CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1576	**Date: November 18, 2015**
	Change Request 9234

Transmittal 1530, dated August 6, 2015, is being rescinded and replaced by Transmittal 1576 because it is no longer sensitive/controversial. This Transmittal also adds a provider education requirement and updated references to the Physician Fee Schedule Proposed and Final Rules. All other information remains the same.

SUBJECT: Chronic Care Management (CCM) services for Rural Health Clinics (RHCs) and Federal Qualified Health Centers (FQHCs)

I. SUMMARY OF CHANGES: This change request (CR) provides instructions for payment for CCM services in RHCs and FQHCs, effective January 1, 2016.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2016

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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SUBJECT: Chronic Care Management (CCM) services for Rural Health Clinics (RHCs) and Federal Qualified Health Centers (FQHCs)

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IMPLEMENTATION DATE: January 4, 2016

I. GENERAL INFORMATION

A. Background: This Change request (CR) provides instructions to the Medicare Administrative Contractors (MACs) for payment to RHCs billing under the all-inclusive rate (AIR) and FQHCs billing under the prospective payment system (PPS) for CCM services for dates of service on or after January 1, 2016.

In Calendar Year (CY) 2015, the Centers for Medicare & Medicaid Services (CMS) began making separate payment under the Medicare Physician Fee Schedule (PFS) for CCM services under current procedural terminology (CPT) code 99490. CCM services are non-face-to-face care management and coordination services for Medicare beneficiaries having multiple (two or more) chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CMS finalized aspects of the payment methodology, scope of services, and requirements for billing and supervision for practitioners permitted to bill Medicare under the PFS in the CY 2014 PFS final rule (78 74414 through 74427) and made further refinements in the CY 2015 final rule (79 67715 through 67730).

As authorized by §1861(aa) of the Social Security Act, RHCs and FQHCs are paid for physician services and services and supplies incident to physician services. CCM services are RHC and FQHC services but payment for the additional costs associated with such services are not included in the RHC AIR or the FQHC PPS rate. In the CY 2016 PFS proposed rule (80 FR 41793), CMS proposed requirements and a payment methodology for CCM services furnished by RHCs and FQHCs. In the CY 2016 PFS final (80 FR 71080), CMS finalized the requirements and payment methodology for CCM services furnished by RHCs and FQHCs.

B. Policy: Effective January 1, 2016, RHCs and FQHCs shall be paid for CCM services furnished to patients with multiple chronic conditions that are expected to survive at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Payment shall be based on the PFS national average non-facility payment rate when CPT code 99490 is billed alone or with other payable services on a RHC or FQHC claim. CCM payment to RHCs and FQHCs would be based on the PFS amount, but would be paid as part of the RHC and FQHC benefit, using the CPT code to identify that the requirements for payment are met and a separate payment should be made. The RHC and FQHC face-to-face requirements are waived when CCM services are furnished to a RHC or FQHC patient. Coinsurance would be applied as applicable to FQHC claims, and coinsurance and deductibles would apply as applicable to RHC claims. RHCs and FQHCs would continue to be required to

meet the RHC and FQHC Conditions of Participation and any additional RHC or FQHC payment requirements.

Specific CCM requirements include all of the following:

- Initiation of CCM services during an Evaluation/Management, annual wellness visit (AWV), or initial preventive physical examination (IPPE) visit. The time spent furnishing these services would not be included in the 20 minute monthly minimum required for CCM billing.

- Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the electronic health record must inform the care plan, care coordination and ongoing clinical care.

- Access to CCM services 24/7 (providing the beneficiary with a means to make timely contact with the RHC or FQHC to address his or her urgent chronic care needs regardless of the time of day or day of the week).

- Continuity of care with a designated RHC or FQHC practitioner with whom the beneficiary is able to get successive routine appointments.

- CCM services for chronic conditions including systematic assessment of the beneficiary's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.

- Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. Share the care plan as appropriate with other practitioners and providers.

- Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.

- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.

- Coordination with home and community based clinical service providers.

- Enhanced opportunities for the beneficiary and any caregiver to communicate with the RHC or FQHC regarding the beneficiary's care through not only telephone access, but also through the use of secure messaging, internet or other asynchronous non face-to-face consultation methods.

- Beneficiary consent—Inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers.

- Document in the beneficiary's medical record that all of the CCM services were explained and offered, and note the beneficiary's decision to accept or decline these services.

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

- Beneficiary consent—Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of the calendar month) and the effect of a revocation of the agreement on CCM

services.

- Beneficiary consent—Inform the beneficiary that only one practitioner can furnish and be paid for these services during a calendar month.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9234.1	Contractors shall accept CCM, HCPCS code 99490 on all RHC (71X) and FQHC (77X) claims.	X								
9234.2	Contractors shall pay RHCs and FQHCs based on the MPFS national average non facility fee rate for CCM, HCPCS code 99490. **NOTE**: Payment is based on the fee amount, regardless of the charges.					X				
9234.3	Contractors shall allow payment for CCM, HCPCS code 99490 with or without an encounter/visit on RHC and FQHC claims.					X				IOCE
9234.4	The IOCE shall send a payment indicator flag of '2' for CCM services, HCPCS code 99490 for FQHC PPS claims.									IOCE
9234.5	Contractors shall apply coinsurance and deductible to CCM services, HCPCS code 99490 on RHC claims.					X				
9234.6	Contractors shall apply coinsurance to CCM services, HCPCS code 99490 on FQHC claims.					X				
9234.7	Contractors shall suppress the MSN for CCM services for all Tribal FQHCs claims.					X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME MAC	CEDI

		A	B	HHH		
9234.8	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
9234.2 - 9234.4	The logic for CCM should be modeled after Telehealth (HCPCS code Q3014) for RHC and FQHC claims.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Corinne Axelrod, 410-786-5620 or Corinne.Axelrod@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0