Transitional Care Management

Keeping up with all the new healthcare payment and delivery models is challenging. Figuring out how to best position your organization for coming changes can be overwhelming. A recent article in the New England Journal of Medicine entitled Lessons Learned in Preparing for Medicare Bundled Payments, offers valuable insight:

[Medicare claims data] show that Medicare typically spends as much or more in the 90 days after discharge as it spends for the initial hospitalization . . . . [T]he data [also] show wide variation in average post-acute care spending . . . . This variation highlights opportunities for hospitals and their partners to improve quality and reduce spending by reaching out to patients after discharge and reconciling medications, scheduling timely primary care visits, establishing plans for addressing common problems, and coordinating with post-acute care providers.

Simply stated, one of the greatest opportunities for increasing savings and efficiency – and for improving outcomes – is to provide patients discharged from an institutional setting with certain follow-up care. Health systems that have implemented even the most rudimentary transitional care management programs have realized impressive results.

Proven Success

A recent Health Affairs article profiled the Coordinated-Transitional Care (C-TraC) Program at the William S. Middleton Memorial Veteran’s Hospital in Madison, Wisconsin. The C-TraC is hardly rocket science:

The program uses a registered nurse case manager to coordinate the veteran's transitional care through active participation in inpatient multidisciplinary discharge rounds, a single brief protocol-driven inpatient encounter, and one to four protocol-driven post-hospital

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telephone calls with the veteran and, if available, the veteran’s caregiver.²

The C-TraC program is credited with an 11 percent reduction in re-hospitalizations, resulting in nearly $1 million in cost avoidance over an 18-month period. After accounting for all program costs, the net cost avoidance per veteran enrolled was $1,225.³

Another program with demonstrated success is the University of Colorado’s Care Transitions Intervention (CTI).⁴ This approach involves nurses and social workers who serve as “transitions coaches.” After meeting the patient in the hospital, the coach follows up with home visits and phone calls over a four-week period.

The transitions coach supports the patient in developing four self-care management skills: (1) managing medications; (2) scheduling and preparing for follow-up care; (3) recognizing and responding to “red flags” that could indicate a worsening condition; and (4) taking ownership of a core set of personal health information.

Like the C-TraC program, CTI shows impressive results. In a large integrated delivery system in Colorado, CTI was credited with reducing 30-day hospital readmissions by 30 percent and 180-day hospital readmissions by 17 percent. These reductions cut average costs per patient by nearly 20 percent.⁵

**Financial Barriers**

Given these impressive results, why have providers been slow to implement transitional care management programs? In a word, money.

Until now, there has been no financial incentive for a hospital, skilled nursing facility, physician practice, or other provider to furnish or arrange for any sort of post-discharge services. Because they generated no revenue to offset their costs, transitional care management programs were viewed as luxuries few could afford. With the new hospital readmission rate penalties having come on line in October 2012, however, these programs are getting a second look. Many hospitals now are exploring transitional care management programs as a tool to reduce costly readmissions.

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³ The C-TraC program toolkit, which includes forms and templates, is available without charge through the Health Innovation Program at the University of Wisconsin-Madison, http://www.hipxchange.org/C-TraC.
⁴ Detailed information regarding the Care Transitions Intervention program is available at http://www.caretransitions.org/overview.asp.
Still, the link between today’s investment in care management and tomorrow’s avoidance of a financial penalty is too tenuous for some. Many believe transitional care management programs will be the exception, not the rule, unless and until providers receive direct payment for those services.

**New Medicare Payment for Transitional Care Management Services**

That day has arrived. As of January 1, 2013, payment is available for transitional care management services. Specifically, Medicare now pays physicians and other qualified non-physician professionals for post-discharge transitional care management services (TCM services) under two new CPT® codes, 99495 and 99496.\(^6\)

Based on the 2014 conversion factor of $35.8228, the national payment rates for TCM are $172.66 (for 99495) and $243.60 (for 99496). (The facility rates are approximately 15 percent less.) Check your Medicare Administrative Contractor’s fee schedule for the payment rate for your location.

Additionally, in 2014, CMS listed TCM as a rural health clinic and federally qualified health center service. RHCs and FQHCs now can bill for TCM services under their applicable all-inclusive rate.

