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National Provider Call Transcript

Centers for Medicare & Medicaid Services
Payment of Chronic Care Management Services Under CY 2015 Medicare PFS
MLN Connects National Provider Call
Moderator: Hazeline Roulac
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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 Hazeline Roulac. Thank you, you may begin.

Announcements and Introduction

Hazeline Roulac: Thank you Victoria. Hello everyone. I am Hazeline Roulac from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on Payment of Chronic Care Management Services Under Calendar Year 2015 Medicare Fee for Service. MLN Connects Calls are part of the Medicare Learning Network. In January, CMS began making separate payment under the Medicare Physician Fee Schedule for Chronic Care Management Services under CPT code 99490.

Chronic Care Management Services are non-face-to-face care management coordination services for certain Medicare beneficiaries having multiple — two or more — chronic conditions. During this MLN Connects National Provider Call, we will review the requirements for physicians and other practitioners to bill the new CPT codes to the Physician Fee Schedule. Following the presentations, the call will be opened, and we will take your questions. Before we get started, I have a couple of announcements.

You should have received a link to the slide presentation for today's call in email. If you have not already done so, you may view or download the presentation from the following URL: www.cms.gov/npc. And again, that is www.cms.gov/npc. At the left side of the web page, select "National Provider Calls and Events," then select today's call by date from the list. Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Calls website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

At this time, I would like to turn the call over to Ann Marshall. Ann is a technical advisor in the Center for Medicare, Hospital, and Ambulatory Policy Group, Division of Practitioner Services. Ann?

Presentation

Ann Marshall: Thanks Hazeline. Good afternoon, everyone. I am here also with Ryan Howe, who is the Deputy Division Director of the Division of Practitioner Services.

And today the agenda for the call is to just give an overview of the new Chronic Care management service that we're separately paying for this year under the Medicare Physician Fee Schedule.

We'll go over just very briefly the extent to which it overlaps with CMS demonstration and other initiatives on coordinating care and primary care. We'll talk about who the eligible population is for this newly payable service, the scope of service elements — so what activities are you required to perform in order to bill to service to the Physician Fee Schedule, who can furnish chronic care management services. Just briefly at the end, we'll go over a little bit of how we arrived at the payment amount under the fee schedule, and then we'll open it up for a question-and-answer session.

Overview of CCM Services Under the CY 2015 Medicare PFS

Ann Marshall: So by way of overview, as Hazeline mentioned, we are paying separately in CY 2015 under the Physician Fee Schedule for a new CPT code — it is 99490 — for certain non-face-to-face care management and coordination services. The payment amount in the office setting — the national average is approximately $43 and the standard beneficiary cost-sharing in terms of coinsurance and deductible — per fee deductible does apply. The eligible population is beneficiaries having two or more chronic conditions; it's a broad population. The new code can be billed once per calendar month — that's the service period — if you furnish a minimum of 20 minutes of qualifying care.

So this is not a per beneficiary, per month code that's automatically paid regardless of whether or not you actually furnish services that month. It is dependent on furnishing a minimum number in each calendar month or service period. In accordance with both the CPT instructions and Medicare policy, only one practitioner can bill this code per month, and there are also restrictions around other codes that can and cannot be billed that describe overlapping care management services during the same service period, and those are listed in the CPT book and also in the Physician Fee Schedule Rules.

Transitional care management is a big one that we often get questions about, and there are also some home health and also other care management services that cannot be billed during the same service period as this new CPT code because they are paying for overlapping services.

Just by way of overview, and in terms of where you can find a detailed discussion of the requirements outside of this call, we finalized most of the requirements in the Calendar Year 2014 Physician Fee Schedule Final Rule. And those provisions would — were effective for this year. In this year's Rule, the Calendar Year 2015 Rule, we addressed just the valuation or payment for the service, supervision in other incident to rules, a scope of service requirement to use an Electronic Health Record, and the intersection with CMS advanced primary care demonstrations.

So just be aware when you are looking for resources in the regulations that there are 2 years to reference. This has been pretty much a multiyear effort to get this service paid and running.

Overlap with CMS Demonstration and Other Initiatives

On slide 7, in terms of overlap with CMS demonstration and other initiatives, practitioners cannot bill a new code for patients who are attributed to their practices for participation in the Multi-payer Advanced Primary Care Practice Demonstration, or the Comprehensive Primary Care Initiative, since these pay for similar services. Practices affiliated with Accountable Care Organizations may be eligible to bill this service. If you do have questions on whether or not your practice can bill and potential billing overlaps, please consult the applicable CMS staff, either in CMMI or in the Center for Medicare, and they will help you figure out whether or not a given patient — whether or not you can bill a new code for patients in your practice.

Eligible Population

On slide 8 we go over the eligible population. As the CPT code describes, it covers beneficiaries with multiple — that means two or more chronic conditions expected to last at least 12 months or until the death of the patient that place the patient at significant risk of death, acute exacerbation, or decompensation or functional decline. This is a broad eligible population. It's approximately two-thirds of Medicare beneficiaries, and we designed it so that we could improve the care coordination for a large population at this point in time.

Scope of Service

I'm starting on slide 9 — we go over the particular scope of service elements or activities that your office would be required to perform in order to bill this code to the Physician Fee Schedule. You'll see that we've referenced Table 33 in the 2015 Physician Fee Schedule Final Rule. This table lists the nine bill-for-service elements, and they are also listed in Table 1 of the Fact Sheet that went up. And the link to the Fact Sheet and the rules is provided on, I believe, slide 19 in this presentation, so you can call those up or look at the Fact Sheet, but those are the elements. And for some of them, there is an activity that's required, and there is a separate electronic technology or Certified Electronic Health Record requirement that goes along with it. And in those tables, we have them aligned there, so you can see for a given activity whether or not there is a corresponding electronic technology requirement. So those may be helpful to view. But we will go over each of them briefly here.

The first one is structured recording of demographics, problems, medications, and medication allergies, and also the creation of a structured clinical summary record using a Certified EHR. So this first element is simply structured or standardized recording of certain patient information in a Certified EHR or other format, and that makes it sharable among different providers to facilitate optimal care management.

And for this and other aspects of the new service, we require the use of a specific version of Certified Electronic Health Record technology that is acceptable under the EHR Incentive Program. The term that you will see used in this presentation and the PFS rules is CCM certified technology. And that was not to make things complicated, but to reference which edition of Certified EHR can be used. As you may know, the Physician Fee Schedule Rules run in a per-calendar-year effective timeframe, but the Certified Electronic Health Record requirement sometimes change in the middle of the year.

So our goal was to align the version of EHR that's required for CCM as much as possible, with the version that the agency requires under the EHR Incentives Programs at the same time, and also to allow for an automatic annual updating. And because of the potential for a just slightly different timeframe, we tied the EH — the CCM requirement to the EHR Incentives Program requirement at the end of each calendar year. So, when we say that a certain activity has to be completed using Certified EHR, it must be completed using the edition of certification criteria that is — edition or editions, plural, because there could be more than one — that is acceptable for the EHR Incentive Programs as of December 31st of each calendar year, preceding each PFS payment year. So for example, this year for Calendar Year 2015 payment, you would be allowed to use either the 2011 or 2014 edition of Certified — of a Certified EHR, where a Certified EHR is required.

