely. And, similarly, the care plan no longer has to be available electronically to individuals providing CCM after hours as long as they have timely information. And there is a discussion of what is meant by "timely" in the educational guidance on the webpage and also the regulations.

We've significantly improved the alignment with CPT code language. We simplified some of the documentation requirements. And, again, we made some changes to who requires that initiating visit so that it's easier for you to get patients started with CCM

without necessarily performing a face-to-face visit that might not be medically necessary.

And, finally, on page 15, we just wanted to make some notes about the cost sharing. This is a topic that we've discussed a lot in the rules and with many stakeholders over time. And we just wanted to note that currently, we lack authority under the law to remove the usual Part B cost sharing that applies to these services just as it would for any Part B service that's not a preventive service or a special service under the statute for which we get special authority to waive the cost sharing. But we did want to make sure folks know that Medigap plans must provide wraparound coverage of cost sharing for CCM just like for other services – most beneficiaries do have Medigap or other supplemental insurance – and that includes qualified Medicare beneficiaries who are the majority of dually eligible beneficiaries, that is, those beneficiaries who have Medicare and Medicaid both. Those beneficiaries are going to be exempt from cost sharing. And we have an FAQ online explaining that.

And now I'm going to turn it over to Corinne Axelrod to talk about the requirements for billing and RHCs and FQHCs.

Billing Requirements and RHCs and FQHCs

Corinne Axelrod: Hi everybody. I am Corinne Axelrod, and I am here with Simone Dennis, and we both work on Rural Health Clinics and Federally Qualified Health Centers. So, we just have a few slides on CCM and RHCs and FQHCs, beginning on slide 16.

Beginning January 1st of 2016, RHCs and FQHCs could start to receive payment for CCM services when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim. The RHC and FQHC face-to-face requirements were waived when CCM services are furnished to an RHC or FQHC patient. And the payment is based on the Medicare Physician Fee Schedule national payment rate – national non-facility payment rate, which in 2017 is $43.28.

****Post-Call Clarification: And the payment is based on the Medicare Physician Fee Schedule national payment rate – national non-facility payment rate, which in 2017 is $42.71****

And I just want to note that the payment rate is based on the Physician Fee Schedule. It is not paid under the Physician Fee Schedule. And this rate is updated annually and there is no geographic adjustment.

On slide 17, we also made changes to the requirements. Starting on January 1st of 2017 that RHCs and FQHCs can furnish CCM services under general supervision requirements instead of under direct supervision requirements. And we revised the scope of service requirements, which include the initiating visit, the electronic care plan, beneficiary consent, etc., consistent with the Physician Fee Schedule scope of service changes that Ann talked about just a few minutes ago. So we hope that these changes will be helpful for RHCs and FQHCs who want to provide CCM services to their patients.

We have received questions on the new complex CCM codes, which are CPT 99487 and 99489, and the initiating visit add-on, which is G0506. So, I just want everybody to understand that RHCs and FQHCs are not authorized to bill these three new codes. And the reason for that is that payments for RHCs and FQHCs are not adjusted for the length or complexity of the visit. So these codes should not be billed by RHCs or FQHCs. And if they are billed, they should not be paid, and if they are paid, then they would be subject to recoupment.

Okay, I'm going to turn this now over to Nicole. And thank you.

Keypad Polling

Nicole Cooney: Thanks, Corinne.

At this time, we're going to pause for just a brief second to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. There'll be a few moments of silence while we tabulate the results.

Holley, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more

of you in the room, enter nine. Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Again, please hold while we complete the polling.

Thank you for your participation. I'll turn the call over to Nicole Cooney.

Nicole Cooney: Thanks, Holley.

And at this time, I'll turn it back over to Michelle Oswald to give the remainder of our presentation.

Michelle?

Presentation (Continued)

Michelle Oswald: Great. Thank you, Nicole.

So, I'm excited to talk to everyone today about a new campaign that we are launching a few weeks from now around chronic care management.

Chronic Care Management Resources

So if you go on to slide 20, you can see that the CMS Office of Minority Health is partnering with the Federal Office of Rural Health Policy at the Health Services and – Health Resources and Services Administration to design and implement a chronic care management campaign. This campaign will promote the benefits of chronic care management services and encourage participation for racial and ethnic minorities and Medicare beneficiaries living in rural areas.

Slide 21. So this campaign will have two interconnected audiences, one being health care professionals and the other being the patient. The health care professional audience will focus on practitioners and suppliers who are eligible to bill for chronic care management services, with an emphasis on reaching health care professionals who practice in underserved rural areas and in communities with a large population of racial and ethnic minorities. The patient audience will include Medicare beneficiaries who have two or more chronic conditions and, again, with a focus on reaching racial and ethnic minorities and individuals in rural areas. We also have a secondary target audience for the campaign, which will include ancillary health care workers, health

system leaders and administrators, and caregivers of patients with chronic conditions who assist those patients with accessing care and making heath decisions.

On the next slide, slide 22, you can see that this is a national campaign, and we are planning to launch in a few weeks. We will be pushing information out to every State. But we have also selected some specific areas to do some targeted outreach. We will target four specific states: Georgia, New Mexico, Pennsylvania, and Washington State. And, using Medicare claims data along with some other factors that you can see listed here, we identified two markets within each of those States—one rural county and one urban area—to implement localized activities, which will include community outreach and media promotion.