The Centers for Medicare & Medicaid Services (CMS) anticipate two-thirds of all discharges will be eligible for TCM. Based on these estimates, CMS expects to spend well over $1 billion on TCM services annually.

**Billing for TCM Services**

The following is a detailed summary of the requirements to bill Medicare for TCM services, based on the preamble to the 2013 Medicare Physician Fee Schedule final rule.\(^7\)

The American Medical Association (AMA) developed the two new CPT codes for TCM services, 99495 and 99496, at CMS’ request.\(^8\) However, CMS diverged from the AMA’s description of these codes in establishing the billing rules for TCM services in two important ways.

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\(^8\) For a discussion of the AMA’s work, see [http://www.ama-assn.org/resources/doc/cpt/03-cms-physician-fee-schedule-bryant.pdf](http://www.ama-assn.org/resources/doc/cpt/03-cms-physician-fee-schedule-bryant.pdf). The AMA also developed new CPT codes for complex chronic care coordination services (99487 and 99488), but CMS decided not to provide payment for these services in 2013.
While it is likely commercial payers will follow CMS’ lead by paying for TCM services, we do not know at this time whether those payers will require compliance with the specific CMS billing rules or instead use the elements identified by the AMA. Thus, the differences between the two are noted in the following Table 1.

<table>
<thead>
<tr>
<th>Table 1</th>
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<tbody>
<tr>
<td><strong>Who is eligible to receive TCM services?</strong></td>
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<td><strong>What is the time period for TCM services?</strong></td>
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<td><strong>Who is eligible to bill for TCM services?</strong></td>
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<td><strong>For what is the qualified professional responsible?</strong></td>
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<tr>
<td><strong>Must the beneficiary be an established patient of the qualified professional?</strong></td>
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</table>
| **What are the required elements for TCM services?** | 1. Communication with patient or caregiver within two business days of discharge (or two separate, unsuccessful attempts at communication) (see further explanation below).  
2. Face-to-face visit within 7 days (99496) or 14 days (99495) (see further explanation below).  
3. Medication reconciliation and management performed no later than date of face-to-face visit.  
4. Non-face-to-face management services (see further explanation below).  
5. Medical decision-making of moderate complexity (99495) or high complexity (99496 during the service period (see further explanation below). |
| What are the requirements for the initial communication? | 1. May be by direct contact, telephone, or electronic means.  
2. Must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care.  
3. May be performed by clinical staff under the general supervision of a qualified professional.  
4. Date of communication (or two failed attempts) must be documented. |
|---|---|
| What are the requirements for the face-to-face visit? | 1. Performed by the qualified professional under whose NPI claim is submitted (billing provider).  
2. Level/elements of visit not specified. Referred to as E&M service; thus should meet at least level 1 visit requirements.  
3. Cannot be furnished by the same qualified professional on the same day as the discharge management service. (The AMA description does not impose this limitation.)  
4. May be performed at any appropriate location.  
5. First E&M service performed by billing provider during 7- or 14-day period bundled into TCM payment; subsequent E&M services separately payable. |
| May the face-to-face visit be performed on the same day the patient is discharged? | Yes, the face-to-face visit may be performed any time after the patient is discharged, even before the patient physically leaves the facility. However, the qualified professional who bills a discharge day management code for a patient cannot rely on the professional’s interaction with the patient on the day of discharge to satisfy the face-to-face visit requirement to bill for TCM services; that professional would have to see the patient again within the 7- or 14-day period. |
| May the face-to-face visit be performed via telemedicine? | Yes, but only if the visit satisfies CMS requirements for billing telemedicine. Specifically, the patient must be present at an approved originating site (i.e., physician office, hospital, critical access hospital, rural health clinic, federally qualified health center, SNF, hospital-based dialysis center, or CMHC). The patient must be physically present at one of these sites, not at his or her home or other location. |
| What constitutes medical decision-making of moderate or high complexity? | Moderate complexity: multiple possible diagnoses and/or management of options; moderate complexity of medical data (e.g., tests) to be reviewed; and moderate risk of significant complications, morbidity, and/or mortality, as well as co-morbidities.  
High complexity: extensive number of possible diagnoses and/or management of options; extensive complexity of medical data (e.g., tests) to be reviewed; and high risk of significant complications, morbidity, and/or mortality, as well as co-morbidities. |

