I. Complex Chronic Care Management Services

As we discussed in the CY 2013 PFS final rule with comment period, we are committed to primary care and we have increasingly recognized care management as one of the critical components of primary care that contributes to better health for individuals and reduced expenditure growth (77 FR 68978). Accordingly, we have prioritized the development and implementation of a series of initiatives designed to improve payment for, and encourage long-term investment in, care management services. These initiatives include the following programs and demonstrations:

- The Medicare Shared Savings Program (described in "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Final Rule" which appeared in the November 2, 2011 **Federal Register** (76 FR 67802)).

- The testing of the Pioneer ACO model, designed for experienced health care organizations (described on the Center for Medicare and Medicaid Innovation's (Innovation Center's) Web site at innovations.cms.gov/initiatives/ACO/Pioneer/index.html).

- The testing of the Advance Payment ACO model, designed to support organizations participating in the Medicare Shared Savings Program (described on the Innovation Center's Web site at innovations.cms.gov/initiatives/ACO/Advance-Payment/index.html).

- The Primary Care Incentive Payment (PCIP) Program (described on the CMS Web site at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/PCIP-2011-Payments.pdf).

- The patient-centered medical home model in the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration designed to test whether the quality and

coordination of health care services are improved by making advanced primary care practices more broadly available (described on the CMS Web site at www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/mapcpdemo_Factsheet.pdf).

- The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice demonstration (described on the CMS Web site at www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/mapcpdemo_Factsheet.pdf and the Innovation Center's Web site at innovations.cms.gov/initiatives/FQHCs/index.html).

- The Comprehensive Primary Care (CPC) initiative (described on the Innovation Center's Web site at innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html). The CPC initiative is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care in certain markets across the country.

In coordination with these initiatives, we also continue to explore potential refinements to the PFS that would appropriately value care management within Medicare's statutory structure for fee-for-service physician payment and quality reporting. For example, in the CY 2013 PFS final rule with comment period, we adopted a policy to pay separately for care management involving the transition of a beneficiary from care furnished by a treating physician during a hospital stay to care furnished by the beneficiary's primary physician in the community (77 FR 68978 through 68993). We view potential refinements to the PFS such as these as part of a broader strategy that relies on input and information gathered from the initiatives described above, research and demonstrations from other public and private stakeholders, the work of all parties

involved in the potentially misvalued code initiative, and from the public at large.

1. Patient Eligibility for Separately Payable Non-Face-to-Face Complex Chronic Care Management Services

Under current PFS policy, the payment for non-face-to-face care management services is bundled into the payment for face-to-face E/M visits because care management is a component of those E/M services. The pre- and post-encounter non-face-to-face care management work is included in calculating the total work for the typical E/M services, and the total work for the typical service is used to develop RVUs for the E/M services. In the CY 2012 PFS proposed rule, we highlighted some of the E/M services that include substantial care management work. Specifically, we noted that the vignettes that describe a typical service for mid-level office/outpatient services (CPT codes 99203 and 99213) include furnishing care management, communication, and other necessary care management related to the office visit in the post-service work (76 FR 42917).

However, the physician community continues to tell us that the care management included in many of the E/M services, such as office visits, does not adequately describe the typical non-face-to-face care management work involved for certain categories of beneficiaries. Because the current E/M office/outpatient visit CPT codes were designed to support all office visits and reflect an overall orientation toward episodic treatment, we agree that these E/M codes may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries. For example, we currently pay physicians separately for the non face-to-face care plan oversight services furnished to beneficiaries under the care of home health agencies or hospices and we currently pay separately for care management services

furnished to beneficiaries transitioning from care furnished by a treating physician during a hospital stay to care furnished by the beneficiary's primary physician in the community.