So, as you can see on slide 23, there are different elements of the campaign that are all important to making it a success. We will include all of these activities at the national, regional, and local levels. We plan to have educational tools and resources that I'll talk about in the next few slides. Our partners such as yourself are essential to implementing this campaign. We will work closely with our Federal partners as well as organizations at the national and local levels that can use existing communication and outreach channels to disseminate messages and reach our target audiences. We will also have media activities planned, which will be a mix of traditional media outreach as well as some social media, and we will be directing folks to our new chronic care management campaign website with all of our new resources that I will give you at a later slide.

On slide 24, one of our new chronic care management products that we'll be launching is a health care professional toolkit. We've heard from doctors on several occasions that they want to implement chronic care management services into their practice, but they don't know how to get started. Others also providing these services aren't billing for them. We're hoping that these resources will help practices to get started. The toolkit will include things like a guide to help getting started, how to talk to your staff and patients, background information, and a resources page to pull together the CMS fact sheets on chronic care management as well as some other educational materials, to include a patient flyer, a poster, and also some testimonials from other health care professionals that will share their experience with implementing chronic care management programs in their practice.

On slide 25, we also are creating some educational materials that can be adapted for physician practices and shared with patients. Again, as I mentioned, we'll have posters for clinics that'll be available for display, some postcards to share with patients that highlight chronic care management benefits, and also we're finalizing an animated video for patients that explains the benefits of chronic care management services that doctors can play in their offices. Again, these materials will be available in the next few weeks on our new website. And that website is go.cms.gov/ccm.

On slide 26, we talk about partnerships. Partnerships are very important for this campaign. We are encouraging organizations that represent health care professionals, health systems, clinics, community health centers, patients, and caregivers to reach out to us and get involved in the campaign at the national, State, and community levels. And if you're interested in partnering, you can email us – ccm@cms.hhs.gov.

And on slide 27 is the website that was listed. We're excited that our new campaign website will be launching soon. And that's go.cms.gov/ccm. Our goal is that this website will be a one-stop shop for chronic care management, with all of our new products as well as links to chronic care management resources, including the existing CMS care management page and CCM fact sheets and FAQs and information on upcoming chronic care management webinars and events.

On slide 28, how can you get involved? We hope that you'll join us in making the chronic care management campaign a success. As you can see on this slide, your support is critical. There are many ways that you can get involved, from becoming a campaign partner to using the tools and resources contained in the toolkits. And we hope you'll visit our website in the future for more information or email us to become a partner.

And I'll turn it now back over to Nicole for the Q&A session.

Question and Answer Session

Nicole Cooney: Thank you.

We are ready to take participant questions. And I want to remind everyone that this call is being recorded and transcribed. Before asking your question, please give your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you'd like to ask a followup

question or have more than one question, you may press star, one to get back into the queue, and we'll address additional questions as time permits.

All right, Holley, we're ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Our first question will come from the line of Jean Acevedo.

Nicole Cooney: Hi, Jean. Did you have a question for us?

Jean Acevedo: Hi. Thank you so very much. So my question is about the new G0506 code, which, as a physician consultant, I'm delighted to see that CMS has implemented this year. This is designated as an add-on code. And, also, CMS has relaxed the requirements that the patient has been – as long as a patient is not a new patient, has been seen within the last year, that there's no reason for a face-to-face visit. But, to really initiate chronic care management well, a face-to-face encounter is really a good idea to go over the care plan and lay out goals for the patient, etc. So, can G0506 be billed on its own if that's all – if I was a physician or a physician practitioner, I had seen Mary Jane last month, called and asked about would she be interested in chronic care management and she said yes, can I bring her back to the office and just spend some time going over a care plan and bill G0506? Or must it be with another visit code?

Ann Marshall: Hi. Thanks for the question, Jean. This is Ann Marshall. So, it sounds like what you're saying is you would do the consent in this scenario verbally, which is fine. And then if you're going to bring the patient in for a visit, you would be billing an E&M visit code for that, Even if it's a 99212, say, a brief visit, it would be a face-to-face with a reporting practitioner, and you would have to meet the requirements for billing that base code in order to bill G0506 on top of it or in association with it. You could do that. But you would be billing G0506 then with an initiating visit code prior to the monthly service code billing.

Operator: And our next question will come from the line of Debbie Bonds.

Debbie Bonds: Hello.

Nicole Cooney: Hi, Debbie. Did you have a question?

Debbie Bonds: I do. On slide 17, you said the RHCs and FQHCs can furnish CCM services under general supervision requirements instead of direct supervision requirements. Can you tell me the difference between general and direct?

Corinne Axelrod: Hi. This is Corinne. So in an RHC or FQHC under direct supervision, the RHC or FQHC practitioner would have to be on the premises while the service is being furnished. Under general supervision, they do not have to be there. So, this will enable RHCs and FQHCs to contract out CCM services.

Debbie Bonds: Oh, okay. Thank you.

Operator: And our next question comes from the line of Norman Brooks.

Norman Brooks: Good afternoon.

Michelle Oswald: Hi.

Norman Brooks: Thanks for the great presentation. You all may be aware that there has been a proliferation of commercialized chronic care management services being offered by the private community. And that includes some of the larger national EHR software companies and even some large Fortune 500 pharmaceutical firms – I'm sorry – pharmacies who are offering to, shall we say, fee split with practices. Can I get your critique on this? Does it meet the intent of the rule under non-FQHC traditional Part B provider status?