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9 Effective January 1, 2015, CMS has revised the “incident to” regulation to require general supervision (as opposed to direct supervision) for clinical staff providing non-face-to-face care management services. See 42 CFR § 410.26(b)(5).
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tr>
<td>When can claims for TCM services be submitted?</td>
<td>No sooner than 30 days following discharge.</td>
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<td>What are the documentation requirements for TCM services?</td>
<td>Documentation must include: (1) timing of initial post-discharge communication; (2) date of face-to-face visit; and (3) complexity of medical decision-making. CMS has not listed specific documentation requirements regarding: (1) content of face-to-face visit performed by qualified professional; or (2) non-face-to-face services furnished by the qualified professional or clinical staff.</td>
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<tr>
<td>Can multiple TCM claims be submitted for the same patient covering the same time period?</td>
<td>CMS will pay for only one TCM claim for the 30-day period following discharge. The first claim to be filed will be paid (similar to radiology interpretation and Annual Wellness Visit). CMS will not pay a second TCM claim in connection with a discharge that occurs within 30 days of the original discharge, i.e., if the patient is readmitted within the 30-day period.</td>
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</table>
| What are the limits on submitting claims for TCM services?              | A qualified professional billing for procedure with 10- or 90-day global billing period cannot bill for TCM services for the same time period. A qualified professional who bills for TCM services cannot bill for the following services during the 30-day period:  
  - Home healthcare oversight (G0181)  
  - Hospice care plan oversight (G0182)  
  - Care plan oversight services (99339, 99340, 99374-99380)  
  - Prolonged services without direct patient contact (99358, 99359)  
  - Anti-coagulant management (99363, 99364)  
  - Medical team conferences (99366-99368)  
  - Education and training (98960-98962, 99071, 99078)  
  - Telephone services (98966-98968,99441-99443)  
  - End-stage renal disease services (90951-90970)  
  - Online medical evaluation services (98969, 99444)  
  - Preparation of special reports (99080)  
  - Analysis of data (99090, 99091)  
  - Complex chronic care coordination services (99481X, 99483X)  
  - Medication therapy management services (99605-99607)  
  
  The fact that the aforementioned services are billed by one or more qualified professionals for a patient during the 30-day post-discharge period alone does not preclude another qualified professional from billing for TCM services, provided that qualified professional satisfies all requirements. No modifier is required. |
| What other payment policies apply to TCM services?                      | 1. TCM services do not qualify for the Primary Care Incentive Payment program.  
  2. Twenty percent beneficiary co-payment applies. Attention should be paid to demonstrating the value of TCM services to beneficiaries to improve collection rates. |
### What are the discharging provider’s responsibilities with regard to TCM services?

1. Inform patient that he/she should receive TCM services, and that Medicare will pay for it.
2. Ask patient to identify the qualified professional from whom patient wishes to receive TCM services. May suggest a specific qualified professional if patient does not identify.
3. Document above in discharge note and discharge instructions.

The discharging provider may also bill for TCM services. However, that provider cannot count services provided on the day of discharge to satisfy the face-to-face visit requirement.

### What non-face-to-face care management services are required?

**CMS expects** the following services to be routinely provided unless qualified professional’s reasonable assessment of the patient indicates a particular service is not medically indicated or needed:

**Performed by qualified professional:**

1. Obtain and review discharge information.
2. Review need for, or follow-up on, pending diagnostic tests and treatments; interact with other providers involved in patient’s care.
3. Educate patient, family, guardian, and/or caregiver.
4. Arrange for needed community resources.
5. Assist in scheduling any required follow-up with community providers and services.

**Performed by clinical staff/case manager under the general supervision of the qualified professional:**

1. Communicate with home health agencies and other community services utilized by patient.
2. Educate patient and/or family/caretaker regarding self-management, independent living, and activities of daily living.
3. Assess and support treatment regimen adherence and medication management.
4. Identify available community and health resources.
5. Facilitate access to necessary care and services.

### Strategies for Successful Transitional Care Management Programs

With some money on the table and rules in place, now is the time to develop and deploy a TCM program. There are several options for delivering these services:

- A physician practice may create a program to serve its patients only. However, only larger practices are likely to have sufficient patient volume to justify the necessary investment in staffing and technology.

