New Medicare Category of Physician Payment: Complex Chronic Care Management

By David J. Hyman, Attorney at Law

Since the time of Galen himself, Medicare has generally paid physicians only for face-to-face patient encounters. As a result, most non-face-to-face services, such as care plan development, care coordination among other practitioners and facilities, laboratory interpretation and chart documentation, are uncompensated. CMS explains that all this non-face-to-face work is adequately compensated by the original E/M fee for the actual encounter. But as physicians devote ever more time to indispensable non-face-to-face tasks, and as reimbursement rates have declined, the inadequacy of Medicare's compensation design is acutely painful.

But CMS has at last recognized this dilemma and has taken a first, albeit tenuous step toward compensating physicians fairly for all their required labor. Starting in 2015, Medicare will pay physicians for "care management" tasks performed for a limited field of patients outside the face-to-face encounter. Specifically, Medicare will reimburse for globally managing the care of a patient who has "multiple chronic conditions" that pose a "significant risk of [the patient's] death, acute exacerbation/decompensation or functional decline."

Though a considerable policy shift for Medicare and a potential boon for general practitioners, the change likely will not benefit most specialty physicians. This is because it does not allow payment for managing only a single medical condition or disease cluster, regardless how complex and chronic the condition and how laborious the physician's burden. Several specialty societies have urged CMS to modify the new policy accordingly.

As adopted, "care management" reimbursement requires the physician to provide an array of services. There must be an assessment of the patient's medical, functional, and psychosocial needs, a coordinated care plan, a system to ensure prompt access and care, steps to prevent medication interactions and to assure the patient's proper use of medications. The physician must manage transitions of the patient's care and referrals to other practitioners. The patient must have 24/7 access to the physician and care team, the patient's electronic health record must continually be accessible to the team, and the team must coordinate with home and community based clinical service providers.

Two new billing codes will be used, one for services performed during the first 90 days following diagnosis, and one for those performed during the next 90 days. At least 60 minutes of management service will be required per code, and payment will be made at the end of the 90 day period. Face-to-face encounters with the patient will still be reimbursed in addition to the care management services.

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