K. Care Management Services

1. Background

In recent years, we have updated PFS payment policies to improve payment for care management and care coordination. Working with the CPT Editorial Panel and other clinicians, we have expanded the suite of codes describing these services. New CPT codes were created that distinguish between services that are face-to-face; represent a single encounter, monthly service or both; are timed services; represent primary care versus specialty care; address specific conditions; and represent the work of the billing practitioner, their clinical staff, or both (*see* Table 19). Additional information regarding recent new codes and associated PFS payment rules is available on our website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html.

TABLE 19: Summary of Special Care Management Codes

Service	Summary
Care Plan Oversight (CPO) (also referred to as Home Health Supervision, Hospice Supervision) (HCPCS Codes G0181, G0182)	Supervision of home health, hospice, per month
ESRD Monthly Services (CPT Codes 90951-70)	ESRD management, with and without face-to-face visits, by age, per month
Transitional Care Management (TCM) (adopted in 2013) (CPT Codes 99495, 99496)	Management of transition from acute care or certain outpatient stays to a community setting, with face-to-face visit, once per patient within 30 days post-discharge
Chronic Care Management (CCM) (adopted in 2015, 2017, 2019) (CPT Codes 99487, 99489, 99490, 99491)	Management of all care for patients with two or more serious chronic conditions, timed, per month
Advance Care Planning (ACP) (adopted in 2016) (CPT Codes 99497, 99498)	Counseling/discussing advance directives, face-to-face, timed
Behavioral Health Integration (BHI) (adopted in 2017) (CPT Codes 99484, 99492, 99493, 99494)	Management of behavioral health conditions(s), timed, per month
Assessment/Care Planning for Cognitive Impairment (adopted in 2017) (CPT Code 99483)	Assessment and care planning of cognitive impairment, face-to-face visit
Prolonged Evaluation & Management (E/M) Without Direct Patient Contact (adopted in 2017) (CPT Codes 99358, 99359)	Non-face-to-face E/M work related to a face-to-face visit, timed
Remote Physiologic Monitoring (adopted beginning 2018 with CPT Code 99091; in 2019, added CPT codes 99453, 99454, 99457; for CY 2020, will add CPT code 99458)	Analysis of patient data used to develop and manage a treatment plan
Interprofessional Consultation (adopted in 2019) (CPT Codes 99446, 99447, 99448, 99449, 99451, 99452)	Inter-practitioner consultation

Based on our review of the Medicare claims data we estimate that approximately 3 million unique beneficiaries (9 percent of the Medicare fee-for-service (FFS) population) receive these services annually, with higher use of chronic care management (CCM), transitional care management (TCM), and advance care planning (ACP) services. We believe gaps remain in coding and payment, such as for care management of patients having a single, serious, or complex chronic condition. In this final rule, we continue our ongoing work in this area through code set refinement related to TCM services and CCM services, in addition to new coding for principal care management (PCM) services, and addressing chronic care remote physiologic monitoring (RPM) services.

2. Transitional Care Management (TCM) Services

Utilization of TCM services has increased each year since CMS established coding and began paying separately for TCM services. There were almost 300,000 TCM professional claims during 2013, the first year of TCM services, and almost 1.3 million professional claims during 2018, the most recent year of complete claims data. However, a recent analysis of TCM claims data by Bindman and Cox[81] found that use of TCM services is low when compared to the number of Medicare beneficiaries with eligible discharges. Bindman and Cox noted that the beneficiaries who received TCM services demonstrated reduced readmission rates, lower mortality, and decreased health care costs. Based upon these findings, we believe that increasing utilization of medically necessary TCM services could positively affect patient outcomes.

In developing the proposal designed to increase utilization of TCM services, we considered factors that could contribute to low utilization. Bindman and Cox identified two likely contributing factors: the administrative burdens associated with billing TCM services and the payment amount to physicians for furnishing these services.

We focused initially on the requirements for billing TCM services. In reviewing TCM billing requirements, we noted that we had established in the CY 2013 PFS final rule with comment period a list of 57 HCPCS codes that could not be billed during the 30-day period covered by TCM services by the same practitioner reporting TCM (77 FR 68990). This list mirrored reporting restrictions put in place by the CPT Editorial Panel for the TCM codes. At the time we established separate payment for the TCM CPT codes, we agreed with the CPT Editorial Panel that the services described by the 57 codes could be overlapping and duplicative with TCM in their definition and scope. Additionally, many of the codes were not separately

[81] Bindman, AB, Cox DF. Changes in health care costs and mortality associated with transitional care management services after a discharge among Medicare beneficiaries [published online July 30, 2018]. *JAMA Intern Med*, doi:10.1001/jamainternmed.2018.2572.

payable or covered under the PFS so even if they had been reported for PFS payment, they would not have been paid separately (*see,* for example, 77 FR 68985).

In response to those initial concerns, we adopted billing restrictions to avoid duplicative billing and payment for covered services. In our recent analysis of the services associated with the 57 codes, we found that the majority of codes on the list are either bundled, noncovered by Medicare, or invalid for Medicare payment purposes. Table 20 provides detailed information regarding the subset of these codes that would be separately payable under the PFS (Status Indicator "A") and, as such, are the focus of CY 2020 policy for TCM. Fourteen (14) codes on the list represent active codes that are paid separately under the PFS and that upon reconsideration, we believe do not substantially overlap with TCM services and should be separately payable alongside medically necessary TCM. For example, CPT code 99358 (*Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service*) would allow the physician or other qualified healthcare professional extra time to review records and manage patient support services after the face-to-face visit required as part of TCM services.

After review of the services described by the 14 HCPCS codes, we determined that the 14 codes, when medically necessary, may complement TCM services rather than substantially overlap or duplicate services. We also believed removing the billing restrictions associated with the 14 codes might increase use of TCM services.

TABLE 20: 14 HCPCS Codes that Currently Cannot be Billed Concurrently with TCM by the Same Practitioner and are Active Codes Payable by Medicare PFS

Code Family	HCPCS Code	Descriptor
Prolonged Services without Direct Patient Contact	99358	Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service
	99359	Prolonged E/M service before and/or after direct patient care; each additional 30 minutes beyond the first hour of prolonged services
Home and Outpatient International Normalized Ratio (INR) Monitoring Services	93792	Patient/caregiver training for initiation of home INR monitoring
	93793	Anticoagulant management for a patient taking warfarin; includes review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment and scheduling of additional test(s)
End Stage Renal Disease Services (patients who are 20+ years)	90960	ESRD related services monthly with 4 or more face-to-face visits per month; for patients 20 years and older
	90961	ESRD related services monthly with 2-3 face-to-face visits per month; for patients 20 years and older
	90962	ESRD related services with 1 face-to-face visit per month; for patients 20 years and older
	90966	ESRD related services for home dialysis per full month; for patients 20 years and older
	90970	ESRD related services for dialysis less than a full month of service; per day; for patient 20 years and older
*Analysis of Data	99091	Collection and interpretation of physiologic data
Complex Chronic Care Management Services	99487	Complex Chronic Care with 60 minutes of clinical staff time per calendar month
	99489	Complex Chronic Care; additional 30 minutes of clinical staff time per month
Care Plan Oversight Services	G0181	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities within a calendar month; 30+ minutes
	G0182	Physician supervision of a patient receiving Medicare-covered hospice services (Pt not present) requiring complex and multidisciplinary care modalities; within a calendar month; 30+ minutes

* In CY 2018, this code was unbundled and added as an active code to the PFS. The 2019 CPT Manual (p. 42) indicates the code cannot be billed concurrently with either TCM code.