Similar to these situations, we believe that the resources required to furnish complex chronic care management services to beneficiaries with multiple (that is, two or more) chronic conditions are not adequately reflected in the existing E/M codes. Furnishing care management to beneficiaries with multiple chronic conditions requires complex and multidisciplinary care modalities that involve: regular physician development and/or revision of care plans; subsequent reports of patient status; review of laboratory and other studies; communication with other health professionals not employed in the same practice who are involved in the patient's care; integration of new information into the care plan; and/or adjustment of medical therapy. Therefore, for CY 2015, we are proposing to establish a separate payment under the PFS for complex chronic care management services furnished to patients with multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

We have performed an analysis of Medicare claims for patients with selected multiple chronic conditions (see http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf). This analysis indicated that patients with these selected multiple chronic conditions are at increased risk for hospitalizations, use of post-acute care services, and emergency department visits. We believe these findings would hold in general for patients with multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the

patient at significant risk of death, acute exacerbation/decompensation, or functional decline. We believe that successful efforts to improve chronic care management for these patients could improve the quality of care while simultaneously decreasing costs (for example, through reductions in hospitalizations, use of post-acute care services, and emergency department visits.)

As described below in more detail in section II.I.3, we intend to develop standards for furnishing complex chronic care management services to ensure that the physicians who bill for these services have the capability to provide them. One of the primary reasons for our proposed 2015 implementation date is to provide sufficient time to develop and obtain public input on the standards necessary to demonstrate the capability to provide these services.

2. Scope of Complex Chronic Care Management Services

We consider the scope of complex chronc care management services to include:

- The provision of 24-hour- a-day, 7-day- a-week access to address a patient's acute complex chronic care needs. To accomplish these tasks, we would expect that the patient would be provided with a means to make timely contact with health care providers in the practice to address urgent complex chronic care needs regardless of the time of day or day of the week. Members of the complex chronic care team who are involved in the after-hours care of a patient must have access to the patient's full electronic medical record even when the office is closed so they can continue to participate in care decisions with the patient.

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

- Care management for chronic conditions including systematic assessment of

patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications. In consultation with the patient and other key practitioners treating the patient, the practitioner furnishing complex chronic care management services should create a patient-centered plan of care document to assure that care is provided in a way that is congruent with patient choices and values. A plan of care is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, 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, revision, of the care plan. The provider should seek to reflect a full list of problems, medications and medication allergies in the electronic health record to inform the care plan, care coordination and ongoing clinical care.

- Management of care transitions within health care including referrals to other clinicians, visits following a patient visit to an emergency department, and visits following discharges from hospitals and skilled nursing facilities. The practice must be able to facilitate communication of relevant patient information through electronic exchange of a summary care record with other health care providers regarding these transitions. The practice must also have qualified personnel who are available to deliver

transitional care services to a patient in a timely way so as to reduce the need for repeat visits to emergency departments and re-admissions to hospitals and skilled nursing facilities.

- Coordination with home and community based clinical service providers required to support a patient's psychosocial needs and functional deficits. Communication to and from home and community based providers regarding these clinical patient needs must be documented in practice's medical record system.

- Enhanced opportunities for a patient to communicate with the provider regarding their care through not only the telephone but also through the use of secure messaging, internet or other asynchronous non face-to-face consultation methods.

3. Standards for Furnishing Complex Chronic Care Coordination Services

Not all physicians and qualified nonphysician practitioners who wish to furnish complex chronic care management services currently have the capability to fully provide the scope of services described in section II.I.2. without making additional investments in technology, staff training, and the development and maintenance of systems and processes to furnish the services. We intend to establish standards that would be necessary to provide high quality, safe complex chronic care management services. For example, potential standards could include the following:

- The practice must be using a certified Electronic Health Record (EHR) for beneficiary care that meets the most recent HHS regulatory standard for meaningful use. The EHR must be integrated into the practice to support access to care, care coordination, care management and communication.

- The practice must employ one or more advanced practice registered nurses or physicians assistants whose written job descriptions indicate that their job roles include

and are appropriately scaled to meet the needs for beneficiaries receiving services in the practice who require complex chronic care management services provided by the practice.

