

HEALTH POLICY CORNER: PART II

Medicare's Chronic Care Management (CCM) Code: Prepare now for 2015

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The Centers for Medicare and Medicaid Services (CMS) created a new service code to pay for the non-face-to-face (NF2F) care management needs of Medicare beneficiaries beginning January 1, 2015. As with other primary care-directed codes such as the annual wellness visits (AWVs) and the transitional care management (TCM) codes, CMS has detailed service expectations. CMS recognizes the deficiencies of the evaluation and management (E/M) service codes used by primary care physicians (PCPs). The post-visit time for the most common E/M service code, 99214, is 10 minutes. This vastly under recognizes the NF2F work of PCPs—work that includes answering patient phone and electronic messages, sorting through formulary changes, responding to labs or consultation recommendations, and providing weekend and night emergency coverage.

Which patients will be eligible for CCM code billing?

Any Medicare patient, “expected to live 12 months or until death,” with two or more chronic conditions will be eligible for CCM services. This code “may be billed for periods in which the medical needs of the patient require establishing, implementing, revising, or monitoring the care plan.” This is a “primary care-centric” definition that would apply to a broad range of Medicare patients. Though CMS cannot prohibit any physician from billing for this service, the intention is clearly to support the myriad of primary care NF2F tasks.

What will be the patient payment implications?

The service would be subject to a 20% copayment (or covered as part of a Medicare Part B supplement). Unlike other Medicare services, monthly CCM billing continues without face-to-face contact.

To bill for the services, the following are required:

- Documentation in the patient's medical record that all of the chronic care management services were explained and accepted by the patient;
- A written agreement that electronic communication of the patient's information with other treating providers is part of care coordination;
- Information about the availability of the services from the practitioner; and
- A written or electronic copy of the care plan that is provided to the beneficiary and recorded in the electronic health record (EHR).

The CCM code cannot be billed concurrently with home health care (VNA) supervision (HCPCS G0181), hospice (HCPCS G0182), TCM services (99495-6), and all service codes applicable to patients in a facility (e.g. nursing home). E/M, AWV, and initial preventive physical examination (IPPE, Welcome to Medicare) service codes can be billed, but none of these is required.

What are the stipulated services for CCM billing?

CMS has provided only a partial list of the services required. The final list

will be available at the end of 2014. A physician or a non-physician clinician (e.g. NP, PA, clinical nurse specialist, certified nurse midwife) can bill as long as the state's scope of service license permits independent billing. CCM services provided in the name of the non-billing clinician must be performed by an employee of the billing clinician or an employee of a practice. This effectively precludes the outsourcing of certain elements of CCM services to contract employees or care management corporations or services.

CCM will be a time-based code—20 minutes of service for every 30 days of billing (CMS implies a strict 30-day billing cycle). Documentation tools will have to record both time and services provided. CMS expects the following from CCM clinicians:

- Continuity of care with a clinician or practice
- Care management that provides the following:
 - A systematic assessment of medical, functional, and psychosocial needs
 - A system-based approach for timely delivery of preventive services
 - Medication reconciliation, both prescription and non-prescription, and a review of interactions and adherence
 - The creation of an updatable patient-centered plan of care that:
 - Addresses all health care issues (including but not limited to the following: “a

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problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community and/or social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identification of the individuals responsible for each intervention, periodic review and, when applicable, revision")

- Is congruent with patient values and choices
- Is based on a physical, mental, cognitive, psychosocial, functional, environmental assessment
- Is based on an inventory of resources and supports
- Management of all care transitions (the TCM stipulated services, TCM cannot be billed separately)
- An EHR that is available 24/7
- Opportunities for patient-to-provider communication via telephone or secure

asynchronous NF2F messaging (e.g. secure Internet messaging)

CMS is considering even more service expectations, but many professional organizations have complained about the level of CMS intrusion into the details of practice management. The unresolved stipulations are the following:

- Higher EHR standards,
- Precise expectations for the non-clinicians who deliver CCM services (CMS may provide job descriptions),
- The need for detailed written protocols, and
- Patient-centered medical home or the equivalent certification.

What will be the RVU value of the CCM code?

The most critical issue will be the relative value units (RVUs) assigned to the CCM service code and how they are distributed between work RVUs (the clinician share) and practice expense RVUs (the payment for the care management provided and the infrastructure). Since there is no risk adjustment and only one service time expectation, practices will have to consider how to amortize

the costs so that those patients who consume higher resources are balanced by those who consume fewer resources, knowing that all patients will receive a minimum 20 minutes of care every 30 days.

The AMA's CPT has developed three CCM service codes for patients, but these codes were designed for patients with much higher levels of instability and included face-to-face care. CMS has no requirement to resolve these differences. Non-Medicare carriers have no obligation to pay for CMS or CPT-defined services.

CMS has established the framework for the CCM code, though there are important details yet to come. Now is the time to address the workflow, personnel, documentation, and payment considerations. Some combination of these factors together will influence each practice or enterprise's decision of whether to support this service code.

Recommended Reading

<https://www.federalregister.gov/articles/2013/12/10/2013-28696/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-clinical-laboratory#h-310> (pages 186-198)

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