Thus, with the goal of increasing medically appropriate use of TCM services, we proposed to revise our billing requirements for TCM by allowing TCM codes to be billed concurrently with any of these 14 codes. In the proposed rule, we solicited comment on four questions related to current billing policies. They included:

- Does overlap of services exist, and if so, which services should be restricted from being billed concurrently with TCM?

- Does overlap depend upon whether the same or a different practitioner reports the services; we note that CPT reporting rules generally apply at the practitioner level?
- Should our policy differ based upon whether the same or different practitioner reports the services?
- Does the newest CPT code in the chronic care management services family (CPT code 99491 for CCM by a physician or other qualified health professional, established in 2019) overlap with TCM or should it be reportable and separately payable in the same service period?

The second part of our analysis examined how current payment rates for TCM might negatively affect the appropriate utilization of TCM services, an idea proposed by Bindman and Cox. Although we sought comment previously about factors affecting utilization of CCM and TCM services, we received too few comments related specifically to TCM to know if payment affected use of the service.

As part of a regular RUC review of new technologies or services during 2018, CPT code 99495 (*Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit within 14 calendar days of discharge*) and CPT code 99496 (*Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least high complexity during the service period; face-to-face visit within 7 calendar days of discharge*) were resurveyed. For this RUC resurvey, several years of claims data were available and clinicians had more experience to inform their views about the work required to furnish TCM services. Based upon the results of the 2018

RUC survey of the TCM codes, the RUC recommended a slight increase in work RVUs for both codes. We believe the results from the new survey better reflect the work involved in furnishing TCM services as care management services. Thus, also for CY 2020, we proposed the RUC-recommended work RVU of 2.36 for CPT code 99495 and the RUC-recommended work RVU of 3.10 for CPT code 99496. We did not propose any PE refinements to the TCM codes.

We received public comments to our proposed policies and questions. The following is a summary of the comments we received.

Comment: With regard to the questions about billing requirements, most commenters wrote in support of our proposal to remove billing restrictions associated with the 14 codes that, at present, cannot be billed concurrently with TCM. A few commenters indicated that overlap, if it does exist, is minimal. Some commenters cautioned that our suggested change to billing might cause increased confusion for payers other than Medicare and suggested that CMS instead work with the CPT Editorial Panel to review and possibly revise the restrictions. In response to our questions about overlap in services, commenters reported that overlap is not dependent upon whether the same or a different practitioner reports the services. Commenters added that policy should not be based upon what practitioner reports the services. Finally, commenters expressed support for allowing CPT code 99491 *(Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of professional time per calendar month)* to be reportable and separately payable in the same service period as TCM.

Response: We thank the many commenters for their comments regarding ways to increase utilization of TCM services. Our goal in proposing to remove the current billing restrictions was to increase appropriate utilization of TCM services, particularly in light of the

potential benefits noted by Bindman and Cox. Since publication of the CY 2020 PFS proposed rule, we have identified two chronic care management codes, CPT codes 99490 and 99491 that are not listed in the TCM section of the CPT manual as being restricted from concurrent billing. However, in the care management section of the 2019 CPT Manual, prefatory language indicates that neither CPT code 99495 nor 99496 (*see*, page 50) can be billed during the same month as CPT code 99490. Given our proposal to remove current billing restrictions, we believe that both CPT codes 99490 and the new 99491 should be added to the list of care management codes that can be billed concurrently with TCM when relevant and medically necessary.

We continue to believe that revising the billing requirements and allowing TCM codes to be billed concurrently with codes currently restricted will help to achieve our goal and may result in other payers implementing similar changes. Additionally, this change may lead the CPT Editorial Panel to consider revising the current prohibitions on billing TCM with certain codes.

Comment: Commenters uniformly recommended that CMS finalize the increased valuations for the two TCM codes. Commenters expressed support for the agency's goal of increasing utilization of medically necessary TCM services given the potential benefits the services provide to patients as noted by Bindman and Cox.

Response: We believe that adopting the RUC-recommended increase in valuation of the work RVUs will support our goal of increasing medically necessary TCM services.

After considering public comments on our questions and proposals, and in light of our goal of increasing utilization of TCM services, we are finalizing our proposal to allow concurrent billing of the care management codes currently restricted from being billed with TCM. This includes allowing concurrent billing of TCM with the 14 codes specified in Table 20, as well as CPT codes 99490 and 99491, which we have identified as codes that also fit this policy. We are

finalizing for both TCM codes the proposed increases in work RVUs and the RUC-recommended direct PE inputs. We look forward to working with the public and other stakeholders to potentially further refine our billing policies through future notice and comment rulemaking.

3. Chronic Care Management (CCM) Services

CCM services are comprehensive care coordination services per calendar month, furnished by a physician or nonphysician practitioner (NPP) managing overall care and their clinical staff, for patients with two or more serious chronic conditions. There are currently two general subsets of codes: one for non-complex chronic care management (starting in 2015, with a new code for 2019) and a set of codes for complex chronic care management (starting in 2017). Tables 21 and 22 list the applicable current codes (abbreviated) and provide a high-level summary of the CCM service elements. We refer readers to the following website for more comprehensive information regarding the CCM codes and the existing requirements for billing them to the PFS, available on our website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management.html.

TABLE 21: Chronic Care Management Codes (CY 2019)

CPT Code	Summary
99490 ("Non-Complex CCM")	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional (QHP), per calendar month
99491 ("Non-Complex CCM")	Chronic care management services, provided personally by a physician or other QHP, at least 30 minutes of physician or other QHP time, per calendar month
99487 ("Complex CCM")	Complex chronic care management services, first 60 minutes of clinical staff time with moderate or high complexity medical decision making by the reporting practitioner
99489 ("Complex CCM")	Complex chronic care management services, each additional 30 minutes of clinical staff time with moderate or high complexity medical decision making by the reporting practitioner

TABLE 22: Chronic Care Management Services Summary

CCM Service Summary*
Verbal Consent • Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance). • Document that consent was obtained.
Initiating Visit for New Patients (separately paid)
Certified Electronic Health Record (EHR) Use • Structured Recording of Core Patient Information Using Certified EHR (demographics, problem list, medications, allergies).
24/7 Access ("On Call" Service)
Designated Care Team Member
Comprehensive Care Management • Systematic needs assessment (medical and psychosocial). • Ensure receipt of preventive services. • Medication reconciliation, management and oversight of self-management.
Comprehensive Electronic Care Plan • Plan is available timely within and outside the practice (can include fax). • Copy of care plan to patient/caregiver (format not prescribed). • Establish, implement, revise or monitor the plan.
Management of Care Transitions/Referrals (e.g., discharges, ED visit follow up, referrals). • Create/exchange continuity of care document(s) timely (format not prescribed).
Home- and Community-Based Care Coordination • Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits.
Enhanced Communication Opportunities • Offer asynchronous non-face-to-face methods other than telephone, such as secure email.

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of CCM.

