Response: We thank the commenters for this feedback. We believe the public comments illustrate how difficult it is to utilize or rely upon such a relatively small set of codes to describe and pay for the work of a wide range of physicians and practitioners in many vastly different clinical contexts. We also believe the public comments illustrate that many of the issues with the E/M documentation guidelines are not simply a matter of undue administrative burden. The guidelines reflect how work was performed and valued a number of years ago, and are intimately related to the definition and description of E/M work as well as its valuation. Opinions on potential redefinition and revaluation of the E/M code set tend to differ by specialty, according to the type of work dominating each specialty (for example, primary care, so-called "cognitive" specialty work, or global procedures that have E/M visits bundled in rather than separately performed and documented). We expect to continue to work on all of these issues with stakeholders in future years though we are immediately focused on revision of the current E/M guidelines in order to reduce unnecessary administrative burden.

2. Care Management Public Comment Solicitation

In the CY 2018 PFS proposed rule, we stated our continued interest in the ongoing work of the medical community and other stakeholders to refine the set of codes used to describe care management services. In section II.H of this final rule, we discuss our final policy to adopt CPT codes for CY 2018 to replace the G-codes we established for several new care management service codes finalized last year, describing cognitive impairment assessment and care planning, and behavioral health integration services. In CY 2018, these codes will be added to the suite of CPT care management service codes we adopted in recent years, including transitional care management and chronic care management (CCM) services. In our proposed rule, we also reiterated our commitment to work with stakeholders on necessary refinements to this code set,

especially codes that would describe the professional work involved in caring for complex patients in additional clinical contexts. Also we solicited public comment on ways we might further reduce the burden for practitioners reporting care management services, including through stronger alignment between CMS requirements and CPT guidance for existing and potential new care management service codes.

We received a few comments on ways CMS might further improve CCM services, and approaches that CMS might take more broadly to improve payment for care management services. In this section, we discuss the comments and respond.

Comment: We received a few comments requesting a change in the coding or payment for CCM services. Several commenters recommended that CMS develop add-on codes to break out and pay for smaller clinical staff time increments (specifically, breaking out increments of greater than 20 minutes of clinical staff time, such as 21-40 minutes and 41-60 minutes).

Response: We appreciate the suggestion from commenters. At this time, we generally intend to consider pursuing future changes to the CPT codes describing chronic care management services, rather than create new add-on G codes that would be used alongside current CPT codes for CCM services. We urge stakeholders to work through the CPT process to make needed changes or create new codes for the CCM code set as appropriate.

Comment: One commenter recommended that CMS not require that a copy of the care plan must be given to the patient (or caregiver as appropriate). The commenter recommended that CMS instead require that a copy of the plan of care must be available to the patient or caregiver.

Response: In the CY 2017 PFS final rule (81 FR 80250), we revised this language to no longer mandate the format in which the care plan must be provided (written versus verbal) and,

rather, to allow the care plan to be provided in a format consistent with patient/caregiver preference. We stated that while beneficiaries must be provided a copy of the care plan, practitioners may choose to provide the care plan in hard copy or electronic form in accordance with patient preferences. We believe our current language is more appropriate than the CPT language or the language recommended by the commenter because it allows flexibility in how the care plan information is transmitted to the patient (or caregiver, if appropriate) in accordance with patient needs or preference, but ensures to a greater degree that the information is actually received by them, whatever the format. We believe a requirement merely to make the information "available" may not ensure that it is actually received and understood. If the patient (or caregiver, if appropriate) prefers, the care plan may be provided to them via an electronic portal. Also, whatever format is used to provide the care plan, we expect that the care plan will be discussed with the patient (and/or caregiver as appropriate) as part of the management of their care and consistent with the other CCM scope of service elements.

Comment: One commenter recommended that CMS not require documentation of each minute of service provided.

Response: In addition to CCM, there are many CPT codes that are timed codes (having time within their code descriptor). The same rules should apply for documentation of time for CCM as for other timed services. For program integrity purposes (to ensure timed services are actually performed in full, as described and defined by the code(s)), we expect practitioners to document in the medical record how they spent the qualifying time. In the case of CCM, they must document that the required time was spent performing qualifying activities. This is routine policy for timed service codes. If practitioners have specific questions about the degree to which

they must document and time their CCM work using the current CPT codes, they should consult their Medicare Administrative Contractor.

Comment: One commenter recommended that CMS reduce the service elements for CPT code 99490 to require only one of the following service elements to be performed: comprehensive care management, management of care transitions, or home- and community-based care coordination.

Response: The current code descriptors and required scope of service elements reflect the results of our notice and comment rulemaking with significant contributions from the AMA/CPT Editorial Panel. We believe we should continue to require, for each month in which the service is billed, all of the service elements that are medically necessary for the patient, which we believe is also consistent with CPT reporting rules for CCM.