- A physician practice may contract with other physician practices to provide TCM services for their patients. For example, a primary care practice may contract with surgical specialists to provide TCM services if the referring physician does not wish to provide the service.
• A hospital or SNF may contract with a physician or mid-level provider to furnish the required professional services and supervision (e.g., the face-to-face visit), with the hospital or facility providing the other services (e.g., medication reconciliation, patient education, follow-up calls). The physician or mid-level provider would reassign his or her right to bill for the service to the hospital.

• A hospital or SNF may develop a TCM program utilizing its currently employed or contracted physicians or mid-level providers. For example, hospitalists may have sufficient capacity to deliver the required professional services and supervision, with other hospital staff delivering the other components of TCM services.

• A physician practice may contract with a hospital, SNF, or other entity (e.g., a management services organization) for the support staff and technology needed to operate a TCM program. Under such an arrangement, the physician practice would bill for the TCM service and pay the hospital, SNF, or other entity fair market value for the support staff and other services. Such an arrangement would permit a smaller practice otherwise lacking necessary resources to provide TCM services.
**Chronic Care Management**

Research studies have demonstrated time and again that care management reduces total costs of care for chronic disease patients while improving their overall health. Despite these impressive results, patients receiving care management services remain the exception, not the rule.

Historically, payers have taken the position that payment for non-face-to-face care management services (e.g., medication reconciliation, coordination among providers, arrangements for social services, remote patient monitoring) is bundled into the payment for face-to-face evaluation and management (E&M) services. But these payments do not cover the significant staffing and technology investments required for chronic care management, and thus providers do not furnish these services.

As a result, chronic disease patients are too often left to manage for themselves between episodes of care. That pattern of sporadic care translates into higher complication rates which, in turn, means more suffering and costly care.

**New Medicare Payment for CCM**

Beginning January 1, 2015, Medicare now pays for chronic care management, or CCM. As detailed below, CCM payments will reimburse providers for furnishing specified non-face-to-face services to qualified beneficiaries over a calendar month.

Specifically, CMS has adopted CPT® 99490 for Medicare CCM services, which is defined in the CPT Professional Codebook as follows:

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.

CMS developed the requirements for providing and billing for CCM over a three-year period. To fully understand those requirements, one must review the three different proposed and three different final rules CMS published during that period. We have analyzed those rules carefully, and condensed them down to three core requirements a provider must meet to bill for CCM:

1. Secure the eligible beneficiary’s written consent.
2. Have five specified capabilities needed to perform CCM.
(3) Deliver 20+ minutes of non-face-to-face care management services for the eligible beneficiary per calendar month.

You will find a complete discussion of each core requirement in the table below (Table 2). The table also provides an explanation of potential revenue; addresses which providers can bill for CCM; outlines which Medicare beneficiaries are eligible for the service; and addresses submission of CCM claims.

Table 2

<table>
<thead>
<tr>
<th>Potential Revenue</th>
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<tr>
<td>What is the reimbursement for CCM?</td>
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<tr>
<td>Does CCM qualify as a preventive service exempt from beneficiary cost sharing?</td>
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</table>

What is the potential revenue associated with providing CCM? The following analysis assumes a family medicine physician with an average size patient panel, an average percentage of Medicare beneficiaries in that panel, and the average number of Medicare beneficiaries with two or more chronic conditions:

<table>
<thead>
<tr>
<th>Potential CCM Gross Annual Revenue</th>
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<tbody>
<tr>
<td>Description</td>
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<tr>
<td>Annual Number of Unique Patients¹</td>
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<tr>
<td>Percent of Patients Covered by Medicare¹</td>
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<tr>
<td>Annual Number of Unique Medicare Patients</td>
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<tr>
<td>Percent with 2+ Chronic Conditions²</td>
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<tr>
<td>Annual Number of Unique CCM Patients</td>
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<tr>
<td>CCM Monthly Payment²</td>
</tr>
<tr>
<td>Estimated Annual Gross Revenue for Family Medicine Physician</td>
</tr>
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</table>

¹ Per the MGMA Cost Survey for Single Specialty Practices: 2013 Report Based on 2012 Data specific to the specialty of family medicine. Includes Medicare A/B and Medicare Advantage.
² CMS.gov – County Level Multiple Chronic Conditions (MCC) Table: 2012 Prevalence, National Average
³ Reimbursement amount from the CY 2015 Physician Fee Service Final Rule; assumes 100% of unique patients are covered by Medicare A/B. Medicare Advantage reimbursement may vary.