Early data show that, in general, CCM services are increasing patient and practitioner satisfaction, saving costs and enabling solo practitioners to remain in independent practice.[82] Utilization has reached approximately 75 percent of the level we initially assumed under the PFS when we began paying for CCM services separately under the PFS. While these are positive results, we believe that CCM services (especially complex CCM services) continue to be underutilized. In addition, we note that, at the February 2019 CPT Editorial Panel meeting, certain specialty associations requested refinements to the existing CCM codes, and consideration of their proposal was postponed. Also, we have heard from some stakeholders

[82] https://innovation.cms.gov/Files/reports/chronic-care-mngmt-finalevalrpt.pdf.

suggesting that the time increments for non-complex CCM performed by clinical staff should be changed to recognize finer increments of time, and that certain requirements related to care planning are unclear. Based on our consideration of this ongoing feedback, we believe some of the refinements requested by specialty associations and other stakeholders may be necessary to improve payment accuracy, reduce unnecessary burden and help ensure that beneficiaries who need CCM services have access to them. Accordingly, we proposed the following changes to the CCM code set for CY 2020.

a. Non-Complex CCM Services by Clinical Staff (CPT code 99490, HCPCS codes GCCC1 and GCCC2)

Currently, the clinical staff CPT code for non-complex CCM, CPT code 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.)* describes 20 or more minutes of clinical staff time spent performing chronic care management activities under the direction of a physician/qualified health care professional (QHP). When we initially adopted this code for payment and, in feedback we have since received, a number of stakeholders suggested that CMS undervalued the PE RVU because we assumed that the minimum time for the code (20 minutes of clinical staff time) would be typical (see, for example, 79 FR 67717 through 67718). In the CY 2017 PFS final rule with comment period, we continued to consider whether the payment amount for CPT code 99490 is appropriate, given the amount of time typically spent furnishing CCM services (81

FR 80243 through 80244). We adopted the complex CCM codes for payment beginning in CY 2017, in part, to pay more appropriately for services furnished to beneficiaries requiring longer service times (see below). Some stakeholders continue to recommend that we should create an add-on code for non-complex CCM performed by clinical staff, such that these services would be defined and valued in 20-minute increments of time with additional payment for each additional 20 minutes of clinical staff time spent performing care management activities.

We agreed that coding changes that identify additional time increments may improve payment accuracy for non-complex CCM. Accordingly, we proposed to adopt two new G codes with new increments of clinical staff time instead of the existing single CPT code (CPT code 99490). The first G code would have described the initial 20 minutes of clinical staff time, and the second G code would have described each additional 20 minutes thereafter. We intended these would be temporary G codes, to be used for PFS payment instead of CPT code 99490 until the CPT Editorial Panel can consider revisions to the current CPT code set. We said we would consider adopting any CPT code(s) once the CPT Editorial Panel completes its work. We acknowledged that imposing a transitional period during which G codes would be used under the PFS in lieu of the CPT codes is potentially disruptive, and solicited comment on whether the benefit of proceeding with the proposed G codes outweighs the burden of transitioning to their use in the intervening year(s) before a decision by the CPT Editorial Panel.

We proposed that the base code would be HCPCS code GCCC1 *(Chronic care management services, initial 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; and comprehensive care plan established, implemented, revised, or monitored. (Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately)). We proposed a work RVU of 0.61 for HCPCS code GCCC1, which we crosswalked from CPT code 99490. We believed these codes would have a similar amount of work since they would have the same intra-service time of 15 minutes.

We proposed an add-on HCPCS code GCCC2 *(Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). (Use GCCC2 in conjunction with GCCC1). (Do not report GCCC1, GCCC2 in the same calendar month as GCCC3, GCCC4, 99491))*. We proposed a work RVU of 0.54 for HCPCS code GCCC2 based on a crosswalk to CPT code 11107 (*Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); each separate/additional lesion (List separately in addition to code for primary procedure)*), which has a work RVU of 0.54, which we believed would accurately reflect the work associated with each additional 20 minutes of CCM services. Both codes would have the same intraservice time of 15 minutes. We noted that the nature of the PFS relative value system is such that all services are appropriately subject to comparisons to one another. Although codes that describe clinically similar services are sometimes stronger comparator codes, codes need not share the same site of service, patient population, or utilization level to serve as an appropriate crosswalk. In this case, we believed CPT code 11107 shared a similar work intensity to proposed HCPCS code GCCC2. Furthermore, although HCPCS codes GCCC1 and GCCC2 would share the same intraservice time, add-on codes may have lower

intensity than the base codes because they describe the continuation of an already initiated service.

We solicited public comment on whether we should limit the number of times HCPCS code GCCC2 could be reported in a given service period for a given beneficiary. It was not clear how often more than 40 minutes of clinical staff time is currently spent or is medically necessary. In addition, once 60 minutes of clinical staff time is spent, many or most patients might also require complex medical decision-making, and such patients would already be described under existing coding for complex CCM. We believed a limit (such as allowing the add-on code to be reported only once per service period per beneficiary) may be appropriate in order to maintain distinctions between complex and non-complex CCM, as well as appropriately limit beneficiary cost sharing and program spending to medically necessary services. We noted that complex CCM already describes (in part) 60 or more minutes of clinical staff time in a service period. We solicited comment on whether and how often beneficiaries who do not require complex CCM (for example, do not require the complex medical decision making that is part of complex CCM) would need 60 or more minutes of non-complex CCM clinical staff time and thereby warrant more than one use of HCPCS code GCCC2 within a service period.

Comment: Several commenters supported the proposed add-on HCPCS code GCCC2, and recommended that there be a limit on its use (frequency) to keep non-complex CCM distinct from complex CCM. These commenters stated that patients requiring multiple uses of the add-on service likely require the moderate to high medical decision making of complex CCM. Other commenters stated that, while they have patients who do not require the complex medical decision making that is part of complex CCM, care management for these patients is time-consuming and would require 60 or more minutes of non-complex CCM clinical staff time

within a service period. These commenters suggested that limiting the frequency of reporting HCPCS code GCCC2 to twice during a service period allows for accurate payments, while preventing inappropriate use of the code. The Medicare Payment Advisory Commission (MedPAC) expressed support for the proposed add-on code for non-complex CCM because it would better reflect the resources involved in furnishing care management services and increase payment accuracy for CCM. Other commenters stated that G codes would help to facilitate earlier implementation and would ease transition to any updates made to CPT codes.

However, a number of commenters were not supportive of the introduction of temporary G codes within the CCM code set, believing it would produce administrative burden and cause confusion. These commenters stated that in September 2019 the CPT Editorial Panel was considering an application for similar changes to refine the code set. These commenters urged us to work with the CPT Editorial Panel regarding changes to the CCM code set and its revaluation. A few commenters suggested that CMS could achieve its burden reduction goals by continuing to recognize CPT codes 99490, 99487, and 99489 and also provide CMS-specific guidance for those codes for purposes of billing Medicare.

Response: We are not finalizing our proposal to create HCPCS codes GCCC1 (or GCCC3 or GCCC4, see below) in consideration of commenters' concerns that the introduction of temporary G codes replacing most of the CCM code set would create administrative burden, especially in light of the CPT Editorial Panel's currently ongoing work in this area. However we are finalizing GCCC2 (the add-on for non-complex CCM clinical staff time), henceforth referred to as G2058, because this code addresses what we believe is an important gap in the current code set that should be addressed more immediately, and that finalizing only this single G code rather than the full range of proposed G codes will allow payment for these services while creating

significantly less administrative burden. Practitioners who choose to use G2058 can report the initial 20 minutes of non-complex CCM under CPT code 99490 and receive increased payment for their work under G2058. We are sympathetic to commenters' concerns that the introduction of temporary replacement G codes across the CCM code set may introduce substantial confusion or administrative burden, but we believe a single new G code to pay more for additional 20-minute increments of non-complex CCM clinical staff time is important to pursue now. We are finalizing the work RVU for G2058 as proposed.