Ann Marshall: Thanks for the question. Sorry. We were discussing among ourselves here. We do have a discussion of this issue in last year's final rule. I think we recognize that it's an important one. As the guidance that we have out there provides, CCM can be subcontracted, or parts of it anyway can be subcontracted to a case management company or a third party provided that there's sufficient oversight by the billing practitioner and sufficient clinical integration. So, I would just refer folks to that

discussion in the final rule. We are aware that it's important to make sure that those two pieces are there in the situations where parts of CCM are going to be farmed out by other folks to do and that there are opportunities but also potential risks in terms of, you know, that having pieces of it done remotely. And it's something that we continue to watch and listen for feedback about and just to do a lot of thinking about.

Operator: Our next question will come from the line of Randy Hoffman.

Randy Hoffman: Thank you. I enjoyed the presentation. In your previous FAQs and earlier in the presentation, you've referenced that both providers and facilities can bill for CCM. Is there a specific code the facility should use for CCM and/or TCM, such as the G0463 that is used for new or established patient visits? Or should the CCM TCM CPT code be billed with a specific modifier code, such as the PO?

Ann Marshall: Yes. The facility would just be reporting the same CPT code, so – or G0506, which is the HCPCS code that we talked about in the presentation. There are no separate codes for facilities to use. And, I think, the modifier you're referring to, the PO, the probably the indicator for a provider-based department. And if that's applicable, it should be reported on the claim. But that would be no different than for any other provider-based service.

Randy Hoffman: Thank you.

Operator: Our next question will come from the line of Cephus Allin.

Cephus Allin: Hello. I have questions about the complex codes; 99487 and 99489 require medical decisionmaking as that's distinct from the 99490. Medical decisionmaking has a problem component, a data component for risk component. Do you aggregate these? Since you may be doing this over a number of different encounters with the patient, the problem component "moderate" requires three data elements. And so, is this three instances of the same diagnosis or does it have to be three different diagnoses? And this also seems to require that only the physician do this. And how do you separate out the complex codes encounters from the ones that would be staff-only, since I have a sense that the 87 and 89 can't be used that well by staff. So, the question is, medical decisionmaking in the context of both staff and physicians putting in information.

Ann Marshall: Thank you for the question. It is a good question. We talk about this piece of complex CCM a bit in the final rule and the guidance because it is a piece that is relevant only for the billing practitioners' time and effort and not for clinical staff. I would just refer folks to the Frequently Asked Question language that we have on this. It would be – we basically have adopted the CPT language in this regard.

So, I think the language just says that it is governed by the E&M documentation guidelines and the complexity of problems addressed by the billing practitioner during the month. I believe that's what it is. You can look at the CPT prefatory language for the complex codes. But, I believe that is what it says.

Operator: And our next question will come from the line of Carol Quan.

Carol Quan: I'm assuming that this would also be subject to the yearly deductible. Correct?

Ann Marshall: That is correct.

Carol Quan: Thank you.

Operator: Our next question comes from Kim Gallegos.

Kim Gallegos: Hi. This is Kim Gallegos. I'm calling from La Familia Primary Care. I didn't want to hang up the line. But, actually, all of the previous callers have had questions that I had initially, and they've all been answered very well. The presentation was great. We've been doing CCM since 2015. I'm real excited about these new changes. And that's all I have. Thank you so much.

Nicole Cooney: Thanks for the great comment. Next question, please, Holley.

Operator: Our next question comes from Jennifer Youngberg.

Jennifer Youngberg: Hi. This is Jennifer. Just to clarify for FQHCs and probably for everyone, nurses, RNs, cannot really be involved with this process at all?

Corinne Axelrod: Hi. This is Corinne. So, as you know, in FQHCs and RHCs, RHC and FQHC practitioners are physicians, nurse practitioners, PAs, certified nurse midwives, clinical

social workers, and clinical psychologists and, in some cases in FQHCs, they can also be diabetes self-management trainee providers. So, even though under the fee schedule clinical nurse specialists are listed, that would not apply to RHCs or FQHCs. So, clinical nurse specialists can certainly provide CCM services, but not as an RHC or FQHC practitioner who would – is required for the initiating visit. So, they would bill – they would not – it would not be a billable visit if the patient was only seen by a clinical nurse specialist. Thank you.

Jennifer Youngberg: So, the billable visits, to clarify, are just physicians or PAs or NPs for FQHC?

Corinne Axelrod: The billable visits can be provided by any RHC or FQHC practitioner. And, as I mentioned, it's the physician, nurse practitioner, PA, clinical social worker, certified nurse midwife, clinical psychologist.

Operator: And our next question will come from Debra Benton.

Debra Benton: Hi. Thank you. Somebody asked my question as far as the deductible. But have you had much experience with patients being hesitant to join the program due to a cost factor? And how do you get around that?

Ann Marshall: Thank you for the question. You know, here in central office, we don't have as much direct interaction with beneficiaries. But we have done some studies of CCM that show more that more– practitioners, anyway, are struggling with how to explain this piece to patients. We haven't, per se, heard that patients, you know, are rejecting – we have heard – I have heard of a few cases where consent is either not given or revoked when someone becomes aware that cost sharing will apply. But, again, at this point, we have limited authority under the statute to remove that to the extent it is a barrier.