Of course, the incremental economic benefit a provider may realize depends on costs incurred in providing the service. The following detailed discussion of CCM requirements should assist a provider in estimating those costs.
<table>
<thead>
<tr>
<th>Will Medicare Advantage (MA) plans reimburse for CCM? Commercial payers?</th>
<th>An MA plan must offer its enrollees at least traditional Medicare benefits, which now will include CCM. Presumably, an MA plan will pay for CCM in the same manner as it now pays for other physician services. Whether commercial payers will pay for CCM remains to be seen, although the fact CMS is paying for this service makes it more likely.</th>
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<tr>
<td>Are there any other financial benefits associated with developing a CCM program?</td>
<td>In addition to the potential for more than $200,000 in new incremental revenue per physician (or other qualified practitioner), CCM offers providers a bridge over the chasm between fee-for-service and value-based reimbursement. By developing and implementing a CCM program, a provider will grow skill sets and internal processes critical to population health management, all the while receiving fee-for-service payment to support those activities.</td>
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<tr>
<td><strong>Eligible Providers</strong></td>
<td><strong>Which practitioners are eligible to bill Medicare for CCM?</strong> Physicians (regardless of specialty), advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse midwives (or the provider to which such individual has reassigned his/her billing rights). Other non-physician practitioners and limited-license practitioners (e.g., clinical psychologists, social workers) are not eligible.</td>
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<td></td>
<td><strong>Can more than one provider bill for CCM for the same beneficiary?</strong> No. CMS will pay only one claim for CCM per beneficiary per calendar month. CMS has not stated how competing claims will be resolved, but presumably the provider with the most recent valid written consent will receive payment.</td>
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<td></td>
<td><strong>Must a practice be recognized as a patient-centered medical home (PCMH) to provide CCM?</strong> At one point, CMS proposed PCMH recognition as a condition to provide CCM, but the Final Rule does not include this requirement. That said, the transformation to PCMH should position a practice to successfully provide CCM. Also, many commercial payers offer financial incentives for PCMH-recognized practices. There are at least four accreditation organizations that have established specific standards and are offering formal recognition for PCMH practices: National Committee on Quality Assurance (NCQA), Accreditation Association for Ambulatory Health Care (AAHC), Joint Commission, and URAC (formerly known as the Utilization Review Accreditation Commission).</td>
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<td></td>
<td><strong>Are there services a provider must furnish to a beneficiary prior to billing for CCM for that beneficiary?</strong> While CMS strongly recommends that a provider furnish an annual wellness visit (HCPCS G0438, G0439) or an initial preventive physical exam (G0402) to the beneficiary, there are no prerequisite services required to bill for CCM.</td>
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<tr>
<td>Are there services for which a provider cannot bill during the same calendar month as CCM?</td>
<td>Yes, there are four: transitional care management (CPT 99495 and 99496), home healthcare supervision (HCPCS G0181), hospice care supervision (HCPCS G0182), and certain end-stage renal disease (ESRD) services (CPT 90951-90970). If the provider furnishing CCM performs any other services for the beneficiary (such as an office visit or immunization), the provider should bill for that service in addition to CCM. However, provider(s) not providing CCM to a beneficiary may provide and bill for the four services listed above.</td>
</tr>
<tr>
<td>Is CCM recognized as a rural health clinic (RHC) service and/or a federally qualified health center (FQHC) service?</td>
<td>For now, CMS has not recognized CCM as an RHC or FQHC service; thus, these providers will not be reimbursed at their all-inclusive rate for CCM services. An RHC or FQHC may have the opportunity to bill for CCM on the Medicare Physician Fee Schedule, provided it satisfies the applicable requirements to bill for non-RHC/non-FQHC services.</td>
</tr>
<tr>
<td>Can Medicare Shared Savings Program (MSSP) participants bill for CCM?</td>
<td>Participants in CMS’ Multi-Payer Advanced Primary Care Practice Demonstration and the Comprehensive Primary Care Initiative cannot bill CCM for those beneficiaries who have been attributed to them for purposes of these programs. Otherwise, participation in other CMS initiatives – including the MSSP – does not disqualify a practitioner from billing CCM for any beneficiary.</td>
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</table>