We agree with commenters that there should be a frequency limit on the reporting of HCPCS code G2058 to maintain the distinction between complex and non-complex CCM and, in response to comments, we are finalizing that HCPCS code G2058 will be reportable a maximum of two times within a given service period for a given beneficiary. We believe the availability of this G code will further our policy goals to improve payment accuracy for care management services and allow practitioners and their teams to spend more time with their patients.

Comment: A few commenters suggested that CMS should revalue the work RVUs for the CCM codes given that we proposed to increase the work RVUs for TCM, and CCM was originally valued based upon the RVUs for TCM.

Response: We appreciate these suggestions but, given the ongoing work of the CPT Editorial Panel regarding these codes, we will consider potential revaluation of this code set in the context of any future changes or recommendations that may be made by the CPT Editorial Panel or the RUC.

b. Complex CCM Services (CPT codes 99487 and 99489, and HCPCS codes GCCC3 and GCCC4)

There are two CPT codes for complex CCM:

- CPT code 99487 *(Complex chronic care management services, 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; establishment or substantial revision of a comprehensive care plan; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month. (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately);* and

- CPT code 99489 *(each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).*

Complex CCM describes care management for patients who require not only more clinical staff time, but also complex medical decision-making and establishment or substantial revision of the care plan. Specifically, the CPT codes for complex CCM include in the code descriptors a requirement for establishment or substantial revision of the comprehensive care plan. The code descriptors for complex CCM also include moderate to high complexity medical decision-making (moderate to high complexity medical decision-making is an explicit part of the services).

We proposed to adopt two new G codes that would be used for billing under the PFS instead of CPT codes 99487 and 99489, and that would not include the service component of substantial care plan revision. We believed it is not necessary to explicitly include substantial care plan revision because patients requiring moderate to high complexity medical decision making implicitly need and receive substantial care plan revision. The service component of

substantial care plan revision is potentially duplicative with the medical decision making service component and, therefore, we believed it is unnecessary as a means of distinguishing eligible patients. Instead of CPT code 99487, we proposed to adopt HCPCS code GCCC3 *(Complex chronic care management services, 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; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month. (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately))*. We proposed a work RVU of 1.00 for HCPCS code GCCC3, which is a crosswalk to CPT code 99487.

Instead of CPT code 99489, we proposed to adopt HCPCS code GCCC4 *(each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). (Report GCCC4 in conjunction with GCCC3). (Do not report GCCC4 for care management services of less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month))*. We proposed a work RVU of 0.50 for HCPCS code GCCC4, which is a crosswalk to CPT code 99489.

We intended these would be temporary G codes to remain in place until the CPT Editorial Panel can consider revising the current code descriptors for complex CCM services. We stated that we would consider adopting any new or revised complex CCM CPT code(s) once the CPT Editorial Panel completes its work. We acknowledged that imposing a transitional period during

which G codes would be used under the PFS in lieu of the CPT codes is potentially disruptive. We solicited comment on whether the benefit of proceeding with the proposed G codes outweighs the burden of transitioning to their use in the intervening year(s) before a decision by the CPT Editorial Panel.

Comment: While expressing general support for the proposed changes to these codes to remove the element of substantial care plan revision, several commenters expressed concerns that the temporary introduction of G codes would produce administrative burden and cause confusion. These commenters stated that in September 2019 the CPT Editorial Panel was considering an application for similar changes to refine the code set and clarify care planning. These commenters urged us to work with the CPT Editorial Panel regarding changes to the CCM code set and its revaluation. However, other commenters stated that G codes would help to facilitate earlier implementation and would ease transition to any updates made to CPT codes. A few commenters suggested that CMS could achieve its burden reduction goals by continuing to recognize CPT codes 99490, 99487, and 99489 and also provide CMS-specific guidance for those codes for purposes of billing Medicare.

Response: We are not finalizing our proposal to create HCPCS codes GCCC3 and GCCC4 in light of concerns raised by commenters, especially in light of the CPT Editorial Panel's currently ongoing work in this area and the concerns expressed by those that we expect would likely provide these services. Instead, given the support for our proposed care planning changes, for CY 2020 we will continue to recognize CPT codes 99487 and 99489, but with a different care planning element for purposes of billing Medicare. Beginning in CY 2020, for PFS billing purposes for CPT codes 99487 and 99489, we will interpret the code descriptor "establishment or substantial revision of a comprehensive care plan" to mean that a

comprehensive care plan is established, implemented, revised, or monitored. This will allow for consistency in the care planning service element of complex CCM and non-complex CCM services provided by clinical staff. While we usually create G codes with alternative code descriptors when our payment policy varies from what is included in a CPT code descriptor(s), the change we proposed for the complex CCM care plan code descriptor is a relatively minor modification to the CPT code descriptor that we believe can be accomplished without the use of G codes. We look forward to reviewing any refinements or other recommendations for these services that may come from the CPT Editorial Panel and the RUC, and will consider such recommendations through our rulemaking process.

c. Typical Care Plan

In 2013, in working with the physician community to develop and propose the CCM codes for PFS payment, the medical community recommended and CMS agreed that adequate care planning is integral to managing patients with multiple chronic conditions. We stated our belief that furnishing care management to beneficiaries with multiple chronic conditions requires complex and multidisciplinary care modalities that involve, among other things, regular physician development and/or revision of care plans and integration of new information into the care plan (78 FR 43337). In the CY 2014 PFS final rule with comment period (78 FR 74416 through 74418), consistent with recommendations CMS received in 2013 from the AMA's Complex Chronic Care Coordination Workgroup, we finalized a CCM scope of service element for a patient-centered plan of care with the following characteristics: it is a comprehensive plan of care for all health problems and typically includes, but is not limited to, the following elements: problem list; expected outcome and prognosis; measurable treatment goals; cognitive and functional assessment; symptom management; planned interventions; medical management;

environmental evaluation; caregiver assessment; community/social services ordered; how the services of agencies and specialists unconnected to the practice will be directed/coordinated; identify the individuals responsible for each intervention, requirements for periodic review; and when applicable, revisions of the care plan.

The CPT Editorial Panel also incorporated and adopted this language in the prefatory language for Care Management Services codes (page 49 of the 2019 CPT Codebook) including CCM services.

As we continue to consider the need for potential refinements to the CCM code set, we have heard that there is still some confusion in the medical community regarding what a care plan typically includes. We re-reviewed this language for CCM, and we believe there may be aspects of the typical care plan language we adopted for CCM that are redundant or potentially unduly burdensome. In our CY 2020 PFS proposed rule, we noted that because these are "typical" care plan elements, these elements do not comprise a set of strict requirements that must be included in a care plan for purposes of billing for CCM services; the elements are intended to reflect those that are typically, but perhaps not always, included in a care plan as medically appropriate for a particular beneficiary. Nevertheless, we proposed to eliminate the phrase "community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identify the individuals responsible for each intervention" and insert the phrase "interaction and coordination with outside resources and practitioners and providers." We believed simpler language could describe the important work of interacting and coordinating with resources external to the practice. While it is preferable, when feasible, to identify who is responsible for interventions, it may be difficult to maintain an

up-to-date listing of responsible individuals especially when they are outside of the practice, for example, when there is staff turnover or assignment changes.

We proposed new language to read: The 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.
- Cognitive and functional assessment.
- Symptom management
- Planned interventions.
- Medical management.
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers.
- Requirements for periodic review.
- When applicable, revision of the care plan.