- The practice must be able to demonstrate the use of written protocols by staff participating in the furnishing of services that describe: (1) the methods and expected "norms" for furnishing each component of complex chronic care management services provided by the practice; (2) the strategies for systematically furnishing health risk assessments to identify all beneficiaries eligible and who may be willing to participate in the complex chronic care management services; (3) the procedures for informing eligible beneficiaries about complex chronic care management services and obtaining their consent; (4) the steps for monitoring the medical, functional and social needs of all beneficiaries receiving complex chronic care management services; (5) system based approaches to ensure timely delivery of all recommended preventive care services to beneficiaries; (6) guidelines for communicating common and anticipated clinical and non-clinical issues to beneficiaries; (7) care plans for beneficiaries post-discharge from an emergency department or other institutional health care setting, to assist beneficiaries with follow up visits with clinical and other suppliers or providers, and in managing any changes in their medications; (8) a systematic approach to communicate and electronically exchange clinical information with and coordinate care among all service providers involved in the ongoing care of a beneficiary receiving complex chronic care management services; (9) a systematic approach for linking the practice and a beneficiary receiving complex chronic care management services with long-term services and supports including home and community-based services; (10) a systematic approach to the care management of vulnerable beneficiary populations such as racial and ethnic

minorities and people with disabilities; and (11) patient education to assist the beneficiary to self-manage a chronic condition that is considered at least one of his/her complex chronic conditions. These protocols must be reviewed and updated as is appropriate based on the best available clinical information at least annually.

- All practitioners including advanced practice registered nurses or physicians assistants, involved in the delivery of complex chronic care management services must have access at the time of service to the beneficiary's EHR that includes all of the elements necessary to meet the most recent HHS regulatory standard for meaningful use. This includes any and all clinical staff providing after hours care to ensure that the complex chronic care management services are available with this level of EHR support in the practice or remotely through a Virtual Private Network (VPN), a secure website, or a health information exchange (HIE) 24 hours per day and 7 days a week.

Some have suggested that, to furnish these services, practices could be recognized as a medical home by one of the national organizations including: the National Committee for Quality Assurance (NCQA), the Accreditation Association for Ambulatory Health Care, The Joint Commission, URAC, etc.; which are formally recognizing primary care practices as a patient-centered medical home. We understand there are differences among the approaches taken by national organizations that formally recognize medical homes and therefore, we seek comment on these and other potential care coordination standards, and the potential for CMS recognizing a formal patient-centered medical home designation as one means for a practice to demonstrate it has met any final care coordination standards for furnishing complex chronic care management services. Any regulatory changes would be addressed through separate notice-and-comment rulemaking.

4. Billing for Separately Payable Complex Chronic Care Management Services and Obtaining Informed Consent from the Beneficiary

To recognize the additional resources required to provide complex chronic care management services to patients with multiple chronic conditions, we are proposing to create two new separately payable alphanumeric G-codes.

> Complex chronic care management services furnished to patients with multiple (two or more) complex chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
>
> GXXX1, initial services; one or more hours; initial 90 days
>
> GXXX2, subsequent services; one or more hours; subsequent 90 days

Typically, we would expect the one or more hours of services to be provided by clinical staff directed by a physician or other qualified health care professional. Initial services include obtaining the initial informed consent from the beneficiary as described below and the initial implementation of the complex chronic care management services described in section II.I.2. of this proposed rule.

Not all patients who are eligible for separately payable complex chronic care management services may necessarily want these services to be provided**.** Therefore, before the practitioner can furnish or bill for these services, the eligible beneficiary must be informed about the availability of the services from the practitioner and provide his or her consent to have the services provided, including the electronic communication of the patient's information with other treating providers as part of care coordination. This would include a discussion with the patient about what complex chronic care management services are, how these services are accessed, how their information will be shared among other providers in the care team, and that cost-sharing applies to these

services even when they are not delivered face-to-face in the practice. To bill for the initial services (GXXX1), the practitioner would be required to document in the patient's medical record that all of the complex chronic care management services were explained and offered to the patient, noting the patient's decision to accept these services. Also, a written or electronic copy of the care plan would be provided to the beneficiary and this would also be recorded in the beneficiary's electronic medical record.

A practitioner would need to reaffirm with the beneficiary at least every 12 months whether he or she wishes to continue to receive complex chronic care management services during the following 12-month period.

The informed consent for complex chronic care management services could be revoked by the beneficiary at any time. However, if the revocation occurs during a current 90-day complex chronic care management period, the revocation would not be effective until the end of that period. The beneficiary could notify the practitioner either verbally or in writing. At the time the informed consent is obtained, the practitioner would be required to inform the beneficiary of the right to stop the complex chronic care management services at any time and the effect of a revocation of consent on complex chronic care management services. Revocation by the beneficiary of the informed consent must also be noted by recording the date of the revocation in the beneficiary's medical record and by providing the beneficiary with written confirmation that the practitioner would not be providing complex chronic care management services beyond the current 90 day period.