Moving on to slide 10, the second scope of service element is 24/7 access to care management services, or providing the patient with the means of timely contact with providers in the practice who have access to the health record in order to address urgent chronic care needs at all times. Most eligible practices already have this requirement in the form of an on-call service, but it is an element of the CCM service.

The third scope of service element is continuity of care with a designated member of the care team, and that includes an ability to obtain successive routine appointments with that individual.

Moving on to slide 9, the fourth scope of service element is a systematic assessment of health needs and receipt of preventive services. And there is a list of things here that focus on systems-based approaches to ensure timely receipt of preventive services. And also key here is medication reconciliation with review of adherence and potential interactions, and basically reconciling medication lists and overseeing how the patient is managing their medication.

On slide 12, we talk about the scope for service element, which is the electronic care plan, and this, of course, is very central to the new CCM service. And we've required the creation and maintenance of a comprehensive care plan that covers all health issues, so not just the chronic conditions that are being directly treated, but it is a patient-centered document that is based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment or reassessment.

In the 2014 Final Rule and the Fact Sheet, we listed some of the elements that are typically found in a qualifying care plan. Certainly it's going to vary per patient but isn't intended to be a comprehensive treatment of any needs that they may have. We do require that a written or electronic copy of the care plan be given to the patient or the caregiver, as appropriate, and that you document provision of the care plan in the Electronic Health Record using the CCM certified technology.

Regarding the care plan, we do not require any format or use of Certified EHR technology in 2015, but we do provide that you have to at least electronically capture the care plan information and make that information available on a 24/7 basis to all practitioners who are furnishing CCM services in your practice. So even if they are furnishing services after hours to the beneficiary, they need to have that electronic care plan available to them to inform decisions and conduct other necessary activities.

We also require that the care plan information be shared electronically using a means other than fax, as appropriate, with other providers and practitioners. You do not have to use a certified electronic technology or capability necessarily, unless you would like to in 2015, to transmit the care plan to another practice or provider.

On slide 13, we talk about the sixth scope of service element being management of care transitions, and this is managing transitions between and among healthcare providers and settings. And that includes things such as a referral to another clinician or practice, followup of the patient after ER or after an ER visit or discharge from a hospital or skilled nursing facility or some other facility.

So since the new code includes this management of care transitions, Medicare doesn't allow billing, as I previously mentioned, of transitional care management codes during the same service period, because essentially that is the activity that is being described here. There are two pieces of this scope of service element. There is a Certified Electronic Health Record technology requirement to create and format the clinical summaries that you would be exchanging with other providers and practitioners in managing care transitions using the CCM certified technology. But when you are transmitting or exchanging that summary care record, we did provide for using any other electronic tool other than fax, at least for Calendar Year 2015.

Moving on to slide 14, the seventh scope of service element is coordination with home and community-based clinical service providers, as appropriate. And that involves communication to and from these providers that must be documented in the Electronic Health Record using the CCM certified technology.

The eighth scope of service requirement is to provide the beneficiary with enhanced communication opportunities and also their caregiver, if appropriate. And this is communication — an opportunity to communicate with the practitioner regarding their

care through telephone, secure messaging, secure internet, or other asynchronous, non-face-to-face consultation method.

Some certified EHR products have secure messaging and other functionalities that would certainly help practitioners to carry out this scope of service element and to document it as well. However, at this time, Calendar Year 2015, we did not require use of the certified technologies because not all qualifying EHRs have those capabilities at this time. Another thing to keep in mind with this element is that, of course, HIPAA and privacy and security rules and regulations and laws must be met in the course of communicating with the beneficiary online or through the other allowed methods.

And on slide 15, we talk about the last scope of service element. You could consider this the scope of service element or just another piece. This was largely covered in a 2014 Final Rule, but informed beneficiary consent. And this is important because it lets the beneficiary know that they will be charged cost-sharing, even though they will not be receiving face-to-face services. It's also important, because it provides a means of obtaining their permission to share protected health information with others, and it helps to ensure that only one practice is providing the service to a beneficiary in any given month.

However, you do need to only obtain informed consent once before furnishing the service, unless the patient chooses to have another practice furnish the CCM service. And in that case, of course, the new practice must obtain consent prior to furnishing the service, but we did not finalize any requirement to update the consent annually. You should not have to revisit it unless they are changing practitioners. And you can see on the slide here — I won't read through it all – because I think we want to allow enough time for Q&A. But there is an extensive list of items that you need to go over with the beneficiary in terms of being eligible for the services, and what they are, and documenting their consent or decline, and also explaining to them how to discontinue the service, that cost-sharing applies, and that only one practitioner can now be paid for the service in a given calendar month.

And on slide 16, we've mentioned one other item that is sometimes —sometimes seems to be missed in our interaction with practitioners today. And that is that the billing practitioner must initiate the CCM service prior to furnishing it or billing it during a face-to-face visit. And that is either an annual wellness visit, the initial preventive physical exam, or a comprehensive evaluation and management visit, all of which can be billed separately and are not technically part of the CCM service, but we did discuss that requirement in the 2014 Final Rules.

This visit is a natural opportunity to obtain and document informed consent, but of course, you can do that at another time, if you wish. It is not a requirement to

necessarily do it at the same time, but that is why we have mentioned it here under the informed consent piece.

Who Can Furnish CCM

Moving on to slide 17. In terms of who can furnish the new CCM service — physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified nurse midwives, subject of course to their state licensures and scope of practice. And also, clinical staff can furnish the service incident to any of these physicians or practitioners, subject to the incident to rules that, of course, apply as they always do, under the Physician Fee Schedule in order to bill an incident to service. And that involves things like supervision and employment and contractual relationships that I'll talk about in a minute.

We often get the question of, "Who qualifies as clinical staff? What about a medical tech assistant? What about the secretary? What about admin. staff?" And clinical staff is a CPT term that you certainly should consult the CPT definition. They do define what they mean by this term, and then also just look at the usual incident to rules to make sure that the staff person meets those rules and that those rules are applied in terms of appropriate supervision and licensure and scope of practice, etc.

But we don't have an exhaustive list — there are too many different certifications out there for us to do that. But with this and with other services that use this term, "clinical staff doing such and such," you should look up the incident to rules in CPT. We did provide an exception under the incident to rules allowing general supervision of clinical staff when they do furnish services. General supervision means that a physician or other appropriate practitioner is —service is furnished under their overall direction and control; however, they could be on-call; they do not necessarily have to be on site in the office.

And that's as opposed to — for most Physician Fee Schedule services, usually we require a supervisor to at least be present in the office suite. So there is an exception here, because this is a non-face-to-face service. We did apply the Physician Fee Schedule incident to rules that apply to other Physician Fee Schedule services that you already bill to Medicare regarding employment and contractual arrangements. And that is found in Section 41026 of the regulations.

Again, we often get a lot of questions about whether this or that specific arrangement applies, and generally we don't approve specific scenarios — there are a lot of different ways that you could do this. And especially for a non-face-to-face service like this that is typically furnished by clinical staff and not by the billing practitioner directly, we are aware that many practices are going to be looking to contract service out to care -management companies or other folks. And as long as those incident to regulations are met, that is appropriate and acceptable.

