PUBLICATION

CMS Creates New G-Code for Chronic Care Management [Ober|Kaler]

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In the final Physician Fee Schedule for 2014, CMS recognized the critical component proper care management plays in improved outcomes and reduced costs through the creation of a new G-code. (G-codes were initially created for tracking beneficiaries' functional outcomes).

Previously, care management was bundled into payment for E/M visits, such as office visits; however, the physician community voiced its opinion that such structure does not appropriately describe the typical non-face-to-face time spent managing a patient. Added to this is the increase in medical practices organized as medical homes, which focus on providing extensive care management to improve the quality and coordination of health care services. From the physician community perspective, E/M codes do not adequately incorporate the types of non-face-to-face care management work provided, especially for beneficiaries with multiple chronic conditions.

In recognition of these concerns, CMS agreed to establish separate payment for chronic care management. However, it is limited to patients with two or more chronic conditions that are expected to last at least twelve months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation or functional decline. From CMS's perspective, this group of beneficiaries is at a great risk for hospitalizations, need for post-acute care services and emergency department visits. Accordingly, improving the care to these beneficiaries, CMS believes, could decrease such risks while also decreasing costs for the Medicare program.

As a result, CMS created one new G-code, separately payable, for “Chronic Care Management Services” that are provided for at least twenty minutes within a thirty day billing period. (Time less than twenty minutes cannot be rounded up.) Such services are to include:

- 24/7 patient access to their health care provider to address the beneficiaries' acute chronic care needs;
- continuity of care with a designated practitioner;
- care management for chronic conditions, including systematic assessment of the patient's medical, functional and psychosocial needs;
- medication reconciliation;
- oversight of patient self-management of medications;
- patient-centered care plans;
- management of care transitions;
- coordination with home and community based clinical service providers; and
- enhanced opportunities for communication between patient and caregivers, e.g., via internet, phone, or secure messaging.

Considering that separate payment for non-face-to-face care management services is a significant policy change, CMS was not ready to create additional payments reflective of different severity levels or add-on codes that account for additional time required for more severe patients. Notwithstanding, CMS did say it would consider such codes in the future.

It is important to note that, before a provider may furnish or bill for chronic care management services, a beneficiary must receive information regarding the services and agree to receive them. Such agreement must be documented in the patient's medical record. In addition, beneficiaries must be informed of their right to revoke their agreement at any time.

Although CMS initially proposed to require an annual wellness visit or initial preventative physical exam within the twelve months prior to providing care management, it instead is only recommending this practice and not making it a requirement of billing the G-code.

While CMS noted that chronic care management may be generally viewed as an aspect of primary care practice, the separate payment will be available to specialists as well. CMS highlighted that, provided all other requirements are met, chronic care management could be furnished incident to a physician's service. Finally, if a practice meets all the conditions to bill chronic care management separately, the time spent by a clinical staff employee providing aspects of these services outside of the practice's normal business hours can be counted toward the time requirements. Such clinical staff person must be employed by the physician or practice, and the services must be: integral to the physician's chronic care management services; provided under the physician's general supervision; and meet the “incident to” requirements.

The new G-Code is not effective until January 1, 2015, and CMS has requested public input on the standards for furnishing chronic care services. CMS is developing the standards in 2014 and will implement them in 2015. The standards will be established through notice and comment rulemaking for the CY 2015 Physician Fee Schedule.

Ober|Kaler's Comments

While seemingly a step in the right direction for compensating physicians for work actually performed, payment is only available for twenty minutes of non-face-to-face activity. In addition, the requirements for billing under the new code could make the provision of services more tedious, though hopefully not to the point of discouraging the service. The CY 2015 Proposed Physician Fee Schedule will be issued later this year and physicians interested in using the standards for furnishing chronic care management services should take the opportunity to raise concerns and make suggestions to CMS upon review of the proposed rule.

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