MPC, Inc.

Summer 2015

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MEDICAL PRACTICE CONSULTANTS, INC.

Chronic Care Management Services

Beginning January 1, 2015, Medicare pays separately under the Medicare Physician Fee Schedule (PFS) under American Medical Association Current Procedural Terminology (CPT) code 99490, for non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions. CPT 99490 is defined as follows: 99490 - 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.

Examples of chronic conditions include, but are not limited to, the following: Alzheimer's disease and related dementia; Arthritis (osteoarthritis and rheumatoid); Asthma; Atrial fibrillation; Autism spectrum disorders; Cancer; Chronic Obstructive Pulmonary Disease; Depression; Diabetes; Heart failure; Hypertension; Ischemic heart disease; and Osteoporosis.

Practitioner Eligibility- Physicians and the following non-physician practitioners may bill the new CCM service: Certified Nurse Midwives; Clinical Nurse Specialists; Nurse Practitioners; and Physician Assistants.

NOTE: Eligible practitioners must act within their State licensure, scope of practice, and Medicare statutory benefit. The CCM service may be billed most frequently by primary care physicians, although specialty physicians who meet all of the billing requirements may bill the service. The CCM service is not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, therefore these practitioners cannot furnish or bill the service. However, CMS expects referral to or consultation with such physicians and practitioners by the billing practitioner to coordinate and manage care.

Services provided directly by an appropriate physician or non-physician practitioner, or by clinical staff incident to the billing physician or non-physician practitioner, count toward the minimum amount of service time required to bill the CCM service (20 minutes per calendar month).

Non-clinical staff time cannot be counted. Consult the CPT definition of "clinical staff" and the Medicare PFS "incident to" rules to determine whether time by specific individuals may be counted towards the minimum time requirement. Practitioners may use individuals outside the practice to provide CCM services, subject to the Medicare PFS "incident to" rules and regulations and all other applicable Medicare rules.

Supervision- CMS provided an exception under Medicare's "incident to" rules that permits clinical staff to provide the CCM service incident to the services of the billing physician (or other appropriate practitioner) under the general supervision (rather than direct supervision) of a physician (or other appropriate practitioner).

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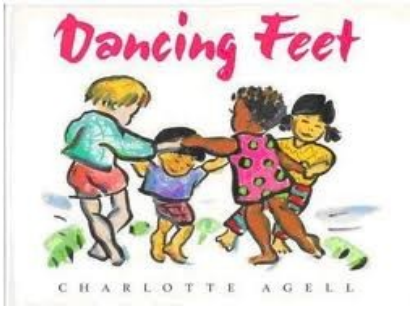

"Sun is shining, weather is sweet, make you wanna move your dancing feet"

—Bob Marley

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Patient Agreement Requirements- A practitioner must inform eligible patients of the availability of and obtain consent for the CCM service before furnishing or billing the service. Some of the patient agreement provisions require the use of certified Electronic Health Record (EHR) technology.

Patient consent requirements include: Inform the patient of the availability of the CCM service and obtain written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers. Explain and offer the CCM service to the patient. In the patient's medical record, document this discussion and note the patient's decision to accept or decline the service. Explain how to revoke the service. Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.

This agreement process should include a discussion with the patient, and caregiver when applicable, about: What the CCM service is; How to access the elements of the service; How the patient's information will be shared among practitioners and providers; How cost-sharing (co-insurance and deductibles) applies to these services; and How to revoke the service.

Informed patient consent need only be obtained once prior to furnishing the CCM service, or if the patient chooses to change the practitioner who will furnish and bill the service.

CCM Scope of Service Elements - Highlights- The CCM service is extensive, including structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. Some of the CCM Scope of Service elements require the use of a certified EHR or other electronic technology. For a complete listing of the CCM Scope of Service elements and electronic technology requirements that must be met in order to bill the service.

Structured Data Recording- Record the patient's demographics, problems, medications, and medication allergies and create structured clinical summary records using certified EHR technology.

Care Plan- Create a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues). Provide the patient with a written or electronic copy of the care plan and document its provision in the medical record. Ensure the care plan is available electronically at all times to anyone within the practice providing the CCM service. Share the care plan electronically outside the practice as appropriate.

Comprehensive Care Plan- A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements: Problem list; Expected outcome and prognosis; Measurable treatment goals; Symptom management; Planned interventions and identification of the individuals responsible for each intervention; Medication management; Community/social services ordered; A description of how services of agencies and specialists outside the practice will be directed/coordinated; and Schedule for periodic review and, when applicable, revision of the care plan.

Access to Care- Ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services, providing the patient with a means to make timely contact with health care practitioners in the practice who have access to the patient's health record to address his or her urgent chronic care needs.

Ensure continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.

Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care. Do this through telephone, secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods, in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Manage Care- Care management services such as: 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.

Manage care transitions between and among health care providers and settings, including referrals to other providers, including: Providing follow-up after an emergency department visit, and after discharges from hospitals, skilled nursing facilities, or other health care facilities.

Coordinate care with home and community based clinical service providers.

EHR and Other Electronic Technology Requirements- CMS requires the use of certified EHR technology to satisfy some of the CCM scope of service elements. In furnishing these aspects of the CCM service, CMS requires the use of a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year.