And we would just continue to encourage practitioners and will be, perhaps, providing some language in the toolkits that the Office of Minority Health is working on how to explain the value of these services and why they're important to patients to engage them and help them understand why they should bear or why they do bear a cost in addition to the Medicare program for the services. And let them know if they have supplemental insurance, the extent to which it would not apply to them.

Operator: And our next question will come from the line of Victoria Midgorden.

Victoria Midgorden: Hi. I also had a question about nurses' roles in this. If a nurse, just an RN, is working under the supervision of a physician and they make telephonic outreach every month, would that be billable for the 99490?

Ann Marshall: So, we have heard that some practices are using a model for CCM where they do perform or use their staff to perform outreach calls to check in on the beneficiary or gain information about other providers that they may have gone to recently and so forth. And, certainly, to the extent to which that is included in the service elements that can count as reportable time. I think what you want to make sure is that if that's the activity that you're doing, that also all the other requirements to bill CCM are being met and that the other pieces of it that are required are being performed as well in order to bill.

Victoria Midgorden: Okay. Thank you.

Nicole Cooney: Next question please, Holley.

Operator: Our next question will come from the line of Lois Munson.

Lois Munson: Hi. This is Lois Munson. I'm with Senior Healthcare Professionals. I work with physicians who work in nursing homes. And, so I have a general question about doing these services in nursing homes and, more specifically, about whether the nursing home certified EHR system and care plan under the supervision of the physician would count toward their requirements.

Ann Marshall: So, let me take the last part of your question first in terms of other care planning. If there's – there is a list of codes that, for example, home health and hospice supervision. I don't think there's one for a nursing homes. But, you do want to make sure if you're doing some billing to any other – any other care plan code being billed to Part B for this service, that it's not a code that can't be billed on the same CCM, because there are a few exclusions there to prevent activities from being counted towards more than one code. But in terms of whether you can perform and bill for CCM to patients in nursing facilities, the answer is yes. And there is an FAQ that explicitly addresses this point on the webpage in the presentation.

Operator: Once again, if you would like to ask a question, press star, one on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

Our next question will come from Samika Williams.

Samika Williams: Will you please add some clarification around what is permissible for billing home health and hospice?

Ann Marshall: I'm not sure I understand the question.

Samika Williams: So…

Ann Marshall: Whether or not home health or hospice…

Samika Williams: So, most physicians are of the impression that they can't do both, provide CCM and also be the primary attending for patients that – for a patient that is receiving home health. And there's some concern that in the first 30 days, that they can't bill for the face-to-face, or they can't bill for plan of care oversight. And, so, given that limitation, they are just not using home health at all. So, I just wanted to get some clarification on what is permissible for home health and also the use of CCM in the practice setting.

Ann Marshall: So there are some G-codes, and again they're listed in the guidance, the FAQs, the fact sheets. I think they're also mentioned in CPT. But, there's codes explicitly for home health supervision or hospice supervision that involve care planning. And if the physician is already reporting those, that may be why they don't want to report CCM on top of that. Or if they're reporting CCM, they don't want to report those other codes because they can't bill both. It doesn't mean they can't provide CCM for someone who's already receiving home health. In fact, what we have been hearing at least in the startup months of the program was that patients were actually getting more services at home compared to those who weren't getting CCM. So, it's not that they are not doing the services. It's that they're watching that they don't do overlapping or duplicative billing.

Operator: Our next question comes from Rita Ness.

Rita Ness: Hi. My question pertains to the plan of care. Once the patient is seen by the provider for the initial visit, face-to-face visit, and the provider develops the plan of care and the nursing staff takes over and they make their notes in the chart about how much time was spent doing certain services, what is – does the provider have to sign off on each and every one of those notes? Or how does that supervision work?

Ann Marshall: In terms of, you know, what staff within a practice a supervising physician has – what notes have to be signed off for, I think the regular rules of regular medical record documentation apart from CCM would apply. I don't think physicians, for example, are required to co-sign every instance where a physician makes a phone call to a patient or helps them with the referral. And that would certainly be the case for a phone call by a nurse or a referral that's documented that's part of CCM. But you would want documentation to show that the billing practitioner is providing required oversight as described in our guidance.

Nicole Cooney: Thank you. Next question, please.

Operator: Our next question comes from Cindy Tomkins.

Cindy Tomkins: Yes, ma'am. I was just wondering if you could address and, previously I just want to thank you for the information that's been provided. But I was wondering if you could address the definition of clinical staff and the credentials that are required for that clinical staff.

Ann Marshall: Thank you for the question. It is a frequently asked one. And, accordingly, we have a frequently-asked question online that explicitly addresses this. What you're going to need to look at is how CPT defines the term "clinical staff." It's a CPT term. So, it's part of the CPT coding convention. It's a term that's used when someone other than the reporting practitioner is reporting – is doing some or all of the service under their supervision. So that's where the term comes from. But in addition to what CPT says about what they mean by clinical staff, you also need to make sure that, like incident-to rules for Medicare such as supervision or any applicable State laws and licensure or scope of practice are being met in terms of whose time can count. And they do have to be clinical as opposed to someone who is a non-clinical member of your staff in order to count the time.

Operator: And our next question comes from the line of Jody Scardino.

Jody Scardino: Yes. Hi. I just have something to clarify from slide number 11. When eligible reporting practitioners and providers – when it says on the bottom one practitioner and one hospital can report CCM per month – and I'm sorry I may have missed it. I had someone interrupt me. Can you just clarify what that means?

