Medicare Payment for Chronic Care Management in 2015: New CPT Code 99490; effective 1/1/15

EXECUTIVE SUMMARY

Medicare beneficiaries with multiple chronic conditions account for a significant portion of total program expenditures, but effectively managing these patients has proved challenging for clinicians and policymakers alike. To address this problem, effective January 1, 2015, Medicare began to reimburse physicians and certain other healthcare practitioners for furnishing "chronic care management" services to beneficiaries with multiple chronic conditions. Medicare payment for such services is made under the Part B Physician Fee Schedule using a newly created billing code, CPT 99490.

BACKGROUND

Historically, Medicare has not paid separately for care management services delivered outside of a physician's face-to-face encounter with a patient, such as telephone check-ins with nurse care managers. Beginning in 2015, Medicare will provide separate reimbursement under the Part B Physician Fee Schedule to physicians and eligible non-physician practitioners for furnishing certain types of non-face-to-face care management services to beneficiaries with multiple chronic conditions. This document summarizes the Centers for Medicare and Medicaid Services' (CMS's) billing and payment policies for Medicare chronic care management services in the following areas: (1) eligibility; (2) scope of chronic care management services; (3) coding and payment; and (4) obtaining consent from the beneficiary.

Eligibility

Medicare beneficiaries are eligible to receive chronic care management services if they have multiple (that is, 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.[1] CMS does not specify the particular diseases or conditions that make Medicare beneficiaries eligible for separately payable chronic care management services.[2] In discussing the rationale for this policy, CMS referred to a claims analysis

of Medicare beneficiaries with 15 common chronic conditions. However, CMS has made it clear that it does not intend to limit the list of eligible conditions to those included in this analysis.[3]

Physicians of any specialty, as well as certain qualified non-physician practitioners, are eligible to bill Medicare for chronic care management services. However, only one physician (or qualified non-physician practitioner) is permitted to bill and receive Medicare payment for chronic care management services furnished to a particular patient during a given calendar month.[4] Note that CMS has not yet indicated how it will resolve situations where more than one physician bills for furnishing chronic care management services to the same patient over the same billing period.

Scope of Chronic Care Management Services

CMS describes various services that are considered to be within the scope of chronic care management, including:

- the provision of 24-hour-a-day, 7-day-a-week access to healthcare providers to address the patient's acute chronic care needs;
- continuity of care with a designated practitioner or member of the care team;
- various care management activities, including: the systematic assessment of the patient's medical, functional, and psychosocial needs; approaches to ensure the patient's timely receipt of preventive care services; medication reconciliation, with a review of adherence and potential medication interactions; and oversight of the patient's self-management of medications;
- the development of a comprehensive patient-centered plan of care document in consultation with the patient, caregiver, and other key healthcare practitioners treating the patient;
- management of care transitions, including referrals to other clinicians and follow-up care after emergency department visits and hospitalizations;
- coordination with home and community-based clinical service providers; and
- enhanced opportunities for patient-provider communications via telephone, secure messaging, the internet, or other non-face-to-face methods.[5]

To satisfy the scope of service element regarding the patient-centered plan of care, practitioners must electronically capture the care plan information from the patient and make this information available 24/7 to all members of the patient's care team within the practice, as well as to the patient's healthcare providers outside of the practice.[6]

In addition, practices must furnish certain of the chronic care management services (e.g., the recording of medications and medication allergies and communications to home and community

based providers) with the use of electronic health record (EHR) technology that meets minimum certification criteria acceptable under the Medicare EHR Incentive Program.[7] For 2015, EHR technology meeting either the 2011 or 2014 certification criteria is acceptable.[8]

A portion of the time that practitioners spend remotely monitoring patients can count toward the Medicare chronic care management services. Specifically, practitioners who engage in remote monitoring of physiological data of eligible beneficiaries may count the time they spend reviewing the reported data towards the monthly minimum time for billing the chronic care management code (discussed in more detail below), but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device.[9]

Billing Code and 2015 Medicare Payment Amount

Physicians can bill for chronic care management services using new Current Procedural Terminology (CPT) code 99490 beginning January 1, 2015, which has the following description:

> *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 required 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.*[10]

The 2015 national average Medicare Physician Fee Schedule payment rate for CPT code 99490 is $42.60.[11] At least 20 minutes of chronic care management services must be provided during the calendar month in order to bill using this code. CMS expects that the 20 minutes or more of chronic care management services will be provided by the practice's clinical staff under the supervision of the physician (or other qualified non-physician practitioner). For purposes of meeting the 20-minute requirement, however, the billing physician can count the time of only one clinical staff member for a particular segment of time.[12]

Given the significant overlap, Medicare will not pay separately for CPT code 99490 and certain other codes describing care management, including transitional care management services (CPT codes 99495 and 99496).[13] In addition, physicians participating in CMS's Multi-Payer Advanced Primary Care Practice Demonstration and Comprehensive Primary Care Initiative will not be permitted to bill Medicare for chronic care management services furnished to any beneficiary attributed to their practice for purposes of these programs.[14]

Obtaining Written Consent from the Beneficiary

Before physicians can furnish or bill for chronic care management services, they must inform the beneficiary about the availability of these services and obtain the beneficiary's written consent, including the beneficiary's permission to share medical information with his or her other healthcare providers. The physician must also document in the patient's medical record (using certified EHR technology) that all of the chronic care management services were explained and offered to the patient and note the patient's decision to accept them. Physicians must also inform beneficiaries of their right to revoke their agreement to receive chronic care management services at any time (either verbally or in writing), which would take effect at the end of the calendar month. Finally, physicians must inform beneficiaries that only one practitioner can be separately paid for furnishing chronic care management services to a particular beneficiary during a given calendar month.[15]

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[1] CMS, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014, 78 Fed. Reg. 74,230, 74,416 (Dec. 10, 2013).
[2] *Id.*
[3] *Id.* The selected chronic conditions included in the Medicare claims analysis include the following: Alzheimer's/dementia; asthma; atrial fibrillation; cancer (breast, colorectal, lung, and prostate); chronic kidney disease; chronic obstructive pulmonary disease; depression; diabetes; heart failure; hyperlipidemia; hypertension; ischemic heart disease; osteoporosis; and stroke/transient ischemic attack.
[4] *Id.* at 74,425.
[5] CMS, 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, and Other Revisions to Part B for CY 2015, Final Rule, 79 Fed. Reg. 67,548, 67,721 (Nov. 13, 2014).
[6] *Id.* at 67,725.
[7] *Id.* at 67,727.
[8] *Id.*
[9] *Id.*
[10] *Id.* at 67,651.
[11] CMS, Addendum B, Relative Value Units and Related Information Used in Determining Final Medicare Payments CY 2015, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html?DLPage=1&DLSort=2&DLSortDir=descending. Note that this is the national average Physician Fee Schedule rate that would apply from January 1, 2015 through March 31, 2015. It is subject to change thereafter based on Congressional activity related to Medicare's Sustainable Growth Rate formula.
[12] 78 Fed. Reg. at 74,422.
[13] *Id.* at 74,423.
[14] 79 Fed. Reg. at 67,729.
[15] 78 Fed. Reg. at 74,425.