We welcomed feedback on our proposal, including language that would best guide practitioners as they decide what to include in their comprehensive care plan for CCM recipients.

Comment: Commenters largely supported CMS' proposed definition of the typical care plan, and stated that it was simpler than the current definition and also comprehensive.

Response: We thank the commenters for their support and are finalizing our proposed changes to the typical care plan for all CCM. We are eliminating the phrase "community/social services ordered, how the services of agencies and specialists unconnected to the practice will be

directed/coordinated, identify the individuals responsible for each intervention" and inserting the phrase "interaction and coordination with outside resources and practitioners and providers." The new language will read: "The 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.
- Cognitive and functional assessment.
- Symptom management
- Planned interventions.
- Medical management.
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers.
- Requirements for periodic review.
- When applicable, revision of the care plan."

We anticipate that this change will reduce burden and simplify the important work of interacting and coordinating with resources external to the practice.

4. Principal Care Management (PCM) Services

A gap we identified in coding and payment for care management services is care management for patients with only one chronic condition. The current CCM codes require patients to have two or more chronic conditions. These codes are primarily billed by practitioners who are managing a patient's total care over a month, including primary care

practitioners and some specialists such as cardiologists or nephrologists. We have heard from a number of stakeholders, especially those in specialties that use the office/outpatient E/M code set to report the majority of their services, that there can be significant resources involved in care management for a single high risk disease or complex chronic condition that is not well accounted for in existing coding (FR 78 74415). This issue has also been raised by the stakeholder community in proposal submissions to the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which are available at https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee. Therefore, we proposed separate coding and payment for Principal Care Management (PCM) services, which describe care management services for one serious chronic condition. A qualifying condition will typically be expected to last between 3 months and 1 year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

Although we did not propose any restrictions on the specialties that could bill for PCM, we expect that most of these services will be billed by specialists who are focused on managing patients with a single complex chronic condition requiring substantial care management. We expect that, in most instances, initiation of PCM will be triggered by an exacerbation of the patient's complex chronic condition or recent hospitalization such that disease-specific care management is warranted. We anticipate that in the majority of instances, PCM services will be billed when a single condition is of such complexity that it cannot be managed as effectively in the primary care setting, and instead requires management by another, more specialized, practitioner. For example, a typical patient may present to their primary care practitioner with an exacerbation of an existing chronic condition. Although the primary care practitioner may be

able to provide care management services for this one complex chronic condition, it is also possible that the primary care practitioner and/or the patient could instead decide that another clinician should provide relevant care management services. In this case, the primary care practitioner will still oversee the overall care for the patient while the practitioner billing for PCM services will provide care management services for the specific complex chronic condition. The treating clinician may need to provide a disease-specific care plan or may need to make frequent adjustments to the patient's medication regimen. The expected outcome of PCM is for the patient's condition to be stabilized by the treating clinician so that overall care management for the patient's condition can be returned to the patient's primary care practitioner. If the beneficiary only has one complex chronic condition that is overseen by the primary care practitioner, then the primary care practitioner will also be able to bill for PCM services. We proposed that PCM services include coordination of medical and/or psychosocial care related to the single complex chronic condition, provided by a physician or clinical staff under the direction of a physician or other qualified health care professional.

We anticipate that many patients will have more than one complex chronic condition. If a clinician is providing PCM services for one complex chronic condition, management of the patient's other conditions will continue to be managed by the primary care practitioner while the patient is receiving PCM services for a single complex condition. It is also possible that the patient could receive PCM services from more than one clinician if the patient experiences an exacerbation of more than one complex chronic condition simultaneously.

For CY 2020, we proposed to make separate payment for PCM services via two new G codes: HCPCS code G2064 *(Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified*

health care professional time per calendar month with the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities) and HCPCS code G2065 *(Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities).* HCPCS code G2064 would be reported when, during the calendar month, at least 30 minutes of physician or other qualified health care provider time is spent on comprehensive care management for a single high risk disease or complex chronic condition. HCPCS code G2065 would be reported when, during the calendar month, at least 30 minutes of clinical staff time is spent on comprehensive management for a single high risk disease or complex chronic condition.

For HCPCS code G2064, we proposed a crosswalk to the work value associated with CPT code 99217 *(Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report*

services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate])) as we believe these values most accurately reflect the resource costs associated when the billing practitioner performs PCM services. CPT code 99217 has the same intraservice time as HCPCS code G2064 and the physician work is of similar intensity. Therefore, we proposed a work RVU of 1.28 for HCPCS code G2064.

For HCPCS code G2065, we proposed a crosswalk to the work and PE inputs associated with CPT code 99490 (clinical staff non-complex CCM) as we believe these values reflect the resource costs associated with the clinician's direction of clinical staff who are performing the PCM services, and the intraservice times and intensity of the work for the two codes will be the same. Therefore, we proposed a work RVU of 0.61 for HCPCS code G2065.

Although we proposed separate coding and payment for PCM services performed by clinical staff with the oversight of the billing professional and services furnished directly by the billing professional, we solicited comment on whether both codes are necessary to appropriately describe and bill for PCM services. We note that we are basing this coding structure on the codes for CCM services with CPT code 99491 reflecting care management by the billing professional and CPT code 99490 reflecting care management by clinical staff directed by a physician or other qualified health care professional.

We acknowledged that we concurrently proposed revisions for both complex and non-complex CCM services. Were we not to finalize the changes for both complex and non-complex CCM services, we stated our belief that the overall structure and description of the CCM services remain close enough to serve as a model for the coding structure and description of services for

the proposed PCM services. We solicited public comment on whether it would be appropriate to create an add-on code for additional time spent each month (similar to HCPCS code GCCC2 discussed above) when PCM services are furnished by clinical staff under the direction of the billing practitioner.

Comment: Most commenters supported separate payment for PCM services, noting the gap in payment for care management and coordination for a patient's single complex or chronic condition. Other commenters were supportive of the policy goal but expressed concerns that the work described by PCM is duplicative of work being furnished as part of CCM and encouraged CMS to work with the CPT editorial panel to develop coding for this service.

Response: We appreciate the support for both the policy goal of appropriate payment for care management services conducted for a patient's single complex or chronic condition and for separate payment for PCM services. We look forward to reviewing and considering recommendations from the CPT Editorial Panel and the RUC, should they develop and value CPT codes describing this or similar services, through our rulemaking process.

Comment: A few commenters stated that HCPCS code G2064 was undervalued and should have a work RVU of 1.45, which is the same work RVU as CPT code 99491 (*Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, 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*). CPT code 99491 describes the work associated with care management performed by the billing

practitioner, in contrast to CPT code 99490, which describes the work associated with supervision of care management performed by clinical staff. Commenters pointed out that CPT codes 99491 and 99490 served as the model for HCPCS codes G2064 and G2065. Commenters stated that CPT code 99491 was a more accurate crosswalk for HCPCS code G2064 because both codes describe the work associated with care management and coordination performed by the billing practitioner, and G2065 describes the work associated with supervising care management done by clinical staff and was valued the same as CPT code 99490. Commenters also pointed out that, although PCM services describe care management associated with a single condition, the fact that this condition has most likely experienced an exacerbation or has caused the patient to recently be hospitalized, results in greater intensity than the work associated with managing multiple chronic conditions, some of which may be more stable.