A beneficiary who has revoked informed consent for complex chronic care management services from one practitioner may choose instead to receive these services from a different practitioner, which can begin at the conclusion of the current 90-day

period. The new practitioner would need to fulfill all the requirements for billing GXXX1 and then GXXX2.

Prior to submitting a claim for complex chronic care management services, the practitioner must notify the beneficiary that a claim for these services will be submitted to Medicare. The notification must indicate: that the beneficiary has been receiving these services over the previous 90-day period (noting the beginning and end dates for the 90-day period), the reason(s) why the services were provided and a description of the services provided. The notice may be delivered by a means of communication mutually agreed to by the practitioner and beneficiary such as mail, email, or facsimile, or in person (for example, at the time of an office visit.) The notice must be received by the beneficiary before the practitioner submits the claim for the services. A separate notice must be received by the beneficiary for each 90-day period for which the services will be billed. A copy of the notice should be included in the medical record.

In addition to the requirement that at least an hour of complex chronic care management services be furnished to the patient, we propose that billing for subsequent complex chronic care management services (GXXX2) would be limited to those 90-day periods in which the medical needs of the patient require substantial revision of the care plan discussed in section II.I.2. Substantial revision to a care plan typically is required when the patient's clinical condition changes sufficiently to require: significantly more intensive monitoring by clinical staff, significant changes in the treatment regimen, and significant time to educate the patient/caregiver about the patient's condition/change in treatment plan and prognosis.

Because the payment for non-face-to-face care management services is generally bundled into the payment for face-to-face E/M visits, the resources required to provide

care management services for patients without multiple chronic conditions or for less than the one or more hours of clinical staff time continues to be reflected in the payment for face-to-face E/M visits. For similar reasons, the resources required to provide care management services to patients residing in facility settings where care management activity by facility staff would be included in the associated facility payment also continues to be reflected in the payment for face-to-face E/M visits.

We propose that complex chronic care management services include transitional care management services (CPT 99495, 99496), home health care supervision (HCPCS G0181), and hospice care supervision (HCPCS G0182). If furnished, in order to avoid duplicate payment, we propose that these services may not be billed separately during the 90 days for which either GXXX1 or GXXX2 are billed. For similar reasons, we propose that GXXX1 or GXXX2 cannot be billed separately if ESRD services (CPT 90951-90970) are billed during the same 90 days.

Practitioners billing a complex chronic care management code accept responsibility for managing and coordinating the beneficiary's care over this period. Therefore, we propose to pay only one claim for the complex chronic care management services (either GXXX1 or GXXX2) billed per beneficiary at the conclusion of each 90-day period. All of the complex chronic care management services delineated in section II.H.2 above that are relevant to the patient must be furnished in order to bill GXXX1 or GXXX2 for a 90-day period.

If a face-to-face visit is provided during the 90-day period by the practitioner who is furnishing complex chronic care management services, the practitioner should report the appropriate evaluation and management code in addition to GXXX1 or GXXX2.

We note that to bill for these services, we propose that at least 60 minutes of

complex chronic care management services must be provided. Time of less than 60 minutes over the 90 day period could not be rounded up to 60 minutes in order to bill for these services. We also propose that for purposes of meeting the 60-minute requirement, the practitioner could count the time of only one clinical staff member for a particular segment of time, and could not count overlapping intervals such as when two or more clinical staff members are meeting about the patient.

In future rulemaking, we intend to propose RVUs for complex chronic care management services. To inform our proposal, we seek input on the physician work and practice expenses associated with these services.