### Eligible Beneficiaries

| Who is an eligible beneficiary? | A beneficiary is eligible to receive CCM if he or she has been diagnosed with 2 or more chronic conditions expected to persist at least 12 months (or until death) that place the individual at significant risk of death, acute exacerbation/decomposition, or functional decline. CMS has not provided a definition or definitive list of “chronic conditions” for purposes of CCM. Nor has the agency offered guidance on how to determine or document the specified acuity level. However, CMS has stated it intends for CCM services to be broadly available. |
| Is there a list of chronic conditions on which a provider can rely? | CMS maintains a Chronic Condition Warehouse (CCW) to provide researchers with beneficiary, claims, and assessment data linked by beneficiary across the continuum of care. The CCW includes information on 22 specified chronic conditions. However, the CCW list is not an exclusive list of chronic conditions; CMS may recognize other conditions for purposes of providing CCM. |

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10 The CCW includes data on the following chronic conditions: Acquired Hypothyroidism; Acute Myocardial Infarction; Alzheimer’s Disease Related Disorders, or Senile Dementia; Anemia; Asthma; Atrial Fibrillation; Benign Prostatic Hyperplasia; Cancer (Colorectal, Endometrial, Breast, Lung, and Prostate); Cataract; Chronic Kidney Disease; Chronic Obstructive Pulmonary Disease; Depression; Diabetes; Glaucoma; Heart Failure; Hip/Pelvic Fracture; Hyperlipidemia; Hypertension; Ischemic Heart Disease; Osteoporosis; Rheumatoid Arthritis/ Osteoarthritis; and Stroke/Transient Ischemic Attack.
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<th>Requirement No. 1: Beneficiary’s Written Consent</th>
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<td><strong>What type of consent is required?</strong></td>
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<td><strong>When and how must the consent be obtained from the beneficiary?</strong></td>
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<tr>
<td><strong>What should a provider do with the consent form once it is signed?</strong></td>
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</table>

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<thead>
<tr>
<th>What happens if a beneficiary revokes his or her consent?</th>
<th>Once a beneficiary revokes his or her consent to receive CCM from a specific provider, that provider cannot bill for CCM after the then-current calendar month. The provider may bill for CCM for the month in which the revocation is made, if the provider has furnished 20+ minutes of non-face-to-face care management services for the beneficiary.</th>
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<tr>
<td>How does a beneficiary revoke consent?</td>
<td>CMS does not specify the manner in which a beneficiary must revoke consent. Presumably, if a beneficiary gives written consent to a second provider to furnish CCM, that will revoke the consent given to the first provider. However, this can create confusion (and billing issues) if the first provider is unaware of the consent given to the second provider.</td>
</tr>
<tr>
<td>Can a provider require a beneficiary to revoke consent in a certain manner?</td>
<td>In an effort to avoid confusion, a provider should specify on the CCM consent form the manner in which the beneficiary should revoke consent (e.g., in writing delivered to the provider). Such an attempt to limit the manner of revocation, however, may or may not be recognized by CMS; CMS may deny payment based on the beneficiary’s revocation in a manner other than specified on the provider’s consent form.</td>
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### Requirement No. 2: Five Specified Capabilities