However, we do want to be clear that nonclinical staff time is excluded from the minimum 20-minute time that is required to bill. Also, I think we were pretty clear in the regulations on this, but we do sometimes get the question of whether a specialist can bill this service. We believe it may typically be furnished by primary care, and as we mentioned in the rules, the requirements are certainly consistent with what is found in a primary care medical home; however, we specified, and continue to specify, that a specialist can bill this service as long as they meet all of the billing requirements.

PFS Valuation

On slide 18, just briefly, in terms of payment, we arrived at the payment amount as we commonly do under the Physician Fee Schedule by looking at comparable services. So the one that we thought was most similar to this was the non-face-to-face portion of the transitional care management services, and so we used that to determine equivalent payment, given the time involved for the new CPT code.

We also wanted to briefly mention that there are two other CPT codes, 99487 and 99489, that are active in Calendar Year 2015 and that have been active for, I believe, at least 1 year under CPT, and they describe what's called complex chronic care management, and that's intended to deal with only very complex, specific patients.

We continue to bundle these codes under the Physician Fee Schedule and not separately pay them at this time. We are continuing to look at payment for complex patients to make sure that we are appropriately handling that, but just be aware, when you say CCM services, there are several CPT codes, and only one of them, 99490, is the one that is separately payable, and that is where you would be looking for your billing requirements if you were in the CPT Manual or some other place.

On a final note, this is not in the slides, but we just wanted to mention because it is frequently asked, that rural health clinics and federally qualified health clinics are not authorized to bill the new CCM service at this time. We do hope to issue a proposed rule this year where we would propose payment for CCM in these centers beginning in 2016, and you can certainly direct questions about that to staff in the Division of Ambulatory Services here at CMS. Our division, mine and Ryan's, does not handle their payment. There is a division here that works specifically on that, and that is where they are at this point in time in considering this issue.

Resources

And lastly, on slide 19, we have listed for you here the links online to the 2014 and 2015 Physician Fee Schedule Final Rules. Please do take a look at them. We know that they are much longer than something like a fact sheet or FAQs, but as you know, they are the most comprehensive sort of repository of what the requirements are to bill. And you should take a look there to make sure that you don't miss something and for

context and discussion about how, you know, we use the notice and comment process to come up with what the requirements are and how we got to where we are.

There is also a Fact Sheet that we have newly posted on the CMS website, under the Medicare LearningNetwork®, and the link to that is provided for you here as well. If you have questions following this call, please contact your Medicare Administrative Contractor. They should have these materials and be able to help you with specific questions and applications in terms of your specific practice setup.

And now I'm going to hand this call back to Hazeline for a few comments before we go into our Q&A session. Thank you.

Keypad Polling

Hazeline Roulac: Thank you Ann — a lot of good information. So at this time we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there will be a few moments of silence while we tabulate the results. Victoria, we're ready to start the polling.

Operator: Certainly. 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 1. 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 9.

Again, if you are the only person in the room, enter 1. 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 9. Please hold while we complete the polling. Please continue to hold while we complete the polling. Thank you.

I would now like to turn the call back over to Ms. Roulac.

Question-and-Answer Session

Hazeline Roulac: Thank you Victoria. So our subject matter experts will now take your questions about payment of chronic care management services under Calendar Year 2015 Medicare Physician Fee Schedule. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many questions as possible, we ask that you limit your question to just one.

If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue, and we'll address additional questions as time permits. All right Victoria, we are ready to take our first question.

Operator: To ask a question, press star, followed by the number 1, on your touchtone 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 into the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Sherry Fisher.

Sherry Fisher: Yes, hello. Our organization wanted to ask if the charting time by the nurse is — can be counted as time, counted toward the CCM?

Ann Marshall: Thank you for the question, Sherry. We think it certainly can. RN is certainly clinical staff, and if they are doing chart documentation related to the CCM services, that time should certainly be counted.

Sherry Fisher: OK, thank you very much.

Hazeline Roulac: Thank you Sherry. Next question, please.

Operator: Your next question comes from the line of Sandy Prepatera.

Sandy Prepatera: Hi, I wanted to know — is there a list of what you guys consider to be the covered chronic conditions?

Ann Marshall: Thanks for the question. There is not, because there is a pretty long list of what could be considered as chronic conditions. And deciding how to pay for the service and the population we wanted to cover, we did look hard at the information in the chronic care data warehouse. And so that is certainly a place to start. I mean, I think that database uses maybe 15, but we have not limited payment of the service to those. And at this point, the only restriction that we've applied is what you see in the CPT code.

Sandy Prepatera: OK, thank you.

Hazeline Roulac: Thank you Sandy. Next question.

Operator: Your next question comes from the line of Marcella Buxton.

Marcella Buxton: Hi, thank you. I — my question is related to the informed consent. If you see the patient for a comprehensive visit and obtain though informed consent at

that time, and then don't see the patient, provide this service, or don't have enough minutes or for whatever reason don't bill the service in the next month, is it still sufficient to have received that, and then maybe a month or two down the road, start billing the service?
Ann Marshall: You can certainly bill the service in another month. You couldn't bill it for that first month where you didn't meet the 20-minute timeframe.

Marcella Buxton: But getting the informed consent some months before the first time you bill it would not be a problem?

Ann Marshall: No, no. In fact, really since that is — you know, done as part of another visit that's separately paid, that could — technically pieces of that, you know, may be done by an admin staff over the phone and may not even necessarily count as qualifying minutes. So the way the time is measured for billing, it's 20 minutes per calendar month. So that is fine for the informed consent to take place in an earlier month. You don't need to repeat it, but if that month or the following month you don't meet the 20 minutes, then you couldn't count that time towards the month in which you end up billing.

Marcella Buxton: OK, thank you.

Hazeline Roulac: Thank you Marcella. Next question.

Operator: Your next question comes from the line of Cheryl Hooper.

Cheryl Hooper: Hi, I'm interested in finding out how CMS is going to allow provider-based physicians to report these services or if this is only allowed for physicians in private practice.

Ann Marshall: Hi Cheryl, thanks. I did get your voicemail this morning. So I'm glad you made it through the Q&A line. We get this question, and sometimes it's not clear exactly what is being asked, so let me step back a little bit and say that hospitals — a hospital outpatient department can certainly bill this CPT code. It's assigned in APC, it's payable under the OPPS. The issue, and I think your question is, whether the physician who is working in that provider-based department can also bill the Physician Fee Schedule, is that correct?

Cheryl Hooper: Yes.

Ann Marshall: OK. We are considering an FAQ on this topic and whether or not there is anything more that we need to say, because we have addressed it already in the regulations a bit. In the 2014 Final Rule, we did provide that the new service cannot be billed if the patient resides in a facility setting because the resources required to provide services are already included in the payment to the facility for care management activity

by the facility staff. And moreover, we said that that specifically continues to be reflected in payments for the face-to-face E&M visit that's already been made to the physician.