5. Complex Chronic Care Management Services and the Annual Wellness Visit (AWV) (HCPCS codes G0438, G0439)

We are proposing that a beneficiary must have received an AWV in the past twelve months in order for a practitioner to be able to bill separately for complex chronic care management services. We believe that the linking of these services to the AWV makes sense for several reasons. First, the AWV is designed to enable a practitioner to systematically capture information that is essential for the development of a care plan. This includes the establishment of a list of current practitioners and suppliers that are regularly involved in providing medical care to the beneficiary, the assessment of the beneficiary's functional status related to chronic health conditions, the assessment of whether the beneficiary suffers from any cognitive limitations or mental health conditions that could impair self-management of chronic health conditions, and an assessment of the beneficiary's preventive health care needs including those that contribute to or result from a beneficiary's chronic conditions. Second, the beneficiary's selection of a practitioner to furnish the AWV is a useful additional indicator to assist us in knowing

which single practitioner a beneficiary has chosen to furnish complex chronic care management services. While a beneficiary would retain the right to choose and change the practitioner to furnish complex chronic care management services, we do not believe that it is in the interest of a beneficiary to have more than one practitioner at a time coordinating the beneficiary's care and we do not intend to pay multiple practitioners for furnishing these services over the same time period. Third, the AWV is updated annually which is consistent with the minimal interval for reviewing and modifying the care plan required for the complex chronic care management services.

We would expect that the practitioner the beneficiary chooses for the AWV would be the practitioner furnishing the complex chronic care management services. For the less frequent situations when a beneficiary chooses a different practitioner to furnish the complex chronic care management services from the practitioner who in the previous year furnished the AWV, the practitioner furnishing the complex chronic are management services would need to obtain a copy of the assessment and care plan developed between the beneficiary and the practitioner who furnished the AWV prior to billing for complex chronic care management services.

Because a beneficiary is precluded from receiving an AWV within 12 months after the effective date of his or her first Medicare Part B coverage period, for that time period we propose the Initial Preventive Physical Examination (G0402) can substitute for the AWV to allow a beneficiary to receive complex chronic care management services.

6. Complex Chronic Care Management Services Furnished Incident to a Physician's Service under General Physician Supervision

We outline the requirements for billing for services furnished in the office, but not personally and directly performed by the physician or qualified nonphysician practitioner

(referred to as a "practitioner" in the following discussion), under our "incident to" requirements in regulations and in section 60, Chapter 12, of Medicare Benefit Policy Manual (100-02). One key requirement of "incident to" services is that a practitioner (as thet term is used in section II.H of this proposed rule directly supervise the provision of services by auxiliary personnel by being in the office suite and able to furnish assistance and direction throughout the provision of the service. Section 60.4 of the Manual specifically discusses the one exception that allows for general supervision of "incident to" services furnished to homebound patients in medically underserved areas. Under that provision, we identify more specific requirements for the personnel that can furnish "incident to" services under general supervision. For example, we require that the personnel must be employed by, employed by the same entity, or an independent contractor of, the practitioner billing the "incident to" services.

One of the required capabilities for a physician to furnish complex chronic care management services is 24-hour-a-day, 7-day-a-week beneficiary access to the practice to address the patient's complex chronic care needs. We would expect that the patient would be provided with a means to make timely contact with health care providers in the practice to address those needs regardless of the time of day or day of the week. If the patient has a complex chronic care need outside of the practice's normal business hours, the patient's initial contact with the practice for that need could be with clinical staff employed by the practice, (for example, a nurse or other appropriate auxiliary personnel) and not necessarily with a physician or practitioner. Those services would be furnished incident to the services of the billing practitioner.

We have also proposed to require that at least one hour of complex chronic care services be furnished to a patient during the 90-day period in order for the practitioner to

be able to bill separately for the chronic care services. The time, if not personally performed by the physician, must be directed by the physician. We are proposing that the time spent by a clinical staff person furnishing aspects of complex chronic care services outside of the practice's normal business hours during which there is no direct physician supervision would count towards the one hour requirement even though the services do not meet the direct supervision requirement for "incident to" services.

We believe that the additional requirements we impose for personnel under the exception for general supervision for homebound patients in medically underserved areas should apply in these circumstances where we are allowing a practitioner to bill Medicare for complex chronic care management services furnished under their general supervision and incident to their professional services. In both of these unusual cases, these requirements help to ensure that appropriate services are being furnished by appropriate personnel in the absence of the direct supervision. Specifically, we propose that if a practice meets all the conditions required to bill separately for complex chronic care management services, the time spent by a clinical staff employee furnishing aspects of these services to address a patient's complex chronic care need outside of the practice's normal business hours is counted towards the one hour requirement when at a minimum the following conditions are met:

- The clinical staff person is directly employed by the physician and the employed clinical staff person meets any relevant state requirements.

