FAQ: Chronic Care Management
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Table of Contents

1. Overview 2

What is CCM? 2
Who are Eligible Patients? 2
What are CCM services? 2
Initiating CCM Services? 2
Payment 3
Key Changes in 2017 3
Where can CCM Services be provided? 3
Who are Qualified Healthcare Providers (QHPs)? 4
What is the Medicare reimbursement rate for CCM? 4

2. How can pharmacists engage in CCM services? 4

3. Core requirements needed to bill for CCM 5

4. How to Implement CCM Services? 6

5. What are the required elements of documentation? 7

6. Opportunities and Challenges related to CCM: 9

Reimbursement Opportunities 9
Potential Challenges 10

7. CCM Service Examples by ASHP Pharmacists' *10*
8. Appendix: Definition of Complex CCM **12**

1. Overview

What is CCM?

Chronic Care Management (CCM) is defined as the non-visit-based payment for chronic care management services per month provided to Medicare Fee-For-Service Part B recipients who have multiple significant chronic conditions that are expected to last at least 12 months, or until the death of the patient.

Who are Eligible Patients?

Medicare beneficiaries who reside in the community setting with two or more chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline are eligible for the CCM service. Medicare beneficiaries residing in long-term care facilities or skilled nursing facilities are not eligible for CCM services.

(Medicare does not have an explicit list of conditions that qualify, however, some examples of chronic conditions are highlighted by CMS in Section 4: How to implement CCM Services).

What are CCM services?

CCM services include interactions with patients by telephone or secure email to review medical records and test results or provide self-management education and support that precludes medication management. CCM services also include interactions with the patients' other healthcare providers to exchange health information, as well as management of care transitions and coordination of home- and community-based services (see section 3D). CCM requires that patients have 24/7 access to physicians or qualified HCPs or clinical staff to address urgent needs.

Initiating CCM Services?

For new patients or patients not seen within a year prior to the start of CCM services, CCM must be initiated by a qualified provider during a "comprehensive" Evaluation/Management (E/M) office visit, Annual Wellness Visit (AWV) or Initial Preventive Physical Exam (IPPE). This initial f*ace-to-face* visit is not part of the CCM service and can be billed separately. The provider must discuss CCM with the patient at this visit and explain the cost to the beneficiary (Part B deductible, 20% copay, and monthly cost-sharing if applicable) and obtain verbal or written consent of the patient. Established patients seen within the past year can have CCM initiated without the need for a separate in-office visit.

Payment

Center for Medicare and Medicaid Services (CMS) began covering for non-face-to-face CCM services starting in 2015 under a single CPT code 99490 (for at least 20 minutes of allotted time for non-face-to-face care management services in a given month).

Key Changes in 2017

- CMS added additional coverage for *complex* CCM (60 minutes or more) using CPT 99487 which takes into account time spent and complexity of patient care. In addition, CMS will pay for a CCM add-on CPT 99489, with *complex* CCM (CPT 99487), for each 30-minute increment that goes beyond the initial 60 minutes of non-face-to-face care management services in a given month. Neither CPT 99487 nor CPT 99489 may be billed in the same month as CPT 99490.

CPT code	Minimum Time Required Per Month
99490	20 minutes
99487	60 minutes
99489	After 60 minutes (using CPT 99487), for each additional 30 minutes

- CMS will now reimburse for care plan development under a new code, G0506 only if the time and effort involved in care plan development is beyond the usual time and effort. This add-on code is to be listed separately in addition to the CCM-initiating visit and billed separately from monthly care management services. There is no specific time allotment associated with G0506. (Note: RHCs and FQHCs cannot bill for G0506.)

- Prior to 2017, the CCM beneficiary had to provide a written consent form. Now, a signed consent is no longer required as a condition of payment. Instead, a verbal consent is acceptable and the practitioner must document in the medical record that the required information was provided and that the beneficiary accepted the services.

- As of January 2018, FQHCs and RHCs are acceptable locations to bill for CCM services. However, these facilities will be paid the national average non-facility rate.

Where can CCM Services be provided?

Physicians' offices, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs).

Who are Qualified Healthcare Providers (QHPs)?

The following healthcare professionals can bill for CCM services: Physicians, Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, and Certified Nurse Midwives. Only one practitioner per patient may be paid for CCM services for a given calendar month.

CCM services may also be furnished by clinical staff that meet Medicare's "incident to" rules. Licensed clinical staff include the following: clinical pharmacists, RN, LSCSW, LPN, MAs or CMAs. The time spent by clinical staff members furnishing CCM services directed by a QHP counts towards the time thresholds. Non-clinical staff time cannot be counted.

What is the Medicare reimbursement rate for CCM?

Exact payment information can be found at CMS Physician Fee Schedule Look-up Tool and is dependent upon geography and if the billing location is a facility or non-facility setting.

Exclusions:

CCM CPT Code **CANNOT** be billed during the same service period as:

- Transitional Care Management (TCM) - CPT 99495 and 99496.
- Home Healthcare Supervision - HCPCS G0181
- Hospice Care Supervision - HCPCS G9182
- Certain End-Stage Renal Disease services - CPT 90951-90970
- Patient Monitoring Services – CPT 99090, 99091

Be sure to regularly review the MAC* regulations in your region as each MAC has the discretion to interpret the regulations and provide additional requirements.

*Note: Medicare Administrative Contractors (MACs) are third parties which have responsibility for processing Medicare Part A and B and durable medical equipment claims for a specific geographic region. This entity administers the operational contract between Medicare and healthcare providers.

