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From international law firm Arnold & Porter LLP comes a timely column that provides views on current regulatory and legislative topics that weigh on the minds of today's physicians and health care executives.

New year, new code: How to get paid for chronic care management in 2015, part 1

--By Catherine Brandon and Paul Rudolf, Arnold & Porter LLP

Beginning in 2015, physicians and other qualified health care professionals will be able to separately bill Medicare for providing non-face-to-face chronic care management services by billing CPT code 99490.

Chronic care management (CCM) includes the development and/or revision of a patient-centered plan of care, coordination with other treating health care professionals and medication management. As detailed below, CCM payments will potentially be available to eligible providers for furnishing at least 20 minutes of non-face-to-face services to qualified beneficiaries during a calendar month.

Which beneficiaries may receive CCM services?

Medicare beneficiaries are eligible to receive this service if they have two or more chronic conditions that are expected to last at least 12 months, or until the death of the patient. There is no specific list of qualifying chronic conditions, but these chronic conditions must place the patient at significant risk of death, acute exacerbation/decompensation or functional decline. A recent *New England Journal of Medicine* article estimated that two-thirds of Medicare beneficiaries may be eligible to receive these services.

Who may provide CCM?

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) are eligible to bill Medicare for CCM services. Only one provider may bill for CCM for a particular beneficiary per month.

CCM services are provided by clinical staff, incident to the services of a physician or mid-level practitioner, under general supervision (ie, the physician or other practitioner does not need to be onsite and can be available by phone to provide assistance, if required). The clinical staff members performing CCM services do not need to be employees of the physician practice. Clinical staff time spent as part of another service (eg, post-evaluation and management visit) does not count toward the 20 minutes required to bill the code. Further, a provider may not count time spent by multiple staff during the same meeting (eg, if three staff members meet for 10 minutes to discuss a beneficiary's chronic care management, only 10 minutes may be counted toward billing the code).

What is the scope of services encompassed by the code?

To bill the new CCM code, a practice must provide the following scope of services:

- 24/7 patient access to the practice to address the patient's acute chronic care needs.
- Continuity of care must be provided through a designated member of the care team.
- Care management for chronic conditions, including systematic assessment of the patient's medical, functional and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
- Creation and provision to the patient of a comprehensive patient-centered care plan document that is based on physical, mental, cognitive, psychosocial, functional and environmental assessments and is consistent with the patient's choice and values.
- Management of care transitions within the health care system (eg, emergency department, hospital, skilled nursing facilities, etc.) and coordination with home- and community-based clinical service providers.
- Enhanced opportunities for the patient or caregivers to communication with the provider through various non-face-to-face means, such as telephone and email.

What are the additional requirements?

Prior to billing for these services, practices must obtain the patient's written consent and document in the patient medical record that the provider informed him that (1) CCM services are available (and described those services); (2) only one provider per month may be paid for furnishing CCM for the beneficiary; (3) the beneficiary's health information will be shared with other providers for care coordination purposes; (4) the beneficiary may stop CCM at any time by revoking consent, effective at end of then-current calendar month; and (5) the beneficiary will be responsible for any associated copayment or deductible.

The practice must also have certain electronic health record and IT capabilities, which are described more fully in part two of this article series.

There are no prerequisite services required to bill for CCM. However, there are a number of services that a provider may not bill during the same calendar month for the same beneficiary. Care management services include care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), anticoagulant management (99363, 99364), medical team conferences (99366, 99367, 99368), education and training (98960, 98961, 98962, 99071, 99078), telephone services (99366, 99367, 99368, 99441, 99442, 99443), online medical evaluation (98969, 99444), preparation of special reports (99080), analysis of data (99090, 99091), transitional care management services (99495, 99496), medication therapy management services (99605, 99606, 99607), transitional care management (99495, 99496), home health care oversight (G0181), and hospice care oversight (G0182). If performed, these services may not be reported separately during the month. Additionally, 99490 may not be reported when providing end-stage renal disease services (90951-90970), or by a provider during the postoperative period of a reported surgery.

What does Medicare pay for CCM?

The national Medicare payment is $42.60 per month per beneficiary. Beneficiaries will be responsible for a 20% copayment ($8.52).

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