Ann Marshall: Sure. It means that only one professional claim and only one hospital/facility claim can be submitted per month. If...

Jody Scardino: So, if I – go ahead. I'm sorry.

Ann Marshall: That's okay. Go ahead.

Jody Scardino: In a multi-practice, when I have 30 physicians, would that mean only one of them can use this per month?

Ann Marshall: Yes. In terms of the claim that you would be submitting for the physician services to the Physician Fee Schedule, yes, only one professional claim – so, only one physician can bill.

Jody Scardino: Okay.

Ann Marshall: But if that physician is located in what's call a provider-based department or an outpatient department of a hospital, what will happen is in addition to that physician submitting their claim, usually the hospital will be submitting a separate claim for their piece of the work, and the physician's payment is going to get decreased a bit since a dual – since two claims are coming in because the hospital is basically doing part of the work.

Jody Scardino: Right. No, they are not being billed by the hospital. We are strictly practices owned by the hospital, so we bill directly as a practice. Okay. But only then, one of the 30 providers. Correct? Is that what you are saying at that time?

Ann Marshall: Per beneficiary. A different beneficiary could – that doesn't mean only...

Jody Scardino: Oh, I see.

Ann Marshall: Right. It's per beneficiary. A different patient in your practice might be seeing a different provider. And you can – it's not that you can't.

Jody Scardino: Got you.

Ann Marshall: You still could claim for that other person. But as far as per beneficiary, only one physician claim and only one hospital claim.

Jody Scardino: Excellent. Sorry about that. I must have missed part of that discussion. Thank you so much for your help.

Ann Marshall: You're welcome.

Operator: Our next question comes from Kristina Hawkins.

Kristina Hawkins: Hi. Thank you. I had a question. Can the initial month of CCM billing for the non-complex CCM patient be billed with the – one of the new codes because we've taken more time to establish the care planning?

Ann Marshall: It sounds like you're asking whether the G0506 code can be billed in association with the 99490 monthly service as well as the complex codes. And the answer is yes. If you're – if there's an initiating visit and the billing practitioner spends the time and effort to meet the requirements for that G0506, then it doesn't matter whether they end up billing 99490 or 99487. They can do that with either one.

Kristina Hawkins: Okay. But they can't bill for 99 – I'm sorry. They can't bill for 99490 – well, they can't bill for 99487 for that initial month because – with that G0506 because of the initial time it took – the 60 minutes and then ongoing months billing the 99490, correct, because that goes off of the complex?

Ann Marshall: So, whether 99490 or 99487 is billed, I think those are separate issues here. G0506 could be billed, I think, the same month as one of the monthly service codes. It doesn't have to be billed in a prior month. It just has to be billed and complete before CCM services start rolling. And the time can't be counted twice. So, if you're counting time by, you know, Doctor A in your practice to set up a care plan and to do that face-to-face visit, you can't also count part of Doctor A's time towards the 20 minutes for 99490 or the complexity of medical decisionmaking or clinical staff time

for 99487. You can't count that initiation time twice. But, conceivably, you could still meet the overall requirements to bill both the same month.

Operator: And our next question comes from the line of Seema Rathor.

Seema Rathor: Hello? Hi. I'm calling from Oregon.

Nicole Cooney: Hi.

Seema Rathor: My question is regarding – yes. For FQHC clinic, can pharmacy bill under a billing provider if they are a clinical pharmacist?

Corinne Axelrod: Hi. This is Corinne. So you're asking if a pharmacist in a FQHC could bill for CCM. Is that right?

Seema Rathor: Yes. Under a billing practitioner in a – yes, clinical pharmacist.

Corinne Axelrod: Right. So, as we mentioned earlier, RHC and FQHC practitioners – they are defined by statute. And they are physicians, nurse practitioners, physician assistants, clinical social workers, certified nurse midwives, and clinical psychologists. A pharmacist is not an RHC or FQHC practitioner, which – again, I always want to just say that has no reflection on their value. It's just that the term RHC and FQHC practitioners are defined in statute. So, a pharmacist that is providing CCM services is – would be considered clinical staff just like a nurse or a social – or any other non-RHC and FQHC practitioner who are considered clinical staff.

****Post-Call Clarification: So, a pharmacist that is providing CCM services is – would be considered clinical staff just like a nurse or a social worker or any other non-RHC and FQHC practitioner who are considered clinical staff.****

So that means that the initiating visit could not be performed by a pharmacist. It would have to be by an RHC or FQHC practitioner. But the CCM services could be performed by clinical staff, which includes a pharmacist. Thank you.

Seema Rathor: Okay. Great. Thank you.

Operator: Our next question comes from the line of Lisa Bae.

Lisa Bae: Hi. Would you give an example of the billing process? For example, the initiation visit face-to-face – if the patient comes in, what CPT and ICD would I code? And in the same month, if we did a phone for a CCM service, what codes would I charge?

Ann Marshall: So, the first part of your question, what codes would you bill for the initiating visit, you would bill whatever E&M code qualified. There's a discussion of what is required for the initiating and what kinds of CPT codes – for example, 99213 would be one of them that you could bill. And you have to separately meet – if you're going to bill those and a CCM code during the same month, you have to separately meet the requirements for each without any overlap in work or time or effort.

Operator: Our next question comes from the line of Barbara ((inaudible)).

Barbara: Hello?

Nicole Cooney: Did you have a question for us?