- The services of the clinical staff person are an integral part of the physician's complex chronic care management services to the patient (the patient must be one the physician is treating and for which informed consent is in effect), and are performed under the general supervision of the physician. General supervision means that the

physician need not be physically present when the services are performed; however, the services must be performed under the physician's overall supervision and control. Contact is maintained between the clinical staff person and the physician (for example, the employed clinical staff person contacts the physician directly if warranted and the physician retains professional responsibility for the service.)

- The services of the employed clinical staff person meet all other "incident to" requirements with the exception of direct supervision.

7. Complex Chronic Care Management Services and the Primary Care Incentive Payment Program (PCIP)

Under section 1833(x) of the Act, the PCIP provides a 10 percent incentive payment for primary care services within a specific range of E/M services when furnished by a primary care practitioner. Specific physician specialties and qualified nonphysician practitioners can qualify as primary care practitioners if 60 percent of their PFS allowed charges are primary care services. As we explained in the CY 2011 PFS final rule (75 FR 73435 through 73436), we do not believe the statute authorizes us to add codes (additional services) to the definition of primary care services. However, to avoid inadvertently disqualifying community primary care physicians who follow their patients into the hospital setting, we finalized a policy to remove allowed charges for certain E/M services furnished to hospital inpatients and outpatients from the total allowed charges in the PCIP primary care percentage calculation. In the CY 2013 final rule (77 FR 68993), we adopted a policy that the TCM code should be treated in the same manner as those services for the purposes of PCIP because post-discharge TCM services are a complement in the community setting to the hospital-based discharge day management services already excluded from the PCIP denominator. Similar to the codes

already excluded from the PCIP denominator, we expressed concern that inclusion of the TCM code in the denominator of the primary care percentage calculation could produce unwarranted bias against ‘‘true primary care practitioners’’ who are involved in furnishing post-discharge care to their patients.

Complex chronic care management services are also similar to the services that we have already excluded from the from the PCIP denominator. For example, complex chronic care management includes management of care transitions within health care settings including referrals to other clinicians, visits following a patient visit to an emergency department, and visits following discharges from hospitals and skilled nursing facilities. Therefore, while physicians and qualified nonphysician practitioners who furnish complex chronic care management services would not receive an additional incentive payment under the PCIP for the service itself (because it is not considered a ‘‘primary care service’’ for purposes of the PCIP), we propose that the allowed charges for complex chronic care management services would not be included in the denominator when calculating a physician’s or practitioner’s percent of allowed charges that were primary care services for purposes of the PCIP.

8. Summary

In summary, we are proposing for CY 2015 to establish a separate payment under the PFS for complex chronic care management services furnished to patients with multiple complex chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, as discussed in section II.I.1. We are proposing the scope of these complex chronic care management services discussed in section II.I.2; the billing requirements for these services as discussed in section II.I.4; the

AWV requirement as discussed in section II.I.5; the general supervision requirements as discussed in section II.I.6, and the PCIP denominator exclusion as discussed in section II.I.7.

We are seeking input from the public on, the standards required to provide these services as discussed in section II.I.3, and the work and PE that would be associated with these services.

We are making this proposal to establish codes and separate payment for complex chronic care management services in the context of the broader multi-year strategy to appropriately recognize and value primary care and care management services. Should this proposal become final policy, it may be a short-term payment strategy that would be modified and/or revised to be consistent with broader primary care, and care management and coordination services if the agency decides to pursue payment for a broader set of management and coordination services in future rulemaking. We also note that as we consider a final policy, we would assess the potential impact of the policy on our current programs and demonstrations designed to improve payment for, and encourage long-term investment in, care management services. Likewise, to assure that there are not duplicate payments for delivery of care management services, we would consider whether such payments are appropriate for providers participating in other programs and demonstrations.

J. Chiropractors Billing for Evaluation & Management Services

Section 1861(r)(5) of the Act includes chiropractors in its definition of "physician" with language limiting chiropractors to "treatment by means of manual manipulation of the spine (to correct a subluxation)." Specifically, the Act says:

The term "physician," when used in connection with the performance of any