So we felt that there was too much duplication of effort to make a separate payment in that case to the physician. For similar reasons, long-standing incident to regulations provide that if the service is being furnished incident to — in other words, the physician or the billing practitioner's clinical staff are furnishing — or other staff are furnishing the service rather than the physician themselves, if the service is furnished in an institutional setting, meaning a hospital or a skilled nursing facility, or to an institutional patient, then the Physician Fee Schedule does not pay for it.

And again, the concern there is for overlap in payment because the facility is already being paid, and it's the facility staff, not the physician staff, who are doing the work. So at this point, that's where we are on the issue. Again, we do continue to consider it and whether there is anything more specific that we need to say or issue about it. But I hope that that helps for now.

Cheryl Hooper: Thank you, it does. Thank you.

Hazeline Roulac: Thanks for your question Cheryl. Next question, please.

Operator: Your next question comes from the line of Alan Nickel.

Alan Nickel: Hi. I just wanted to clarify under clinical staff when you said it was nonexhaustive, if pharmacists were also included in the nonexhaustive list of clinical staff.

Ann Marshall: So I think a pharmacist would definitely meet the clinic — the term clinical. So if you have a pharmacist that your practice is working with or who happens to be employed by your practice — I don't know how common that is — who is helping with the medication management, certainly that time spent by the pharmacist could count towards the minimum 20 minutes for the practice to bill. Just keep in mind, as you probably already know, that the pharmacist can't bill Medicare directly; there is no statutory benefit enabling them to do that under the Physician Fee Schedule. But the time is counted …

Alan Nickel: But it …

Ann Marshall: … because it is clinical.

Alan Nickel: But it still could be the clinical staff in this case because it's for the non-face-to-face CCM.

Ann Marshall: I'm sorry, could your repeat that last part of your question?

Alan Nickel: They could be the non-face-to-face clinical staff providing the CCM to the patient.
Ann Marshall: Within their scope of practice. I don't think that all of the activities are necessarily within their scope of service, but certainly if they are providing medication management and there is something that is within their licensure and scope of practice, you could count that time towards the 20 minutes. I do think that it would be unusual for a pharmacist to be furnishing the entirety of service.

Alan Nickel: OK, because I am a pharmacist and that is what I do inside the practice.

Ann Marshall: I think what I would say is, talk maybe to the practice's Medicare Administrative Contractor. And again, in any individual case, it's just a matter of whether you are licensed and appropriately qualified to furnish the services and whether the incident to and other rules are being met.

Alan Nickel: OK, thank you.

Hazeline Roulac: Thank you Alan. And just a reminder, before asking your question, please state your name clearly and the name of your organization. Next question.

Operator: Your next question comes from the line of Marlena Tice.

Marlena Tice: Hi, thank you. My name is Marlena Tice, I'm from UPMC Health Plan. And I have a question regarding slide 7, the second bullet point, where you talk about ACOs may be eligible to bill. And to contact the applicable people there — can you repeat that, who they would need to contact?

Hazeline Roulac: Thank you for your question. One moment, please.

Marlena Tice: OK.

Dr. Terri Postma: Hi, this is Terri Postma from the Shared Savings Program. So we recently put out — and if you're part of an ACO currently, ACO staff recently got a newsletter article about chronic care management codes. And that has some Q&As for you and some further information for you. In general, most ACO organizations are not Medicare-enrolled entities and, therefore, they cannot bill Medicare for CCM or any other fee-for-service services that are rendered to fee-for-service beneficiaries.

Marlena Tice: OK.

Dr. Terri Postma: But the Medicare-enrolled ACO participants that are part of the ACO may be eligible to bill for CCM services. And it's possible that the ACO administrative

staff could help ACO participants meet the CCM's scope of service for billing requirements. So, you know, for more information on that, you could — whatever Medicare-enrolled providers that are part of your ACO that are interested in billing for CCM services, you could have them talk to their MACs and find out — their Medicare Administrative Contractors, who handle all the billing, and to get more details on exactly, you know, in the presentation that Ann gave about the details of billing for those.

If you have additional questions for — I mean, this is just one more fee-for-service payment code that can be used under fee-for-service Medicare, so you know, you know that all your Medicare-enrolled providers that are participating in your ACO continue to bill Medicare as they normally would. This is one more code that is at their disposal to use within the rules that have been laid out. If you have more questions about that though, feel free to email us at aco@cms.hhs.gov. Or if you're a current ACO, you could get in contact with your CMS coordinator, and they can help you — help send you more resources.

Marlena Tice: OK, very good. Thank you so much Terri.

Dr. Terri Postma: You're welcome.

Hazeline Roulac: Thank you Marlena. Next question.

Operator: Yes, your next question comes from the line of Donelle Kirby.

Donelle Kirby: Hi, yes. I am Donelle Kirby with Prime Health Medical Center, and my question is …

Hazeline Roulac: I'm sorry Donelle, can you speak up just a little bit?

Donelle Kirby: Yes, ma'am. I am calling with Prime Health Medical Center in Memphis, Tennessee. And we have a question on the place of service code that we should be using when billing the service.

Ann Marshall: Hi, this is Ann Marshall again, in the Division of Practitioner Services. We have not issued a specific requirement on that at this point in time. Because it's a non-face-to-face service, it's a little less straightforward than other situations. So I would say certainly look at the manual provisions — that provisions are already in the manual about place of service, even though at this time those are not specific to CCM, and we will continue to consider whether or not we need to be prescriptive. But at this point we have not instituted a requirement one way or another on this point.

Donelle Kirby: But if we're filing our claims using the office service code of 11, are we doing that correctly since it's not specified, or…

Ann Marshall: Yes, since at this point we have not specified, that would certainly be fine. And at this point, we do not have any automated claims edits in the system to reject claims based on this or that place of service, so at this point in time, that is certainly fine.
Donelle Kirby: OK, thank you very much.

Hazeline Roulac: Thank you Donelle. Next question, please.

Operator: Your next question comes from the line of Nancy Costello.

Nancy Costello: Hello, this is Nancy Costello with Adams Health Network. If we have a physician in our call group that's not part of our group but has access to the medical record, does that meet the definition of the 24/7 access?

Ann Marshall: So the 24/7 access is — let me look at it again myself, at the language, exactly what it says. It says "with health care providers in the practice."

Nancy Costello: So if we have a call with a physician that is not in our practice, then we couldn't bill the service?

Hazeline Roulac: One moment Nancy.

Nancy Costello: OK.

Hazeline Roulac: Thank you. Thank you for waiting.

Ann Marshall: Yes, thanks for waiting. So we think that tech — that that then really falls under a contractual type of arrangement, where you have agreed with — to have someone else do something that would normally be done by — by your practice. So it would fall under the incident to rules, so I would just say look at the manual and on the provisions in the Section 410.26, and as long as the appropriate relationship and supervision is there, and the other incident to rules are met, so for practice, state licensure, etc., then that would be acceptable.

Nancy Costello: Great, thank you.

Hazeline Roulac: Thank you Nancy. Next question, please.

Operator: Your next question comes from the line of Angela Miller.

Angela Miller: Hi, I'm Angela Miller with Medical Auditing Solutions. My question is — in all the research that I've done, can a 99091, which is collection and interpretation of physiological data of at least 30 minutes be billed in addition to the CCM 99490?