Response: After considering these comments, we agree that the work RVU we proposed for code G2064 (1.28 RVUs) should be valued through a crosswalk to CPT code 99491, and we agree with the points made by commenters regarding the intensity of care management for a single condition, especially when that condition has likely experienced an exacerbation. We also agree that the relativity between CPT codes 99490 and 99491 should be preserved in HCPCS codes G2064 and G2065. Therefore, we are finalizing an RVU of 1.45 for HCPCS code G2064.

Comment: A few commenters supported creation of an add-on code for additional time spent engaged in PCM services beyond the initial 30 minutes, similar to HCPCS code G2060 discussed above.

Response: We thank commenters for their input. Given that this is a new service, we believe it would be more appropriate to monitor uptake and stakeholder response, and we will

consider whether to establish a separate add-on code for additional time spent furnishing PCM services beyond the initial 30 minutes for possible future rulemaking.

Although we believe that PCM services describe a situation where a patient's condition is severe enough to require care management for a single complex chronic condition beyond what is described by CCM or performed in the primary care setting, we are concerned that a possible unintended consequence of making separate payment for care management for a single chronic condition is that a patient with multiple chronic conditions could have their care managed by multiple practitioners, each only billing for PCM, which could potentially result in fragmented patient care, overlaps in services, and duplicative services. Although we did not propose additional requirements for the PCM services, we did consider alternatives such as requiring that the practitioner billing PCM must document ongoing communication with the patient's primary care practitioner to demonstrate that there is continuity of care between the specialist and primary care settings, or requiring that the patient have had a face-to-face visit with the practitioner billing PCM within the prior 30 days to demonstrate that they have an ongoing relationship. We solicited comment on whether requirements such as these are necessary or appropriate, and whether there should be additional requirements to prevent potential care fragmentation or service duplication.

We received public comments on whether requirements such as these are necessary or appropriate, and whether there should be additional requirements to prevent potential care fragmentation or service duplication. The following is a summary of the comments we received and our responses.

Comment: Many commenters' shared CMS' concerns. Some commenters recommended that CMS not finalize separate payment for PCM services, stating that this would move away

from patient-specific, continuous, comprehensive value based care management and coordination toward a more disease specific care management, resulting in fragmented care and service duplication. A few commenters with concerns about care fragmentation suggested that CMS first implement PCM through a demonstration. Others supported requiring the billing practitioner document ongoing communication and care coordination with any other practitioners overseeing care of the patient, such as primary care practitioners, pharmacists, hospitalists, or social workers, as applicable. These commenters stated that this would be sufficient to maintain coordination and continuity of care in the instance where multiple practitioners are involved in furnishing care to the beneficiary. A few commenters also suggested that CMS not allow billing of PCM services by multiple practitioners for the same indication. Still other commenters stated that it was not necessary to include any requirements pertaining to care fragmentation or service duplication, and that such requirements would be a barrier to uptake.

Response: While we share commenters' concerns regarding care fragmentation and service duplication, we do not believe they rise to the level that separate payment should not be adopted for these services. The type of care management services that we believe are appropriately described by the PCM codes involve work intensively focused on managing a single condition and, with very few exceptions, could not be replaced by a single practitioner billing CCM services for management of multiple chronic conditions. However, we also believe it necessary to put in place some requirements so as to avoid a situation where each of a patient's individual conditions are being managed separately by different practitioners who all bill for PCM services. Therefore, we are finalizing a requirement that ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record.

Due to the similarity between the description of the PCM and CCM services, both of which involve non-face-to-face care management services, we proposed that the full CCM scope of service requirements apply to PCM, including documenting the patient's verbal consent in the medical record. We solicited comment on whether there are required elements of CCM services that the public and stakeholders believe should not be applicable to PCM, and should be removed or altered.

A high level summary of these requirements is available in Table 23 and available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf. Both the initiating visit and the patient's verbal consent are necessary as not all patients who meet the criteria to receive separately billable PCM services may want to receive these services. The beneficiary should be educated as to what PCM services are and any cost sharing that may apply. Additionally, as practitioners have informed us that beneficiary cost sharing is a significant barrier to provision of other care management services, we solicited comment on how best to educate practitioners and beneficiaries on the benefits of PCM services.

TABLE 23: Chronic Care Management Services Summary

CCM Service Summary*
Verbal Consent • Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance). • Document that consent was obtained.
Initiating Visit for New Patients (separately paid)
Certified Electronic Health Record (EHR) Use • Structured Recording of Core Patient Information Using Certified EHR (demographics, problem list, medications, allergies).
24/7 Access ("On Call" Service)
Designated Care Team Member
Comprehensive Care Management • Systematic needs assessment (medical and psychosocial). • Ensure receipt of preventive services. • Medication reconciliation, management and oversight of self-management.
Comprehensive Electronic Care Plan • Plan is available timely within and outside the practice (can include fax). • Copy of care plan to patient/caregiver (format not prescribed). • Establish, implement, revise or monitor the plan.
Management of Care Transitions/Referrals (e.g., discharges, ED visit follow up, referrals). • Create/exchange continuity of care document(s) timely (format not prescribed).
Home- and Community-Based Care Coordination • Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits.
Enhanced Communication Opportunities • Offer asynchronous non-face-to-face methods other than telephone, such as secure email.

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of CCM.

We received public comments on whether there are required elements of CCM services that the public and stakeholders believe should not be applicable to PCM, and should be removed or altered. The following is a summary of the comments we received and our responses.

Comment: Most commenters supported application of the required elements of CCM to PCM with a number of refinements, although a few urged CMS not to add overly burdensome billing requirements. Commenters requested that CMS clarify that elements of CCM, such as the "systematic needs assessment," "receipt of preventive services," and a "comprehensive care plan" must be furnished only for the specific chronic condition for which the billing practitioner is treating the patient. Some commenters pointed out that a "comprehensive care plan" was not

needed when a practitioner is engaged in care management and coordination of a single complex or chronic condition, and instead suggested it be changed to "disease-specific care plan." Other commenters suggest that we remove this language entirely. Commenters expressed concern with requiring that the EHR be certified to a particular standard. Commenters generally recommended that an initiating visit be furnished within a window of time to demonstrate that a relationship has been established between the beneficiary and the practitioner furnishing PCM. Commenters supported the retention of the requirement that there be the capacity for in-person care management. Commenters also recommended that verbal and or written consent be documented in the medical record so that the patient is aware of the service and any applicable cost sharing, although some stated that this was a burdensome requirement given that they may not know in advance which beneficiaries will require PCM services.

Response: We thank commenters for all their input. We agree with commenters that a "disease-specific" care plan is more appropriate than a comprehensive care plan, as the practitioner will be providing care coordination and management for a single condition, and as such, the care plan may be more limited. We also agree that certain aspects of CCM, such as "systematic needs assessment" and "receipt of preventive services" should only be furnished as applicable to the condition being treated and should not be a requirement to bill for PCM services. Table 24 shows the elements of CCM, as revised in response to comments, that will be required for PCM.

TABLE 24: Principal Care Management Services Summary

PCM Service Summary*
Verbal Consent • Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance). • Document that consent was obtained.
Initiating Visit for New Patients (separately paid)
Certified Electronic Health Record (EHR) Use • Structured Recording of Core Patient Information Using EHR (demographics, problem list, medications, allergies).
24/7 Access ("On Call" Service)
Designated Care Team Member
Disease Specific Care Management Disease Specific Care Management may include, as applicable: • Systematic needs assessment (medical and psychosocial). • Ensure receipt of preventive services. • Medication reconciliation, management and oversight of self-management.
Disease Specific Electronic Care Plan • Plan is available timely within and outside the practice (can include fax). • Copy of care plan to patient/caregiver (format not prescribed). • Establish, implement, revise or monitor the plan.
Management of Care Transitions/Referrals (e.g., discharges, ED visit follow up, referrals, as applicable). • Create/exchange continuity of care document(s) timely (format not prescribed).
Home- and Community-Based Care Coordination • Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits, as applicable.
Enhanced Communication Opportunities • Offer asynchronous non-face-to-face methods other than telephone, such as secure email.