Barbara: Yes, I do. Thank you. I don't know if you can answer this. But, you know, the NCCI edits don't contain any of these – the G-codes for the psychiatric collaborative care management services. And I was trying to figure out if those services, which are billed by the physicians and not by the psych staff, can be billed during the same month or during the same day as one of these chronic care management codes – so, G0502, G0503, 04, and 07.

Ann Marshall: So thank you for the question. We didn't want to use this call to get into requirements for billing the behavioral health integration codes, including the ones you mentioned, because they do have separate requirements. All I will say about this…

Barbara: I'm not interested in their requirements. I just want to know if they would bounce out, you know, because of an edit.

Ann Marshall: Right. At this time, there are no edits. And technically, CCM could be reported the same month as a behavioral health integration code. We are going to be monitoring the claims data to see how often that happens and to continue to think about whether and in what circumstances it's medically necessary for both sets of codes to perhaps be billed the same month. We didn't preclude it. We have questions about it. We didn't get a whole lot of public comment on it. And so, at this time, there's no formal prohibition and there are no claim edits. And we will just be looking at the claims that actually come in and doing some more thinking about it.

Barbara: Okay. That's helpful. Thank you.

Michelle Oswald: And just make sure if you are reporting both that you're not counting the time or effort or any other, you know, work or activities more than once towards more than one code.

Operator: Our next question comes from Mark Rostek.

Mark Rostek: Yes. Good afternoon. Great webinar so far. I have a comment more than a question. We're in Florida, and we started the CCM program in 2015. But we've had significant resistance because of the advance patient consent. And I think that's something that maybe you guys really should take a look at. It's been horrendous here because we have multiple patients that have more than two chronic care conditions but toward the – as the program progresses, they're really reluctant about their kind of like co-insurance on the matter.

Ann Marshall: Yes. Thank you. We appreciate the feedback. As I mentioned, it's an issue that we continue to think about. I'm curious whether these are patients who have supplemental insurance or do you have a large majority of patients who don't have any wraparound coverage to help with the cost sharing? Because that may make a difference.

Mark Rostek: And that's the answer.

Ann Marshall: Yes. That may make a difference. And as Michelle mentioned, I think part of the outreach and education campaign is going to include some messaging for providers to use in discussing with patients versus discussion with staff. And so, obviously, we haven't completed that material yet. But, there may be some helpful language or materials for you to use forthcoming.

Mark Rostek: Thank you.

Operator: Our next question comes from the line of Tonette Osby.

Tonette Osby: Hi. This is Tonette. I'm calling from the Kidney Associates. He just answered my question. I wanted to confirm that the cost share does not apply to the CCM. And that's correct, right?

Ann Marshall: At this point in time, usual cost sharing does apply. However, many, if not most, patients have a supplemental insurance that will pay that cost sharing on their behalf.

Tonette Osby: Okay.

Ann Marshall: So, you should be careful in – and I don't mean that to sound pedantic. But, it's something to – when you explain that cost sharing applies to your patients, it would be most helpful if you could be cognizant if they have supplemental insurance to let them know that their insurance is going to pay the cost.

Tonette Osby: Okay. Thank you.

Operator: Our next question comes from the line of Deeann del Rio.

Deeann del Rio: Hello?

Nicole Cooney: Hi. Did you have a question?

Deeann del Rio: Yes. We have a question. I'm sorry. On the code G0506 – can you explain in a little more detail – since the physician has to perform the service by themselves, what are you expecting in terms of documentation on – especially on care planning? I'm not concerned about the assessment. I think that's going to be clearly in there. But, our physicians are not usually the ones that create a formalized care plan. Can they – can their documentation include the beginning of a care plan that is then later picked up by a nurse and completed?

Ann Marshall: So I think in this scenario, the care planning that the clinical staff – that the nurse picks, up his or her time – the nurse's time, that is, would be counted towards billing the month – towards the monthly code. Whereas the time and effort of the physician to start the care plan would be counted towards G0506 and the base E&M code for that, because they're billing a face-to-face visit, and G0506 is when their time and effort exceeds the usual for that visit. So...

Deeann del Rio: And I understand that. So my issue isn't really about time allocation. It's about – let's say the doctor does do it and it's – there's significant time. Do they have to have in their documentation a completed care plan? Or can they start this whole

process, including the assessment, and then that's their time and it's got to be appropriate and, then, later that month or the next time, the clinical staff pick it up and do a more comprehensive care plan? I just don't want our documentation to be lacking if it gets audited.

Ann Marshall: Right. So for documentation, I think, as always, just look at what we stated. And I don't – unless I'm mistaken, I don't believe we stated anywhere that G0506 includes a complete care plan. It includes care planning by the billing practitioner. So you would need to be documenting some and, obviously, the time and effort would have to be there if your MAC, for example, were to come and look at it. But we did not specify more than that. And it could be more than one individual doing the care planning. But you would want to show in your documentation who did what and the time should add up.

Operator: And our next question will come from the line of Crystal Chambers.

Crystal Chambers: Hi.

Nicole Cooney: Did you have a question for us?

Crystal Chambers: I do. So we use a third party company to do our CCM phone calls. So our question is – and this is just a little concern – can they legally bill the time if they're just leaving messages on our patients' voicemails or attempting to call them?