Ann Marshall: OK, thanks for the question. It was one that we received a lot after the rule went out. No, it cannot be billed during the same service period. That is very clear. If you look in the CPT guidance, it's a code that's excluded from billing during the same month. That said, what I think raised the question was, in the 2015 Final Rule, we received public comment saying, hey, you know, the activities described by this CPT code are very similar to some of the activities under this new CCM code and, you know, specify how we're to bill those activities.

And so what we said was that those remote patient monitoring activities, that time could be counted towards billable times for billing CPT 99490. However, what you can't do is bill both codes; you have to choose one or the other. And, of course, if you're billing the 99490, there is a whole other set of requirements that have to be met in addition to the remote monitoring. So that wouldn't be the only thing that you have to do during that month in order to be able to bill that code.

Angela Miller: Great. Thank you.

Hazeline Roulac: Thank you Angela. Next question, please.

Operator: Your next question comes from the line of Jeff Goat.

Jeff Goat: My question has been answered. My question was answered, thank you.

Hazeline Roulac: Thank you. Next question.

Operator: Your next question comes from the line of Vivian Cool.

Vivian Cool: This is Vivian Cool calling from Dr. Roland Ing's office. I have a question regarding slide 12, number 5, electronic care plan. You know, it says to share the care plan information electronically with other providers. What happens if one of the providers cannot receive that information electronically?

Ann Marshall: So thanks for the question, that's another good one. So the issue seems to be when we hear about this one is receiving providers who don't have a certified EHR and then for the care plan, we didn't require use of a certified technology to send, we said you could use some other electronic technology such as email, but we instituted prohibition on fax and we've heard from only a very few providers — but that they do work with some practitioners who cannot accept, for example, a HIPAA compliant encrypted email, which is perhaps a bit surprising. But I know there are some areas of the country where, you know, electronic capability and Internet is very limited.

So we talked to the Office of the National Coordinator for Health IT about this, but apparently some providers are — do have a system, Certified EHR, that translates the CCDA language into a fax for recipients who don't have that electronic receipt capability.

And you could certainly use that, I believe, if your practice's Certified EHR has that capability. ONC has mentioned that their interoperability policies in the next few years should help resolve this issue and move all providers towards being able to receive and not just send electronically.

But in the meantime, I would just say use a HIPAA-compliant encrypted email or a workaround if your Certified EHR provides it, or work with another provider.

Vivian Cool: You know, some of the providers, they just choose not to adopt actually any EMR — Electronic Health Record —because it's too costly. So we can either get the information to them by mail or fax, those are the only means we can do it. Does that prevent us from billing this code?

Ann Marshall: Right, I understand that. I know one physician's office that I spoke with last week mentioned sending an encrypted email; have you tried to send via email — HIPAA compliant email or do you …

Vivian Cool: Well, we decided not to do that, because you know, with all this hacking activities, we have to respect the HIPAA, so we try not to do that. So in cases like this, what do we do?

Ann Marshall: You can use the HIPAA compliant encrypted email, or you can look for an EHR product that has a workaround. I know that the physician's office I spoke with last week on this was simply considering referring to other providers.

Hazeline Roulac: OK Vivian. Thanks for your question.

Vivian Cool: Thank you.

Hazeline Roulac: Next question, please.

Operator: Your next question comes from the line of Ashley Adamo.

Ashley Adamo: Yes, our question has to do with a chronic conditions question. I know one's been asked already, but the question is, how to be sure which conditions apply because 27 general categories — but for example, within those, there are multiple ICD-9 codes. Are there impermissible combinations? Like, for example, can you take two ICD-9 codes within the same general category? How do we know what's permissible and what's not permissible?

Ann Marshall: At this point, we have not implemented any automatic claims edits or provisions other than what is listed in the CPT code descriptors. So if they are two — if you believe that there are two or more distinct chronic conditions, then you may bill them. You may want to talk to your Medicare Administrative Contractor, to your MAC,

to see how they may consider auditing that provision. You know, we're the payment folks. We don't do the auditing on the backend, and they may have insights as to how they will look at that particular provision.

But as far as payment policy, we have not been any more prescriptive than what is in the CPT codes at this time.

Hazeline Roulac: Thanks for your question. Next question.

Operator: Your next question comes from the line of Marlena Shaw.

Female participant: For Marlena Shaw.

Brian Batson: Hey, this is Brian Batson from Hattiesburg Clinic. I just wanted to clarify on this — that the yearly renewal of the consent form is not a requirement.

Ann Marshall: That is correct. We did not require it annually. In the 2014 Final Rule, we said that you don't have to repeat the consent unless the patient changes practices and someone else is going to bill.

Brian Batson: OK, thank you.

Hazeline Roulac: Thank you. Next question, please.

Operator: Your next question comes from the line of Laura Bond.

Laura Bond: Hi, this is Laura Bond with TYA. On page 10 of the presentation, it indicates that the 24/7 access to care requires the care team member to have access to the patient's health record. Is it actually sufficient to have access to the care plan? It seems like that is the reference in that – in the Final Rule.

Ann Marshall: The reference in the Rule is to the care plan — I think here we were a little broad, because this is a presentation that is a little more general. I think it will suffice if you go with what is in the Rules where it references specifically access to the care plan.

Laura Bond: So access to the care plan, as opposed to full access to the patient's EHR.

Ann Marshall: Yeah, I would like to take a look through the rest of the Rule and make sure that we didn't phrase it differently in another place. Could you give me your email or your phone number and let me just take a second look offline when I have a little more time before I tell you an answer that's …

Hazeline Roulac: One moment. We don't want you to give out your email or phone number.
Laura Bond: Thank you.

Hazeline Roulac: Hold on just a second.

Laura Bond: OK.

Hazeline Roulac: Hi, can you give your information to the operator? Victoria, can you take her information?

Operator: One moment. We'll have someone do that, one moment.

Hazeline Roulac: Thank you.

Operator: Would you like to take the next question?

Ann Marshall: Yes, please. We're ready for the next …

Operator: Your next question comes from the line of Julie Hill.

Julie Hill: Hi, I'm Julie Hill with the Center for Integrated Health. I just had a quick question on how to get informed consent for multiple providers. So for saying, hey, you are giving your consent to consult with other providers, how to make that a blanket statement?

Ann Marshall: Are you talking about informing them that you'll be sharing their information with other providers? Because the consent as far who can bill …

Julie Hill: Right, right.

Ann Marshall: … is just for your practice, so it would be anyone in your practice.

Julie Hill: Um-hum. But like — oh, so we're saying we're sharing in the prac — within the practice?

Ann Marshall: No, the consent for who — part of their consent is to let the beneficiary know that only one practice can bill the service, right? That's your practice. But you are also required to let them know that you will be sharing their information with other treating providers and practitioners. And we have not specified how you need to word that sentence.

Julie Hill: OK.

Ann Marshall: I know some providers get frustrated with us if we try to be too prescriptive, and we didn't feel like we needed to be more prescriptive than that.
Julie Hill: OK. And that wouldn't affect HIPAA or anything?

Ann Marshall: Well, the language is "authorization for the electronic communication of his or her medical information with other treating providers." You may wish to reference HIPAA. I think in the rule, we have certainly been clear that HIPAA provisions require — I mean, apply, and you may want to explain that to them, and that may provide them with some comforting confidence.