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of PCM.

With regard to the certified EHR, we continue to believe that use of certified EHR technology is vital to ensure that practitioners are capable of providing the full scope of PCM services, such as timely care coordination and continuity of care (see our prior discussion of this issue at 79 FR 67723). The use of certified EHR technology helps ensure that members of the care team have timely access to the patient's most updated health information. Also, we believe that use of certified EHR technology among physicians and other practitioners will increase as we move forward to implement the Quality Payment Program, including MIPS and Advanced

Alternative Payment Models, as well as other value-based payment initiatives. Accordingly, we are not modifying the proposed use of certified EHR technology as an element of PCM services.

We received public comments on how best to educate practitioners and beneficiaries on the benefits of PCM services. The following is a summary of the comments we received and our responses.

Comment: Commenters recommended that CMS issue guidance for billing and coding criteria, clinical situations in which PCM may be billed, and what defines a complex condition.

Response: We look forward to continued engagement with the public to revise and refine PCM services as they are implemented. We encourage stakeholders to submit questions and information to CMS so that we might consider changes or clarification for future rulemaking.

Additionally, we proposed to add HCPCS code G2065 to the list of designated care management services for which we allow general supervision as described in our regulation at § 410.26(b)(5).

Comment: Commenters supported adding HCPCS code G2065 to the list of designated care management services for which we allow general supervision.

Response: We thank commenters for their support and are finalizing as proposed.

Due to the potential for duplicative payment, we proposed that PCM could not be billed by the same practitioner for the same patient concurrent with certain other care management services, such as CCM, behavioral health integration services, and monthly capitated ESRD payments. We also proposed that PCM will not be billable by the same practitioner for the same patient during a surgical global period, as we believe those resource costs will already be included in the valuation of the global surgical code.

We also solicited comment on any potential for duplicative payment between the PCM services and other services, such as interprofessional consultation services (CPT codes 99446-99449 (*Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional*), CPT code 99451 (*Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time*), and CPT code 99452 (*Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes*) or remote patient monitoring (CPT code 99091 *(Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days),* CPT code 99453 *(Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment),* and CPT code 99457 *(Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month).*

Comment: Commenters generally supported restricting the number of care management services billable by the same practitioner for the same patient, stating that this was necessary to

avoid service duplication. A few commenters also stated that services such as interprofessional consultation and chronic care RPM should not be separately billable in the same month as PCM by the same practitioner for the same beneficiary. Others disagreed, stating the RPM and interprofessional consultations describe distinct services not accounted for in the work of PCM. RPM in particular was described by these commenters as being complimentary to PCM services, rather than duplicative.

Commenters requested clarification as to potential overlap between PCM and CCM and some commenters suggested that PCM could be billed concurrent with CCM for the same beneficiary, if billed by different practitioners. Commenters also requested that CMS clarify any potential overlap between PCM and HCPCS code GPC1X (*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established).*

Response: We do not believe there will be a duplication of care management between PCM and other care management services solely as a result of separate payment for the new PCM codes, particularly with the revised list of required elements which better distinguish PCM services from CCM. However, we also agree with commenters that PCM services should not be furnished with other care management services by the same practitioner for the same beneficiary, nor should PCM services be furnished at the same time as interprofessional consultations for the same condition by the same practitioner for the same patient. However, we are convinced by stakeholders who stated that RPM services are distinct from PCM and could be billed

concurrently by the same practitioner for the same beneficiary provided that the time is not counted twice. We will also be monitoring billing of these services. We will appreciate continued input and engagement on these issues with the public and stakeholder community, and may make refinements to these policies in future rulemaking.

With regard to the relationship between PCM services and HCPCS code GPC1X, we do not believe there is any overlap. We note that PCM describes ongoing care management services and is billed monthly, whereas HCPCS code GPC1X is an adjustment to an office/outpatient E/M visit (which are separately billable alongside PCM) to capture additional resource costs associated with performing either a primary care visit or a visit that is part of ongoing care of a patients single, serious, or complex condition.

Comment: A commenter requested that RHCs and FQHCs be allowed to furnish and report PCM services.

Response: We thank the commenter for the suggestion. While we did not propose a new mechanism for RHCs and FQHCs to report PCM services specifically, we recognize that the requirements for the new PCM codes are similar to the requirements for the services described by HCPCS code G0511, which is the RHC/FQHC-specific general care management code, and will consider adding PCM to G0511 in future rulemaking.

5. Chronic Care Remote Physiologic Monitoring Services

Chronic care remote physiologic monitoring (RPM) services involve the collection, analysis, and interpretation of digitally collected physiologic data, followed by the development of a treatment plan, and the managing of a patient under the treatment plan. The current CPT code 99457 is a treatment management code, billable after 20 minutes or more of clinical staff/physician/other qualified professional time with a patient in a calendar month.

In September 2018, the CPT Editorial Panel revised the CPT code structure for CPT code 99457 effective beginning CY 2020. The new code structure retains CPT code 99457 as a base code that describes the first 20 minutes of the treatment management services, and uses a new add-on code to describe subsequent 20 minute intervals of the service. The new code descriptors for CY 2020 are: CPT code 99457 (*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes*) and CPT code 99458 (*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes*).

In considering the work RVUs for the new add-on CPT code 99458, we first considered the value of its base code. We previously valued the base code at 0.61 work RVUs. Given the value of the base code, we did not agree with the RUC-recommended work RVU of 0.61 for CPT code 99458. Instead, we proposed a work RVU of 0.50 for the add-on code, which we believed was supported by CPT code 88381 (*Microdissection (i.e., sample preparation of microscopically identified target); manual*) and which has the same intraservice and total times of 20 minutes with an XXX global period and work RVU of 0.53, as well as the survey value at the 25th percentile. We proposed the RUC-recommended direct PE inputs for CPT code 99458.

Finally, we proposed that RPM services could be furnished under general supervision. Because care management services include establishing, implementing, revising, or monitoring treatment plans, as well as providing support services, and because RPM services include establishing, implementing, revising, and monitoring a specific treatment plan for a patient

related to one or more chronic conditions that are monitored remotely, we believed that CPT codes 99457 and 99458 should be included as designated care management services. Designated care management services can be furnished under general supervision. Section 410.26(b)(5) of our regulations states that designated care management services can be furnished under the general supervision of the "physician or other qualified health care professional (who is qualified by education, training, licensure/regulation and facility privileging)" (see also 2019 CPT Codebook, page xii) when these services or supplies are provided incident to the services of a physician or other qualified healthcare professional. The physician or other qualified healthcare professional supervising the auxiliary personnel need not be the same individual treating the patient more broadly. However, only the supervising physician or other qualified healthcare professional may bill Medicare for incident to services.

We received public comments on the proposed valuation of the RPM add-on CPT code 99458 and our proposal to designate CPT codes 99457 and 99458 as care management services. The following is a summary of the comments we received in response to our two proposals, as well as our responses.