Ann Marshall: So I would be hesitant to say that you could not count their time when they make a phone call and are not able to reach the patient. That could take, say, five minutes. But if, for example, they tried multiple times – for example, we got an inquiry the other day, "What if I tried someone over the course of several times in the month and I never reach them?" And, basically, in the scenario that was being raised, they're really not able to do any care management for the patient because they're not able to reach them or engage them or update any of their information. And, so, in that scenario, I would say there are other pieces to CCM. Really, what's not being – CCM is not being performed then. And so you wouldn't – shouldn't be billing it in that situation. But I wouldn't want to say that every single time that you call a patient and get their voicemail that you can't count the time of the staff reaching out to them because we certainly would not say that.

Crystal Chambers: Okay. Thank you.

Operator: Our next question will come from the line of Sarip Weiler.

Sarip Weiler: Thank you. I thought I was forgotten. Thank you for the great webinar. I wanted to know, can G0506, which is an add-on code, is to be added only with 99213, 214, 212, whatever, or can it also be added to 99490?

Ann Marshall: So the sort of base codes for G0506, it's structured as an add-on to an E&M visit. So 99490 is not a visit. It's a monthly service code, and it's usually non-face to face. So, no, you wouldn't be billing G0506 as an add-on to 99490. But you might be billing it during the month as 99490.

Sarip Weiler: Yes. It does not have to be face-to-face, like we do telephone or texting or email and things like that to follow up on the chronic care.

Ann Marshall: I'm not sure I understand what your question is.

Sarip Weiler: No. The 99490 – I mean, I – obviously, I will have to go and learn more later. But, the – so, G0506 – you answered that it has to be with the 99213 or one of those E&M codes when we initiate the chronic care management. Correct?

Ann Marshall: That is right.

Sarip Weiler: And then the 99490 is when we follow up on the chronic care and may or may not be face-to-face?

Ann Marshall: That's right.

Sarip Weiler: And – but it has to be like 20 minutes – I mean, the time – we have to write the time?

Ann Marshall: The 99490 is a specifically timed code, and G0506 is not.

Operator: Our next question comes from Richard Fairley.

Richard Fairley: Hi. Thanks for taking my call. The – I just have – I mean, all of my questions have been answered and re-answered. But one on the non-complex – the

99490, 99487, 99489 – those wouldn't require any physician or billable person's effort or time is not necessarily counted in any of those. Is that correct?

Ann Marshall: I wouldn't necessarily say that for the complex CCM codes because the 99487 and 9 – because those explicitly have a service element for moderate to highly complex medical decisionmaking, which is a function and role of the biller rather than clinical staff. So they have to be doing something during the month that the biller does that completes that service element.

Richard Fairley: Okay. So there is an element of that in that code – it's not like this month I see them and I do the moderate- to high-complexity decisionmaking and then, next month, they get 61 minutes from my chronic care management nurse. I can't bill 99487 if I didn't see them also that month or talk to them and do – can I do telephonically that moderate decisionmaking that month? I'm a physician.

Ann Marshall: I believe that you can. I mean, the language, again, in the CPT prefatory language says that that is – that phrase, the moderate to highly complex medical decisionmaking, is governed by the E&M guidelines and reflects the complexity of the problems addressed by the reporting individual during the month. But, that doesn't necessarily mean face-to-face. That's right. And you may not see them at all face-to-face the next month.

Richard Fairley: Okay. Thanks.

Operator: And our next question will come from the line of Kyla Andrews-McNeil.

Nicole Cooney: Did you have a question for us?

Operator: That question has been withdrawn.

Our next question comes from Nancy Brixey.

Tim Ruesch: Hello. My name is Tim Ruesch. I'm with Premier Health. I'm actually a colleague of Nancy's. She's the one who calls in for us. My question has to do with clarification on what diagnoses are considered chronic conditions. There are 19 that are listed on the website. So, do the chronic diagnoses have to be two of those 19? And then, how many have to be on the claim?

Ann Marshall: Hi. As we mentioned in the presentation, there – CCM is not – there's no specific list of applicable diagnoses. What you want to look at is whether the patient meets the criteria in – that's within the code descriptor, which is two or more chronic conditions expected to last at least 12 months or until death and, then, the other language about placing them at risk of functional decline and so forth. And then for complex CCM, you need to be also addressing problems of moderate to high complexity during the month. But those are the only criteria, is what's in the code descriptor. We have listed some examples. But those are just that. They are examples.

Tim Ruesch: Okay. And how many diagnoses need to be on the claim?

Ann Marshall: Yes. I'm sorry. For physician claims, there are no edits around diagnosis. I think our preference would be that you report the diagnoses that are relevant and the ones that you're dealing with that particular month. But you're being paid under the Physician Fee Schedule based on the service that you report rather than the diagnoses in the vast majority of cases, including CCM.

Tim Ruesch: Excellent. I appreciate that. That helps.

Ann Marshall: Sure.

Operator: Our next question will come from the line of Linda Kinard.

Linda Kinard: Yes. Thank you so much for taking my call and thank you so much for the presentation. We've been doing this since the beginning of 2015. And our problem is the difficulty in attaining consent from nursing home patients that have dementia. And we have a good many patients that have dementia, no power of attorney, and no family listed. What do you do in a situation like this?

Ann Marshall: That is a good question. You know, there is a requirement to obtain advance consent. And I don't know how you would meet that requirement if the patient can't give it themselves and there's no legal proxy to do it on their behalf. I think we would be interested in information about how often that really happens so that we can consider, you know, whether we need to make any adjustments to the payment rules to accommodate that.