Julie Hill: OK.

Hazeline Roulac: OK, thank you. Next question, please.

Operator: Your next question comes from the line of Karen Trent.

Hazeline Roulac: Karen?

Operator: Karen Trent, your line is open. If you are on mute, please unmute your line and proceed with your question.

Hazeline Roulac: Victoria, can we go to the next question?

Operator: Your next question comes from the line of Kim Greene.

Kim Greene: Hi, this is Kim Greene from Atenahealth. My question is regarding the date of service on claims, it being a calendar month time period. I'm just wondering what edits will be in place for the date of service that should be on the ECCM claim.

Ann Marshall: Thank you for the question. At this time, as I mentioned earlier, we do not have any automated edits in the claim system, so your claim will not be rejected based on putting one date of service vs. another. Just like with place of service, we have not been prescriptive yet — we are still considering in talking to the claims folks whether or not we need to be, whether or not it would be the span for the month or the dates that say you wrap up your 20 minutes. So at this point, it would be fine however you want to report it.

Kim Greene: So it could either be a range of dates or a single date, and does that mean that you could bill on the 15th of the month if you complete the 20 minutes of care management by that date?

Ann Marshall: We have not specified a submission date requirement — that is another thing, along with the date of service, that we're considering whether or not we need to be more prescriptive. But please do call your Medicare Administrative Contractor

because they may have preferences for both date of service and when you submit. I know that some of them have mentioned they have a first in/first out policy, and you would want to certainly understand that — on what order do they pay claims as they come into their system.

So I would give your Medicare Administrative Contractor a call and see if they have any additional instructions for you, but at central office here, at this time we have not been more prescriptive yet on that — we are continuing to consider.

Kim Greene: Thank you.

Hazeline Roulac: Thank you Kim. Next question, please.

Operator: Your next question comes from the line of Jennifer Bowler.

Jennifer Bowler: My question has been answered.

Operator: Your next question comes from the line of Ross Roby.

Ross Roby: Yes, my question is how is time documented into the EHR system?

Ann Marshall: So, you know, we are not experts on the Certified EHR and how their documentation works. I imagine that probably varies from vendor to vendor and product to product. So I'm not clear exactly what your question is.

Ross Roby: Well, if we're calling back and forth to different providers like, let's say our nurses, and our nurses — how do they document — how do we prove that document — that that documentation has taken place? Do we just put a note in the patient's file and do we document the time? Or how is that taken care of to substantiate the 20 minutes that we're actually utilizing?

Ann Marshall: So I think that for this code as well — there are many CPT codes first of all that are timed, that require a certain amount of time of services to be furnished.

So I think this is a question that applies not just to this service, but to many services under the Physician Fee Schedule, and again, you may want to talk to your local claims administrator as to how, you know, they review and audit these codes, and what they want to see on the medical record. But for our purposes, no, we have not specified what is in the rule.

If there is something specific that has to be documented in the medical record as an activity, then it is listed there, and you should be sure that that is very clearly stated in the medical record whether — and that if it's a requirement to do it in a certified record, that it be in the certified format.

Ross Roby: OK. One other question if I could, please. Is – I know that — is this just covered by Medicare or is this also going to be covered by managed Medicare insurances?

Ann Marshall: So we are the fee-for-service — you are talking to the fee-for-service payment folks. There is no one from managed care in the room, but we have been talking to them, and you should just contact them if you have specific questions about how they are going to apply this. My understanding so far has been that on the fee-for-service side, we view this as not a new Medicare benefit of services that were already being covered; they were just being paid in a different way and bundled into other services. And my understanding is, then, that managed care will follow that, and in terms of the bidding and payment, they won't treat it as a new activity. But you should direct that question to the Medicare Advantage staff in the agency or to your — yes, if you have — if you want a more specific explication of how exactly they are looking at this.

Ross Roby: OK, thank you.

Hazeline Roulac: Thank you sir. Next question, please.

Operator: Your next question comes from the line of Melinda Connard.

Melinda Connard: I had wanted to know about the consent forms being signed annually; so mine has already been answered. Thank you.

Hazeline Roulac: Thank you. Next question.

Operator: Your next question comes from the line of Stacey Wagner. Stacey, your line is open, please proceed with your question.

Your next question comes from the line of Amy Modglin.

Amy Modglin: Hi, my name is Amy Modglin. I'm calling from Sentara Medical Group. My question is, if there is a certain cutoff for the amount of time for which we can provide the chronic care management services?

Ann Marshall: A cut off for the amount of time —— I'm not sure that I understand your question.

Amy Modglin: Can we provide the services for 2 or 3 years? Or is there a cutoff on the amount of time for which we can do the services?

Ann Marshall: No, there is no cap as far as the beneficiaries, as far as benefits go. Like, you know, only 1 year or 2 years. No, there is no restriction.

Amy Modglin: OK, great. Thank you.

Hazeline Roulac: OK, thanks Amy. Next question.

Operator: Your next question comes from the line of Kelly Martinelli.

Kelly Martinelli: Hi, this is Kelly Martinelli from Aultman Medical Group. And I was — would like just some clarification. In the *Federal Register,* it says the practice must employ one or more advanced practice registered nurses or physician assistants who will, you know, whose written job descriptions indicate their job roles include the appropriate needs. Is that — the practice actually has to have an advanced practitioner or a physician assistant, or does it just mean that they have to be employed by the practice — they really — a physician practice without one of those can do that?

Ann Marshall: Thanks. So you're describing something that we proposed in the 2014 proposed rule but we did not finalize it. So there is no such requirement.

Kelly Martinelli: Great. Thank you.

Ann Marshall: Yes.

Hazeline Roulac: Thank you Kelly. Next question.

Operator: Your next question comes from the line of Brian Batchelder.

Brian Batchelder: Brian Batchelder from Akron General Medical Center. The question is whether you can use the time that it takes to create the electronic care plan mentioned on slide 12 as part of the 20 minutes attributed to that month.

Ann Marshall: I would think so, so long as clinical staff are doing that activity.

Brian Batchelder: Thank you.

Hazeline Roulac: Thanks Brian. Next question.

Operator: Your next question comes from the line of Pamela Ford.

Pamela Ford: Yes, Pam Ford from Tice Valley Internal Medicine. I wanted to know, can we use a face-to-face from, say, fall of 2014 in order to start billing this code, or do we have to have a new face-to-face this year — do we have to have that before we start billing this service?

Ann Marshall: So the face-to-face visit is for purposes of initiating the service. So I think if at that visit you talked to the patient about CCM, and, you know, described and offered it to them and explained what it is, then it could probably count. But if you just had a visit for something that is unrelated, and you didn't discuss CCM with them, then I would say no, you need to do another visit.

Pamela Ford: OK, because the patient's homebound, the wife came in and discussed this. So we count that?

Ann Marshall: I'm sorry, who came in and discussed it?

Pamela Ford: The wife came in and they discussed it with the wife because the patient is homebound.

Ann Marshall: So this was an E&M visit with the wife?