Comment: One commenter asked CMS to further align its rules with CPT reporting rules by removing the requirement to use a certified EHR.

Response: We continue to believe that use of certified EHR technology is vital to ensure that practitioners are capable of providing the full scope of CCM 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 interdisciplinary 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 removing the requirement to use a certified EHR.

Comment: One commenter recommended that CMS not require an initiating visit for any CCM patient. The commenter believes that patient consent to receive CCM services could be obtained by a care manager verbally by phone.

Response: Starting in CY 2017, we removed the requirement for all CCM patients to receive initiating visits, instead only requiring it if the patient has not been seen within a year prior to commencement of CCM. Also we changed the consent requirement to allow verbal consent (rather than the written consent we previously required) for all patients, including patients who require an initiating visit. In other words, consent can already be obtained verbally independent of the initiating visit, as long as it is obtained prior to commencement of the monthly CCM services. We continue to believe that if the patient has not been seen within a year, there should be an initiating visit so the billing practitioner can assess or re-assess the patient, gather all necessary data to inform the care plan, and perform other preparatory work. Therefore we are not changing this requirement. We remind stakeholders that consent does not have to be obtained as part of an initiating visit and can be done separately, as long as it is obtained before the first CCM monthly service commences.

Comment: We received a few comments on the add-on code (G0506) describing practitioner assessment and care planning in conjunction with an initiating visit. One commenter said there should not be a requirement for the billing practitioner to create the comprehensive care plan as part of this code. The commenter believes their role should instead be to identify and support patients during the enrollment process, and to generally supervise the creation of the CCM care plan. Another commenter recommended that CMS allow pharmacists to have the care planning in HCPCS code G0506 delegated to them.

Response: We created HCPCS code G0506 explicitly to separately identify and pay for the time and work of the billing practitioner reporting the monthly CCM service, to ensure appropriate payment for their comprehensive assessment and involvement at the outset of CCM, if needed by the patient (81 FR 80245). We did this because we expect that much of the subsequent CCM services will be performed incident to the professional services of the billing practitioner and we wish to ensure appropriate personal involvement of, and payment to, the practitioner who is directly reporting CCM. The purpose for adopting this add-on code was to describe and provide appropriate payment for work that is personally and directly performed by the billing practitioner themselves in preparation for furnishing CCM services. Care planning that is performed by clinical staff incident to the services of the billing practitioner may be counted towards the clinical staff time of the monthly CCM service code(s), but cannot be counted towards G0506.

Comment: One commenter asked CMS to clarify that the CCM planning code, HCPCS code G0506, can be billed on a day separate from an E/M date of service.

Response: G0506 is comprised of a face-to-face assessment and care planning personally performed only once by the practitioner reporting the monthly CCM service, in conjunction with (as an add-on code to) an initiating visit. The face-to-face assessment would be performed the same day as the initiating visit, but some or all of the care planning piece could be performed by the billing practitioner on a subsequent day. Accordingly, we would expect the date of service for HCPCS code G0506 on the claim to be the same as for the base initiating visit code, and we will consider issuing an FAQ specifying this.

Comment: Several commenters recommended that CMS seek ways to eliminate cost sharing for CCM and other care management services. These commenters expressed that it is

difficult to explain the mechanics and benefits of care management to patients, given the added cost sharing. They recommended that CMS seek ways to remove the cost sharing, for example through designating the services as preventive services or working with Congress to accomplish it legislatively.

Response: As we stated in our CY 2017 PFS final rule (81 FR 80240), we appreciate the commenters' concerns and recognize many of the challenges associated with patient cost sharing for these kinds of services. At this time, we do not have authority to remove cost sharing for care management services. We appreciate the commenters' acknowledgement of our current limitations and we will continue to consider this issue.

Comment: We received a few comments recommending ways in which we might better involve specialists in the provision of CCM or care management broadly (such as payment to emergency department physicians when they act as primary care practitioners, or payment to multiple practitioners involved in managing a given patient at a given time). Also a few commenters recommended that CMS allow more than one practitioner to bill CCM per month. They believe there were situations where more than one practitioner co-manages a patient, or that particularly complex patients who would benefit from CCM services also benefit from seeing multiple health care providers.

Response: At this time, only one practitioner can report CCM per month, consistent with both CPT guidance and the authorizing statute for payment of CCM services (section 1848(b)(8)(B) of the Act). However, we agree there may be circumstances in which more than one practitioner expends resources managing or helping manage a CCM patient. We will continue to explore ways in which we might better identify and pay for costs incurred by multiple practitioners who coordinate and manage a patient's care within a given month, and are

interested in hearing more about the relevant circumstances, potential gaps in coding, and the exact nature of the work performed or costs incurred.