Dr. Lovelace: This is Dr. Lovelace. And I – my office administrator was the one that asked the question because it really – for those of us who are providing that continuity of care for nursing home patients, this is a real problem because what happens is you may be aware of this, but so many doctors no longer follow their patients to the nursing home. And what happens – what takes place then is a doctor will come to town and say that he'll take care of nursing home patients, but he doesn't even live in the community, and then every time the patient is having a problem, the doctor will say or the nurse practitioner covering the practice will say, "Well, just send them to the ER." Well, for those of us who have taken care of our patients for, you know, 20 plus years – I've been in practice for 28 years – one of the reasons I went into family medicine is I wanted to care for someone over the whole continuum of their life. And they may still know me, but be very, very demented.

And so, the problem I have is now that we have finally a way to get reimbursed for all these phone calls that we get back and forth to the nursing home and looking at lab results and telling the nurses how to treat a skin rash or do whatever, I don't have a mechanism to feel like I can get reimbursed for actually the most needy patients we have. The majority of the faxes that come into this office in a day are nursing home patients. And I would venture to say that about 20 to 25 percent of them are competent and I am able to get consent from. And very few people have a formal health care power of attorney, at least in our area.

Ann Marshall: Yes. I mean, it's an interesting area that kind of intersects with advanced care planning. And we do have some new codes to try to encourage the provision of that service so that folks are better prepared, you know, for who needs to make decisions in these cases. I guess I'm wondering how many of these patients might be dual eligibles or at least in the process of a spend down, because the goal around consent was just to ensure that there's not duplicative providers billing and that the patient is not getting an unexpected bill for cost sharing. And if neither of those two things are an issue, then arguably it would not be a situation where advance consent would be needed. But at this point in time, you know, we haven't fleshed that scenario out or really gotten enough information about it to create to formal exception. So I wouldn't want to be telling you that you can bill in those cases without getting consent. But...

Dr. Lovelace: It is a problem for all of us who are taking care of these patients, because many of them are the – they're the sickest, they're the most needy patients. And, you know, with the amount of regulatory constraints that they now have on the use of antipsychotics, anything that has to do with fall risk – you know, there're just a number of phone calls, faxes that keep coming into the office. And I've been in practice 28 years and none of my partners want to do nursing home work because of this. I do – I continue to do it myself. But there's no other doctor in our community that does nursing home work other than a doctor who does about seven nursing homes, you know, in a three- or four-county area.

Ann Marshall: Right. And who may not necessarily be acting as a primary physician. We have heard from, you know, some folks, and we've been in discussions with some of the long-term care associations that there is a lot of interest in providing CCM. And a lot of folks who are already providing it – we can see that place of service on some of the claims coming in. So, it's certainly allowed. But the consent adds a dimension to it that, you know, is important to think about. And we will take that under advisement going forward.

Dr. Lovelace: Yes. I think, from my standpoint, because of these patients in that place, being at the end of their life and having issues, it would seem to me that if it was documented, there was no responsible party, no power of attorney and the patient was mentally incompetent. They basically have to meet those three standards. And if you've cared for them the previous year, you should be able to bill for it. And, you know, these are people I've had a relationship with for a very long time.

Operator: And our next question will come from the line of Beth Allen.

Nicole Cooney: Just one second. Just one second. To the last caller, Michelle had a comment.

Michelle Oswald: And just to add to that. This is an important topic. And what we're asking is if the doctor who was just speaking could email us at the CCM mailbox at ccm@cms.hhs.gov so we can follow up with the issue and with you in particular, we would appreciate that. Thank you.

Nicole Cooney: And this is actually coming up, our final question that we'll take right now.

Operator: Okay. And that question will be from Beth Allen.

Beth Allen: Okay. Thank you. What I am inquiring about is we are at the same time looking at providing the chronic care management services we're looking at doing the transitional care management as well. And there's been mixed discussion on other webinars that I've attended on the transitional care management as to whether you can bill those services in the same month. So could I bill the chronic care management code in the same month that I may bill a transitional care management code if I had an individual that was receiving the chronic care management services and then discharged from a hospital?

Ann Marshall: This is Ann. There's an FAQ specifically on this. I think what we and CPT intend is that there not be overlap in any of the services where you're counting time or anybody's work or effort more than once towards any of the codes, and there can't be any overlap in the service period. So, let's say your transitional care management period runs 30 days from a discharge in the middle of January. That means that the TCM service period will end mid-February. And if that ends and then you complete – you meet the requirements and complete enough additional TCM work in the end of February for the rest of it, to bill CCM, you can report CCM for the end of February. So, conceivably, they could come in for the same month as long as there's no overlap. But I would encourage you look at the FAQ on that as we have put out some explicit language to help explain that.

Beth Allen: Okay. Thank you.

Additional Information

Nicole Cooney: Unfortunately, that's all the time we have for questions today. If we did not get to your question, please see slide 29 in the presentation for the appropriate email address to submit your question. If you missed any information presented today or would like to review again, an audio recording and written transcript of today's call will be posted to the MLN Connects Call website, and we will place an announcement in the MLN Connects newsletter when these resources are available.

On slide 31 of the presentation, you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you'll take a few moments to evaluate your call experience.

Again, my name's Nicole Cooney, and I would like to thank our presenters and thank you, our participants, for joining us for today's presentation on Understanding and Promoting the Value of Chronic Care Management Services. Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-


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