Pamela Ford: No, the patient was in, in December. We had seen the wife since then, she's been in, and they discussed it — the husband — they discussed the service with the husband with the wife. She agreed to it, because she is the Power of Attorney. But he hasn't been seen since 2014.

Ann Marshall: Why don't you send that question to your MAC? I think it's specific enough in terms of having a caregiver, you know, and a Power of Attorney involved and it — and what CPT code you billed and whether it was really an E&M visit. It's a very — it sounds like a very specified situation …

Pamela Ford: OK.

Ann Marshall: … that would be better answered by them. Thank you.

Pamela Ford: Thank you.

Ann Marshall: Um-hum.

Operator: Your next question comes from the line of Debra Brackton.

Debra Brackton: Hello. I'm in clinical health. Does generating a care plan in the EMR satisfy the requirements that the patient was given a copy, or does there need to be a separate documentation that the patient received a copy?

Ann Marshall: Are you talking about how the care plan is given to the patient, or how you document that it was given to them?

Debra Brackton: Yes. Yes.

Ann Marshall: Let's see. Let me look at it here where the — at the language myself.

Debra Brackton: It says it has to be given — go ahead.

Ann Marshall: I believe it says written or electronic copy.

Debra Brackton: So if it's generated in the EMR, to get a —an electronic – we would have to document that we printed it.

Ann Marshall: OK, it says, "Provide the beneficiary with a written or electronic copy of the care plan and document the provision in the EMR." So you can give them either a written or an electronic copy, but you have to document in your Certified EHR that you gave them the copy.

Debra Brackton: OK. Could I ask one more question?

Ann Marshall: Sure.

Debra Brackton: If a provider sees a patient face-to-face, and the — and he has the nurse create the care plan, does he need to sign it or can he just mark that he reviewed it in the EMR?

Ann Marshall: That sounds to me like a general medical record documentation thing and not something that is specific to CCM.

Debra Brackton: OK.

Ann Marshall: So I would talk to your MAC about that.

Debra Brackton: All right. Thank you.

Hazeline Roulac: Thanks, Debra. Next question, please.

Operator: Your next question comes from the line of Joanne Delmonico.

Joanne Delmonico: Hi, Joanne Delmonico, New Providence Internal Medicine. My question is, can a certified medical — or registered medical assistant enter all the information, or does it have to be an RN?

Ann Marshall: So when you say enter all the information, I assume you mean the parts of the CCM service that involve documentation in the medical records?

Joanne Delmonico: Yes.

Ann Marshall: And so, for — first of all, they would have to meet the definition of clinical staff in CPT and then also be meeting the incident to regulations in terms of being under general supervision, and it must be within their licensure and scope of practice to perform the activity that they are performing. I would also again — just consult your MAC or whoever you usually consult as far as who is authorized to document certain things in a medical record.

That's not really a payment policy — that sounds more like a very specific documentation and who is allowed to document what in a medical record issue.

Joanne Delmonico: Right. Because our nurses are — I mean, we call them nurses, but they are medical assistants, and they are certified or registered. They are allowed to enter, you know, the information, all the vitals and whatever they get when they take a patient into a room. But the — I knew you had said it was a very broad group of people that could or could not. Where is this CPT item I can look at to see …?

Ann Marshall: It's in the introduction to the CPT book — is there — does your office have a coding book?

Joanne Delmonico: Oh, OK.

Ann Marshall: If you look at the Preface, they define the term "clinical staff."

Joanne Delmonico: OK.

Ann Marshall: It's used for this code and for many other codes where they say "clinical staff" can do such and such…

Joanne Delmonico: Right.

Ann Marshall: Along with where they define the term "qualified healthcare professional," I believe. That's also often used, and that's how the language got into CCM. But we're not using it any differently here than it is used for other services.

Joanne Delmonico: OK, great. Thank you very much.

Ann Marshall: Sure.

Hazeline Roulac: Thanks Joanne. Next question.

Operator: Your next question comes from the line of Karen Waypan.

Karen Waypan: Hi, I just had one clarification on slide 12, the electronic care plans. Can you just clarify "no Certified EHR in 2015" to — I assume that means generate the care plan. So you could have a written care plan in 2015, but you have to electronically capture the information which goes on the plan. Am I understanding that correctly?

Ann Marshall: That's correct.

Karen Waypan: OK, thank you.

Hazeline Roulac: Thanks Karen. Next question.

Operator: Your next question comes from the line of Sally Finkel.

Sally Finkel: Hi, this is Sally Finkel at Park Medical Associates. I have another question about the electronic care plan. And I think you said that there was no specific format of the electronic care plan. But I wanted to know if the initial face-to-face visit where the care plan is discussed, if the care plan is discussed and documented in that note, does that count as the electronic care plan?

Ann Marshall: Wherever it is in the medical record, it just has to be electronically captured. And I would just be aware if it includes information around medication, just reference back to the first scope of service element for demographics, problems, medications, allergies, etc. that do have to be documented in a Certified EHR format, an acceptable one. So make sure that those pieces of it, I would say, are using the certified format.

Sally Finkel: But those are two separate documents, aren't they? The clinical summary and the electronic care plan? Or they could be the same?

Ann Marshall: Right, but, I'm assuming there are probably other places in your medical record where you referenced those things.

Sally Finkel: Yes.

Ann Marshall: So wherever they are referenced in the medical record, they should be referenced using "certified technology."

Sally Finkel: And is "certified technology" the same thing as "meaningful use technology?"

Ann Marshall: In terms of the version, like what year it is and whether it has like a structured vs. an unstructured data field, yes. It is the — we are referencing the version that is acceptable under the EHR Incentive Programs at a certain point in time. But we are not — what we didn't do was adopt the meaningful use payment measures, where

you have to be using that — doing that a certain amount of time. Like say, 50 percent of the time the care plan has to be done this way or that way or 10 percent of the time you have to be exchanging this or that document. That is how the meaningful use requirements work; we didn't adopt those percentages.

But what we did adopt was the version of EHR and the data format and structure that's required for the EHR Incentive Program.

Sally Finkel: OK, because in the meaningful use, it does require — have a structured clinical summary record just like you specify here. So I assume they can be used for both purposes.

Ann Marshall: So the clinical — the requirements for those clinical summary records should not be confused with the requirements for the care plan; they are separate.

Sally Finkel: Yes.

Ann Marshall: Right. And …

Sally Finkel: But there is a clinical summary in meaningful use, and so it seems like that could be used for the clinical summary and then the electronic care plan would be a separate document.

Ann Marshall: That sounds right. The requirement related to the clinical summary is that you create the document using the certified technology format, but when you transmit and exchange it with other providers, at this point in time, we're just requiring any electronic method other than fax because the EHR incentive programs are not far along yet where they are requiring everyone to receive as well as send.

Hazeline Roulac: Thanks Sally. We'll need to move on to the next question.

Sally Finkel: No, I appreciate it. Thank you.

Ann Marshall: Thank you.

Operator: Your next question comes from the line of Debbie McKenzie.

Debbie McKenzie: Hi, this is Debbie McKenzie from First Health. I have two questions — they coincide with each other. The first one, based on slide 16: Can the care plan be initiated at the time of the TCM visit?

Ann Marshall: I'm not sure what you mean by initiate the care plan.