Comment: We received numerous comments regarding our valuation of the new RPM code, CPT code 99458. Commenters uniformly disagreed with our proposed work RVU of 0.50 writing that there are no efficiencies to be gained when continuing the same treatment management service for an additional 20 minutes. Some commenters questioned our use of CPT code 88381 (*Microdissection (i.e., sample preparation of microscopically identified target); manual*) as a reference code, a code that does not resemble the work and the intensity of the work furnished during a care management session.

Response: We thank the many commenters for their insights into the work required for CPT codes 99457 and 99458.

Comment: Commenters uniformly agreed with our proposal to designate CPT codes 99457 and 99458 as care management services so that the services can be furnished under general supervision.

Response: We agree with commenters that the add-on code requires the same work time and intensity as the RPM base code. Therefore, we are finalizing the RUC-recommended work RVU 0.61 for CPT code 99458. We are also finalizing the RUC-recommended direct PE. In addition, we are finalizing our proposal to designate both CPT code 99457 and CPT code 99458 care management codes as defined in § 410.26(b)(5) of our regulations.

Comment: Several commenters expressed concerns about the ambiguity of the code descriptors for the RPM codes. Commenters requested that CMS define what is meant by "physiologic parameters", "digitally transmitted data" (as opposed to patient-reported data), "medical device," and "interactive communication". Several commenters asked if we could expand the list of practitioners allowed to furnish RPM services, while others requested that we clarify who can furnish and bill for the RPM services. One commenter stated that the prefatory language for the codes should state explicitly that an established patient-practitioner relationship must exist prior to billing for RPM services. Another commenter recommended that we provide guidance related to billing and documentation for RPM. Some commenters questioned whether the codes could be used for patients that without chronic conditions.

Response: We appreciate the many questions raised by commenters about the set of RPM codes and understand the frustration commenters expressed with the current code

descriptors. Therefore, given the numerous questions raised by commenters, we plan to consider these and other questions related to RPM in future rulemaking.

Comment: We received a few comments asking whether RPM is a billable service in RHCs and FQHCs.

Response: RHCs are paid an all-inclusive rate (AIR) when a medically necessary, face-to-face visit is furnished by an RHC practitioner. FQHCs are paid the lesser of their charges or the FQHC PPS rate when a medically-necessary, face-to-face visit is furnished by an FQHC practitioner. Both the RHC AIR and the FQHC PPS rate include all services and supplies furnished incident to the visit. Services such as RPM are not separately billable because they are already included in the RHC AIR or FQHC PPS payment.

6. Comment Solicitation on Consent for Communication Technology-Based Services

In the CY 2019 PFS final rule, we finalized separate payment for a number of services that could be furnished via telecommunications technology. Specifically, we finalized HCPCS code G2010 (*Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment*)), HCPCS code G2012 (*Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*)), CPT codes 99446-99449 (*Interprofessional telephone/Internet/electronic health record assessment*

and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional), CPT code 99451 (*Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time*), and CPT code 99452 (*Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes*).

As discussed in that rule, (83 FR 59490 through 59491), while a few commenters suggested that it would be less burdensome to obtain a general consent for multiple services at once, we stipulated that verbal consent must be documented in the medical record for each service furnished so that the beneficiary is aware of any applicable cost sharing. This is similar to the requirements for other non-face-to-face care management services under the PFS.

We have continued to hear from stakeholders that requiring advance beneficiary consent for each of these services is burdensome. For HCPCS codes G2010 and G2012, stakeholders have stated that it is difficult and burdensome to obtain consent at the outset of each of what are meant to be brief check-in services. For CPT codes 99446-99449, 99451 and 99452, practitioners have informed us that it is particularly difficult for the consulting practitioner to obtain consent from a patient they have never seen. Given our longstanding goals to reduce burden and promote the use of communication technology-based services (CTBS), we sought comment in the CY 2020 PFS proposed rule on whether a single advance beneficiary consent could be obtained for a number of communication technology-based services. During the consent process, the practitioner will make sure the beneficiary is aware that utilization of these

services will result in a cost sharing obligation. We solicited comment on the appropriate interval of time or number of services for which consent could be obtained, for example, for all these services furnished within a 6-month or 1-year period, or for a set number of services, after which a new consent will need to be obtained. We also solicited comment on the potential program integrity concerns associated with allowing advance consent and how best to minimize those concerns.

We received public comments on the appropriate interval of time or number of services for which consent could be obtained and the potential program integrity concerns associated with allowing advance consent and how best to minimize those concerns. The following is a summary of the comments we received and our responses.

Comment: Many commenters supported requiring a generalized consent for multiple communication technology-based services or interprofessional consultations. Most commenters suggested that a year was an appropriate interval for which consent should be obtained, although some commenters suggested other time intervals, such as every 6 months, quarterly, or no requirement at all.

A few commenters suggested that there should be separate consent processes for services that involve an interaction with the patient, such as HCPCS codes G2010 to report the remote evaluation of recorded video and/or images for an established patient and G2012 to report brief communication technology-based service for an established patient, and services that do not involve direct interaction with the patient, such as CPT codes 99446 through 99449, 99451 and 99452, which describe services such as electronic assessment and management by a consultative physician.

Other commenters raised more general concerns with beneficiary cost sharing, pointing out that beneficiaries may not be accustomed to being charged cost sharing for non-face-to-face services. These commenters urged CMS to eliminate cost sharing for these services.

Response: We appreciate commenters' support for allowing a single consent to be obtained for multiple CTBS or interprofessional consultation services over an interval of time, rather than requiring consent to be obtained prior to each service. Given the commenters' support, we are finalizing a policy to permit a single consent to be obtained for multiple CTBS or interprofessional consultation services. Based on feedback from commenters, we believe an appropriate interval for the single consent is one year, and we are finalizing that the single consent must be obtained at least annually. We will continue to consider whether a separate consent should be obtained for services that involve direct interaction between the patient and practitioner, and those that do not involve interaction such as interprofessional services; and we may address this issue in potential future rulemaking.

We also appreciate commenters' continued concerns about the burden associated with cost sharing for CTBS and interprofessional consultation services. Although we do not have statutory authority to eliminate cost sharing for these services, we appreciate the continued input from the public as to how best to educate both practitioners and beneficiaries to reduce instances of unexpected bills.

7. Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

RHCs and FQHCs are paid for general care management services using HCPCS code G0511, which is an RHC and FQHC-specific G-code for 20 minutes or more of CCM services, complex CCM services, CCM furnished by a physician or other qualified health care professional, or general behavioral health services, and we are allowing G0511 to also be billed

when the requirements for PCM are met. Payment for this service is set at the average of the national, non-facility payment rates for CPT codes 99490, 99487, 99491, and 99484. We proposed to use the non-facility payment rates for HCPCS codes GCCC1 and GCCC3 instead of the non-facility payment rates for CPT codes 99490 and 99487, respectively, if these changes were finalized for practitioners billing under the PFS; as indicated above, these codes were not finalized. We note that we did not propose any changes in the valuation of these codes.

Comment: Regarding the use HCPCS codes GCCC1 and GCCC3, commenters noted they would be supportive of this change if they were finalized for practitioners billing under the PFS for RHCs and FQHCs.

Response: Since HCPCS codes GCCC1 and GCCC3 are not being finalized for use under the PFS, we are not finalizing this change for RHCs and FQHCs. Therefore, payment for HCPCS G0511 will continue to set based on the average of the national, non-facility payment rates for CPT codes 99490, 99487, 99491, and 99484.