TIPS FROM OUR CONSULTANT

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In the CY 2015 Final Rule, the Centers for Medicare & Medicaid Services (CMS) again acknowledged its support for primary care physicians and other qualified healthcare professionals.

> As we *[CMS]* discussed in the CY 2013 PFS final rule with comment period, we *[CMS]* are committed to supporting primary care and we *[CMS]* have increasingly recognized care management as one of the critical components of primary care that contributes to better health for individuals and reduced expenditure growth (77 FR 68978).

Effective with dates of service 1/1/2015, Medicare began paying for Chronic Care Management Services (CCM).

Based on how long it took CMS to develop educational materials explaining Transitional Care Management (TCM) Services, NCI believes it will be several months before CMS issues a transmittal detailing all the coverage and coding requirements for CCM.

Recognizing that not all physicians monitor the Federal Register and/or read the entire (or even portions of) Medicare Final Rule that details the changes for the following year, we decided to write this article to provide some of the highpoints about coverage for CCM.

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The information included in this article should not be construed as an official source that includes all the details and criteria for reporting CCM services. This article is based on the following three (3) references:

- Federal Register 11/13/2014 – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015 Final Rule
- Federal Register 12/10/2013 – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014 – Final Rule
- American Medical Association's *CPT* and RBRVS 2015 Annual Symposium – 11/19/2014 – Presentation by Kathy Bryant, Director, Division of Practitioner Services, CMS

Physicians participating in one of the following CMS models/demonstration programs cannot bill CCM services for Medicare beneficiaries participating in the program; however, when appropriate, the practice can bill CCM services provided to Medicare beneficiaries who **chose not to participate** in the program.

- Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration
- Comprehensive Primary Care (CPC).

We believe it is important to note that although there are two sets of codes for chronic care management in *CPT*® 2015, Medicare will only reimburse CCM services reported with *CPT* code 99490.

Chronic Care Management Services

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following elements:

- multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline;
- comprehensive care plan established, implemented, revised, or monitored
  - Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately

Complex Chronic Care Management Services – Bundled by Medicare

99487 Complex chronic care management services, with the following requirements:
- multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline;
- establishment or significant revision of a comprehensive care plan
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional per calendar month
  - Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not separately reported

99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure *[99487]*

Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month

CPT coding notes clearly state that providers **cannot report both TCM and CCM for the same calendar month.**

"If care management resumes after a discharge during a new month, start a new period or report transitional care management. If discharge occurs in the same month, continue the reporting period or report TCM."

The CY 2015 Final Rule includes:

We *[CMS]* believe that the new ***CPT* code 99490 appropriately describes CCM services for Medicare beneficiaries.**

At this time, we *[CMS]* believe that Medicare beneficiaries with two or more chronic conditions as defined under the CCM code can benefit from care management and want to make this service available to all such beneficiaries.

Like all services, we *[CMS]* recognize that some beneficiaries will need more services and some less, and thus we *[CMS]* pay based upon the typical service. However all scope of service elements apply for delivery of CCM services to any eligible Medicare beneficiary. We *[CMS]* will evaluate the utilization of this service to evaluate what types of beneficiaries receive the service described by this *CPT* code, what types of practitioners are reporting it, and consider any changes in payment that may be warranted in the coming years.

We *[CMS]* are maintaining the **status indicator "B" (<u>Bundled</u>) for CY 2015** for the complex care coordination codes, ***<u>CPT</u>* <u>codes 99487 and 99489</u>.**

Based on the above information, which Ms. Bryant confirmed during the *CPT* Symposium, the appropriate code for reporting CCM to Medicare is 99490.

Reporting 99487 with or without 99489 will result in the charges being denied as bundled even if no other services are reported on the same date of service.

As with all bundled services, physicians cannot execute a Medicare Advance Beneficiary Notice of Noncoverage (ABN) and bill the codes for the more intensive Complex Chronic Care Management Services and hold the patient financially responsible for the charge for the complex CCM service.

We appreciated Ms. Bryant's clarification that **CCM is not a "per beneficiary/per month payment.**" This type of payment typically means the physician automatically receives the payment regardless of whether services were provided during the calendar month. The difference with CCM is that physicians/ other qualified healthcare professional **must bill CCM using 99490 <u>when the practice meets</u> CCM billing requirements.**

Thus, when CCM criteria are met for a given month, the practice must report *CPT* code 99490. The 2015 Indiana Medicare Fee Schedule for **<u>99490</u>** for dates of service 1/1/2015 through 3/31/2015 is **<u>$40.70</u>**!

Ms. Bryant explained that **when the criteria for reporting 99490 is met** (at least 20 minutes of clinical staff time during the calendar month), the **CCM code should be reported using <u>the last day of the calendar month</u>** as the date of service, regardless of whether that date falls on a weekend or holiday.