Debbie McKenzie: Right, the comprehensive care plan, the CCM. Can it be initiated at the time that a trans — that a transition care management visit is done?

Ann Marshall: You could initiate the CCM service…

Debbie McKenzie: Um-hum.

Ann Marshall: There is no requirement to initiate the care plan — the care plan requirement is separate. The requirement that you initiate during a visit, that does — an E&M visit and transitional care management — does include a face-to-face visit, so you could use that as your face-to-face visit where you initiate the CCM service. But that has nothing to do with the care plan.

Debbie McKenzie: Right.

Ann Marshall: You could initiate the service and do the care plan entirely separately.

Debbie McKenzie: But you could use your — that face-to-face TCM visit at that time in initiating the comprehensive care plan?

Ann Marshall: Yes, you could. Just be aware that you can't bill that TCM code during the same service period, so you're going to be starting a new service period …

Debbie McKenzie: Yes, ma'am.

Ann Marshall: You'll be actually counting your 20 minutes for CCM.

Debbie McKenzie: And then other question with the TCM; can rural health — has it been decided if the rural health can bill the TCM codes, the 99495 and 99496? Do you know?

Ann Marshall: Yes. We believe that it is allowed, but you may want to confirm that with the staff who handles the RHQs and the FQHCs here at CMS. We believe so.

Debbie McKenzie: OK, thank you.

Hazeline Roulac: Thanks, Debbie. Next question.

Operator: Your next question comes from the line of Sherry Fisher.

Sherry Fisher: Yes, ma'am. We were wondering if you have a transition of care in your bill and also the CCM, what date does Medicare go by the transition of care? Does it count when the patient was seen or the date of service that we bill?

Ann Marshall: Can you repeat the question? I'm not sure I completely understand.

Sherry Fisher: OK, so we're doing a transition of care along with the CCM. The transition of care was done like in January and then we were going to bill — but we have to use a date of service for February for the transition of care to bill it. But for — we also did a CCM and we weren't sure if the transition of care counted for the month of January, or did it count for the month of February?

Ryan Howe: So that's a good question, this is Ryan Howe. I think that the — the answer to your question is that the — in terms of the billing for the transitional care management service, that — I'm assuming that that is what you are referring to, the 99495 and 96;

Sherry Fisher: Yes.

Ryan Howe: The date of service should be on the final day of the 30 days following the discharge. And then for the CCM, it would be for the — per calendar month. So I think in principle, the answer to your question would be that if the TCM service is for 30 days, say from January 15th to February 14th, that you couldn't start counting the minutes separate from the TCM for the CCM until that subsequent date in February.

So under that scenario it would be February 15th, and if you hit the 20 minutes between February 15th and February 28th, then you could bill the CCM code for February, if you didn't hit the 20 minutes, then it would restart as of March 1st. Does that make sense?

Sherry Fisher: Yes, sir. It makes perfect sense, thank you so much. I appreciate it.

Ryan Howe: Sure.

Hazeline Roulac: Thank you, next question.

Operator: Your next question comes from the line of Melissa Caporicci.

Melissa Caporicci: OK, the question that we have is really in generalities — as far as what is included in the 20 minutes that's required — is this just like creating and reviewing the care plan from — for that month? Or does this include like a mandatory phone call to the patient or their Power of Attorney or their care — you know, their caretaker at their home, or — we're just a little confused as to what is included in the 20 minutes, and exactly how we document a care plan.

I mean, does it just need to be like some kind of templated generic kind of memo note that we create in the chart or is there a specific form that needs to be filled out?

Ann Marshall: So I'll start with your last question first. As far as the electronic care plan, I think we are pretty clear that there is no format other than that it needs to be

electronic, for 2015 anyway. And I'm sorry, I lost what your first question was, thinking about the second question. Oh, what is included? OK. It is all of the activities that we describe in the scope of service elements. I mean, there may be a month where your patient is not admitted to a hospital so they don't have a transition of care and so that particular scope of service element you're not going to have any time under it.

But during most months, we expect that most of the activities, you know, will apply and you'll be furnishing them to the patient. But any of those activities that are described in the scope of service elements can count towards the 20 minutes.

Hazeline Roulac: So thanks for your question. Victoria, we'll take two more questions.

Operator: Your next question comes from the line of Donna Ring.

Donna Ring: Good afternoon, this is Donna Ring, Central Penn Management Group. My question was in regard to the electronic care plan and it's been answered. Thank you.

Hazeline Roulac: Thank you. Next question.

Operator: Your next question comes from the line of Ginger Wedemeyer.

Ginger Wedemeyer: Hi, this is Ginger Wedemeyer with MissionPoint Health Partners. My question is, does the interaction — the 20-minute interaction — have to be non-face-to-face? Or can it take place in like a meeting at the patient's home or if one of our health partners were to meet them offsite somewhere?

Ryan Howe: I think the — I think it is fair to assume that the service would — needn't be exclusively non-face-to-face, that they are the kind of services that are generally furnished non-face-to-face.

Ginger Wedemeyer: OK. So not a typical office visit is mostly what the concern is about?

Ryan Howe: Right, the kind of care coordination activities that get — if it happened to take place face-to-face as opposed to say, electronically, then they could be counted. But they wouldn't ordinarily be furnished as face-to-face.

Ginger Wedemeyer: OK. I think that makes sense. Thank you.

Operator: Your next question comes from the line of Maurice Rosenbaum. Maurice, your line is open.

Hazeline Roulac: You can go onto the last question, Victoria.

Operator: Your final question comes from the line of Linda McCaid.

Linda McCaid: Yes, this is Lynn McCaid and I'm with Mercy Health. And my question has to do with the capturing of the actual 20 minutes. Can it be that we document electronic medical record in increments of 5, 10 minutes, 15 minutes, or does there actually need to be kind of a timekeeper that keeps it within a minute, 30 seconds, that type of thing for documentation?

Ann Marshall: For this service, we have not been any more prescriptive than it has to be at least 20 minutes. You may want to talk to your Medicare Administrative Contractor again, your claims adjudicator, to see if they have any documentation requirements and what they typically use when they go in to audit timed services.

Linda McCaid: OK, thank you.

Additional Information

Hazeline Roulac: Thank you – so a lot of good questions. Thank you so much, everyone. Unfortunately, that is all the time that we have for questions today. As a reminder, slide 19 gives you links to several related resources, the 2014 and 2015 Final Rules with their respective page numbers for the chronic care management section and the MLN Chronic Care Management Fact Sheet.

If you have questions following this call, we ask that you direct them to your Medicare Administrative Contractor, your MAC; that is the contractor who processes your Medicare claims. To find you MAC, go the CMS.gov website and in the search field, type MAC jurisdiction. And once on the MAC jurisdiction web page, you'll find a link to an interactive map that will help you identify your MAC. And it will also give you their contact information.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website; we will release an announcement on the MLN Connects Provider eNews when these are available. On slide 22 of the presentation, you will find information in a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Hazeline Roulac. I would like to thank our subject matter experts and also thank you for participating in today's MLN Connects Call on Payment of Chronic Care Management Services Under Calendar Year 2015, Medicare Physician Fee Services.

Have a great day, everyone.

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

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