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<tr>
<th>What are the five capabilities CMS requires a provider to have to bill for CCM?</th>
<th>The five capabilities include: (1) use a certified EHR for specified purposes; (2) maintain an electronic care plan; (3) ensure beneficiary access to care; (4) facilitate transitions of care; and (5) coordinate care. When a provider submits a claim for CCM, the provider is, in effect, attesting to the fact the provider has each of these capabilities for providing CCM. Each of these capabilities is discussed in the following sections.</th>
</tr>
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</table>
| For what purposes must a provider use a certified EHR in furnishing CCM (1st capability)? | A provider is not required to be a meaningful user of a certified EHR technology, but is required to use “CCM certified technology” (i.e., for 2015, an EHR that satisfies either the 2011 or 2014 edition of the certification criteria for the EHR Incentive Programs) to meet the following core technology capabilities:  
  - Structured recording of demographics, problems, medications, and medication allergies, all consistent with 45 CFR 170.314(a)(3)-(7)  
  - Creation of summary care record consistent with 45 CFR 170.314(e)(2)  
  The provider must be able to transmit the summary care record electronically for purposes of care coordination. CMS does not specify acceptable methods of transmission, but does state that facsimile transmission is not acceptable.  
  Additionally, a provider must use CCM certified technology to fulfill any CCM requirement that references a health or medical record. Specifically, the following must be documented in the beneficiary’s record using CCM certified technology:  
  - Beneficiary consent  
  - Provision of care plan to beneficiary  
  - Communication to and from home- and community-based providers regarding beneficiary’s psychosocial needs and functional deficits (care coordination) |
| What is the requirement for an electronic care plan (2nd capability)? | The provider must develop and regularly update (at least annually) an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment of the beneficiary's needs. The plan should include a list of current practitioners and suppliers that are regularly involved in providing medical care to the beneficiary, the assessment of the beneficiary’s functional status related to chronic health conditions, the assessment of whether the beneficiary suffers from any cognitive limitations or mental health conditions that could impair self-management, and an assessment of the beneficiary’s preventive healthcare needs. The plan should address all health issues (not just chronic conditions) and be congruent with the beneficiary’s choices and values. While required to bill for CCM, the preparation and updating of the care plan is not part of the reimbursable service. Instead, these activities may be billed separately as an evaluation and management service (e.g., an AWV, an IPPE, or regular office visit), provided the applicable requirements are satisfied. |
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| What items are typically included in a care plan? | CMS has identified the following items typically included in a care plan (although the agency does not specifically require a care plan to include each): • Problem list; expected outcome and prognosis; measurable treatment goals • Symptom management and planned interventions (including all recommended preventive care services) • Community/social services to be accessed • Plan for care coordination with other providers • Medication management (including list of current medications and allergies; reconciliation with review of adherence and potential interactions; oversight of patient self-management) • Responsible individual for each intervention • Requirements for periodic review/revision |
| Does the care plan have to be created, maintained, and updated using a certified EHR? | CMS requires a provider to “use some form of electronic technology tool or services in fulfilling the care plan element,” but acknowledges that “certified EHR technology is limited in its ability to support electronic care planning at this time.” Accordingly, providers “must have flexibility to use a wide range of tools and services beyond EHR technology now available in the market to support electronic care planning.” |
### Who must have access to electronic care plan?

CMS imposes three requirements with respect to electronic access to the beneficiary’s care plan:

1. The care plan must be electronically accessible on a 24/7 basis to all care team members furnishing CCM services billed by the provider.
   - *E.g.*, remote access to EHR, web-based access to care management application, web-based access to an electronic health information exchange (HIE) (facsimile is not sufficient).

2. The provider “must electronically share care plan information as appropriate with other providers” caring for the beneficiary.
   - *E.g.*, secure messaging, participation in HIE (facsimile not sufficient).

3. The provider must make available a paper or electronic copy to beneficiary.
   - Must be documented in CCM certified technology.

### What is required with respect to beneficiary access to care (3rd capability)?

A provider furnishing CCM must:

1. Provide a means for the beneficiary to access a member of the care team on a 24/7 basis to address acute/urgent needs in a timely manner (who constitutes a member of the care team is discussed below).

2. Ensure the beneficiary is able to get successive routine appointments with a designated practitioner or member of care team.

3. Provide enhanced opportunities for beneficiary-provider (or caregiver-provider) communication by telephone and asynchronous consultation methods (*e.g.*, secure messaging, internet), although the beneficiary is not required to use these methods.

### What is required with respect to transitions of care (4th capability)?

A provider must have the capability to do the following:

- Follow up with the beneficiary after an ER visit.

- Provide post-discharge transitional care management (TCM) services as necessary (although the provider cannot bill for TCM and CCM during the same month).

- Coordinate referrals to other clinicians.
  - Share information electronically with other clinicians as appropriate (see prior discussion of summary care record and electronic care plan).

### What is required with respect to coordination of care (5th capability)?

The provider must have the capability to coordinate with home- and community-based clinical service providers to meet beneficiary’s psychosocial needs and functional deficits (including providers of home health and hospice, outpatient therapies, durable medical equipment, transportation services, and nutrition services).