Ms. Bryant presented a synopsis of the requirements for reporting 99490

- Beneficiary must have two (2) or more chronic problems
- Based on clinical staff time – must be at least 20 minutes or more per calendar month
- Not a per beneficiary / per month payment
- Coinsurance applies
- In order to bill
  - Practitioner must inform beneficiary
  - Obtain written agreement
  - Must provide beneficiary a copy of the plan of care
  - Only one practitioner can bill
- CCM – Elements of scope of service
  - The practice must be able to demonstrate the **use of written protocols** by staff participating in the furnishing of CCM services that describe:
    - The **methods and expected ''norms''** for furnishing each component of chronic care management services furnished by the practice.
    - The strategies for **systematically furnishing health risk assessments** to identify all beneficiaries eligible and who may be willing to participate in the chronic care management services.
    - **Guidelines for communicating** common and anticipated clinical and non-clinical issues to **beneficiaries**
    - The procedures for informing eligible beneficiaries about chronic care management services and obtaining their consent
    - The **steps for monitoring** the medical, functional and social needs of all beneficiaries receiving chronic care management services
    - System based approaches to ensure timely furnishing of all recommended preventive care services to beneficiaries
      - ✓ CMS recommends, but does not require, the provider to perform the Welcome to Medicare Visit and/or the Annual Wellness Visits
    - Contacting beneficiaries **post-discharge from an emergency department or other institutional health care setting**, to assist beneficiaries with follow up visits with clinical and other suppliers or providers, and in managing any changes in their medications.
    - A **systematic approach to communicate and electronically exchange clinical information** with and coordinate care among all service providers involved in the ongoing care of a beneficiary receiving chronic care management services.

- A **systematic approach for linking** the practice and a beneficiary receiving chronic care management services with long-term services and supports including home and community-based services.
- A **systematic approach** to the care management of **vulnerable beneficiary populations** such as racial and ethnic minorities and people with disabilities.
- **Patient education** to assist the beneficiary to self-manage a chronic condition that is considered one of his/her chronic conditions.
- These protocols **must be reviewed** and updated as is appropriate based on the best available clinical information **at least annually.**

- Patient access, 24 hours a day, 7 days a week
- Continuity of care with specified member of team
- Care management for chronic conditions
- Management of transitions, including referrals
- Coordination with home and community based clinical service providers required to support a patient's psychosocial needs & functional deficits
- Enhanced opportunities for patient communicate, including through secure messaging, Internet, etc.

- Use EHR *[electronic health record]* that is acceptable for the EHR Incentive Programs as of December 31st prior to each PFS *[Physician Fee Schedule]* payment year

  NCI Comments: Ms. Bryant verbally explained that this means the practice must be using a certified EHR meeting meaningful use criteria for the previous year. For example, if your practice adopted a certified EHR and attested for the incentive payment in 2013, on December 31, 2014, Stage 1 meaningful use criteria were applicable. Thus, for 2015 CCM services, you must be using a certified EHR that meets Stage 1 Meaningful Use.

  If you adopted and attested for the incentive payment in 2011, on December 31, 2014, Stage 2 meaningful use criteria were applicable. For 2015 CCM services, you must be using a certified EHR and meeting Meaningful Use Stage 2 requirements. Ms. Bryant explained if the physician met and applied for the very narrow EHR Stage 2 Hardship Exception and Stage 1 requirements were applicable on December 31, 2014, the exception is sufficient for CCM services during 2015.

  Record certain core portions of the patient's medical record (demographics, problem list, medications and medication allergies and creation of clinical summaries informing care transitions).

  Document informed patient consent, provision of the care plan to patient, and communication with home and community based providers.

  One exception, for CY 2015, the practice can use any electronic tool (other than fax) to create the care plan; make the care plan available 24/7 within the billing practice; share the care plan with other providers; and transmit clinical summaries in managing care transitions

- CMS will allow "incident to" billing for CCM with "general supervision" when services are performed by clinical staff
  - Due to the requirement of 24/7 patient access, CMS created a narrow exception to the direct supervision requirement
  - Also applies to non-face-to-face for TCM
  - All other incident to regulations apply
  - Reference CRT 410.26

Payment for CCM does not include a face-to-face component. Physicians will separately report any evaluation and management (E/M) services using the appropriate level of care code to describe any face-to-face encounter that occurs during the calendar month. '

Caveat: You cannot count the clinical staff's time related to the face-to-face E/M when determining whether at least 20 minutes of CCM was provided to the Medicare beneficiary.

We realize this is a very brief overview of CCM services, but hopefully it will begin your process for meeting the criteria for reporting CCM.