The provider’s communication with these service providers must be documented in CCM certified technology.
<table>
<thead>
<tr>
<th>Requirement No. 3: 20+ Minutes of Non-Face-to-Face Care Management Services</th>
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<tbody>
<tr>
<td><strong>What types of services constitute non-face-to-face care management services?</strong></td>
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<tr>
<td><strong>Who may perform non-face-to-face care management services?</strong></td>
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<tr>
<td><strong>What level of supervision is required for clinical staff providing non-face-to-face management services?</strong></td>
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<td><strong>What documentation is required?</strong></td>
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<tr>
<td><strong>What time counts toward the 20-minute minimum requirement?</strong></td>
<td>Time spent providing services on different days or by different clinical staff members in the same month may be aggregated to total 20 minutes. However, if two staff members are furnishing services at the same time, only the time spent by one individual may be counted. Time of less than 20 minutes during a calendar month cannot be rounded up to meet this requirement; nor may time be carried over from a prior month.</td>
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<tr>
<td><strong>Can a physician practicing in a hospital outpatient department count the time spent by licensed clinical staff furnishing non-face-to-face care management services toward the 20-minute requirement?</strong></td>
<td>CMS does not expect a physician to furnish all non-face-to-face care management services; instead, the rules provide that licensed clinical staff may provide these services incident to the physician services. CMS recognized the direct supervision requirement of the “incident to” rules (i.e., physician present in the same suite of offices immediately available to provide assistance) was not practical for CCM, and thus revised the regulations to provide for general supervision (i.e., available for telephonic consultation) for CCM (as well as transitional care management). Herein lies the problem: the “incident to” rules apply in the office setting only; “incident to” billing is not permitted in the hospital inpatient or outpatient setting. If, for billing purposes, a hospital treats its employed physician practices as hospital outpatient departments, the question arises whether any time spent by licensed clinical staff can be counted toward the 20-minute requirement. As of now, CMS is aware of this issue, but has not furnished a definitive answer. Assuming CMS permits licensed clinical staff time to be counted, there remains the question whether the hospital can charge a separate facility fee for CCM. Again, CMS has not addressed this matter directly. However, given that the Medicare Physician Fee Schedule lists separate facility and non-facility rates for CCM (with the facility rate being about $9.00 less), it appears a separate hospital charge would be appropriate.</td>
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<td><strong>Are there circumstances in which time spent providing non-face-to-face care management services cannot be counted toward the 20-minute requirement?</strong></td>
<td>CMS stated in the rulemaking process that time spent while the patient is in an inpatient setting cannot be counted. In its general discussion of care management services, the CPT Manual states non-face-to-face care management services furnished the same day as an E/M visit cannot be counted. CMS has not specifically recognized this rule, although the CPT Manual generally is considered authoritative unless contradicted by CMS. Thus, unless the same-day non-face-to-face service is wholly unrelated to the E/M visit, it should not be counted.</td>
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<tr>
<td><strong>Can remote monitoring be included in the 20 minutes?</strong></td>
<td>According to CMS, “[p]ractitioners who engage in remote monitoring of patient physiological data of eligible beneficiaries may count the time they spend reviewing the reported data toward the monthly minimum time for billing the CCM code, but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device.”13</td>
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### Billing for CCM

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<td>When filing a claim for CCM, what should be listed as the date of service? As the site of service? As the relevant diagnosis?</td>
<td>CMS has stated that there are no claims edits in place for date of service, site of service, or diagnosis codes, and thus CCM claims will not be denied based on the information listed for these items. As a practical matter, we recommend the date of service be the date on which the 20-minute requirement is satisfied, the site of service be listed as the practitioner’s primary practice location, and that at least two of the beneficiary’s chronic conditions be listed as the diagnosis codes.</td>
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<tr>
<td>When should a claim for CCM be submitted?</td>
<td>Again, CMS has not provided guidance on this point, but we believe it is appropriate to submit the claim any time after the 20-minute requirement has been satisfied for that calendar month.</td>
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### Conclusion

As a result of new payment and delivery system models – everything from shared savings to bundled payments and beyond – today’s investments in care management will yield the greatest dividends over the next several years.

In addition to focusing attention on high-cost patients and conditions, a care management program offers an excellent training ground for provider integration. Working together to coordinate post-discharge patient care teaches the value of teamwork between primary care and specialist physicians and hospital staff.

Now, with Medicare reimbursement for transitional and chronic care management services, there is even more reason for providers to move forward with formal care management programs.