Resources and References:

1) CMS CCM Payment FAQ
2) Centers for Medicare and Medicaid Services, Medicare Learning Network. Chronic Care Management Services. December 2016.
3) Description on MAC
4) Chronic Care Management Services Changes for 2017

2. How can pharmacists engage in CCM services?

Under CMS guidelines, pharmacists are recognized as "clinical staff" who can provide CCM services within their scope of practice under general supervision of a QHP. The pharmacist can be directly employed, or under contract (independent contractor) or leased employment of the qualified billing healthcare professional that is providing CCM services. The QHP must be able to provide general supervision of CCM services provided by a pharmacist but is not required to be physically present or co-located (must be available by phone). Under CCM guidelines, a pharmacist cannot consent a patient, develop a comprehensive care plan, or bill for CCM services. As a member of the care team, a

pharmacist may perform the following CCM services: collect structured data, maintain/inform updates for the care plan, manage care, provide a 24/7 access to care, document CCM services, and provide support services to facilitate CCM.

Resources and References:

1) CMS Chronic Care Management. Accessed February 7, 2018.
2) Chronic Care Management Services Changes for 2017.
3) Chronic Care Management Services
4) Frequently Asked Questions about Physician Billing for Chronic Care Management Services.

3. Core requirements needed to bill for CCM

A. *Have the following five specified capabilities*:

1. Utilize a CCM certified Electronic Health Record (EHR) to meet core technology capabilities (i.e. use a structured format to record demographics, problems, medications, medication allergies, and creation of a summary care record).
2. Maintain an electronic care plan
3. Ensure beneficiary 24-hour-a-day, 7-day-a-week access to care
4. Facilitate transitions of care
5. Coordinate care

B. *Secure the eligible beneficiary's consent to CCM and discuss required information*:

- Only one CCM provider can furnish and be paid for CCM services during a calendar month
- Patient has the right to revoke consent to receive CCM from a specific provider and stop services at any-time (effective at the end of the calendar month).
- Document that required information was reviewed and patient's consent or decline of CCM services is recorded in the EHR

C. *Provide a Comprehensive Care Plan:* CMS has identified the following as items typically included in a care plan (which may be implemented, revised, or monitored by pharmacist):

- Problem list; expected outcome and prognosis; measurable treatment goals
- Symptom management and planned interventions (including all recommended preventive care services)
- Planned interventions and identification of individuals responsible for each intervention
- Medication management (including list of current medications and allergies; reconciliation with review of adherence and potential interactions; oversight of patient self-management)
- Community/social services to be accessed
- Schedule for periodic reviews and revision of the care plan

D. Types of *CCM service activities* that count towards the 20-minute time requirement:

- Perform medication reconciliation, review medications, and help the beneficiary to manage their own medications.
- Create a structured clinical summary of the beneficiary's demographics, health and medical information using a certified EHR.
- Ensure that beneficiary receives all recommended preventive care services
- Monitor the beneficiary's condition (physical, mental, social) and share plan as appropriate with other health-care professionals.

- Provide education and address opportunities for the patient/caregiver to communicate about the patient's care (by telephone, secure messaging, and/or secure electronic patient portal)
- Follow-up with beneficiary after Emergency Room visits, hospital discharges, or other health care facilities
- Coordinate transitions of care or with home and community based clinical service providers
- Ensure that complex CCM services (CPT 99487 and 99489) require and include medical decision-making of moderate to high complexity (by the CCM provider). (See Appendix for definition of Complex CCM). Pharmacists can assist in complex CCM services with CCM provider, but pharmacists cannot be the sole provider of these services.
- Provide the beneficiary with a written or electronic copy of the care plan and document that you provided the information in the beneficiary's electronic medical record.
- Documentation of patient interactions.

Resources and References:

1) CMS CCM Services Guide 2016
2) American Osteopathic Association. Chronic Care Management FAQ

4. How to Implement CCM Services?

A. Meet Standards of *CCM Service Elements* (see above)
B. Create Educational Materials for CCM Services:
   - Provide patient-specific handouts that highlights the benefits of CCM services and costs to the patient (recommend that CCM providers furnish handouts to eligible patients).
   - Provide in-service education to providers and staff on the benefits, required CCM information disclosure, patient consent of CCM services, and referral process
C. Identify *CCM Eligible Patients*: (review Section 1 for eligible patients)
   - Examples of chronic conditions highlighted by CMS include, but are not limited to:

Alzheimer's disease and related dementia	Arthritis (osteoarthritis and rheumatoid)	Asthma
Atrial fibrillation	Autism spectrum disorders	Cancer
Cardiovascular disease	Chronic Obstructive Pulmonary Disease	Depression
Diabetes	Hypertension	HIV/AIDS

D. *Collaborate with CCM Eligible Providers* (review section 1 for Qualified Healthcare Providers).
E. *CCM Eligible Provider to Obtain Patient Consent with Patient:*
A Medicare Part B Provider must document that an annual wellness visit, initial preventive physical exam, or a comprehensive management and evaluation visit was furnished prior to initiating CCM services (see section 1 – Initiating CCM Services). These visits are important to review required CCM information and obtain consent (written or verbal) from the patient to enroll in CCM services and document consent within EHR. Additionally, documentation is required if the patient declines CCM

services or indicates that he or she is participating in CCM services elsewhere. Once enrolled, pharmacist may provide non-face-to-face telephonic or other support CCM services in which patient contact is not directly made (such as refills, prior authorization, coordination of care, etc).

F. *Partner with Other Clinical Staff Already Providing CCM Services*
Often there are others care team members in an organization already engaged in providing CCM services. This often includes nurse care management staff. Find out who else in the organization is already doing this work and what systems have already been developed. Many of the processes already in place may be utilized by pharmacists in providing CCM services with the need for little to no customization. Work together to develop processes that maximize the delivery of CCM services to the patient while minimizing duplication.

G. *Establish a Referral Process for the CCM Eligible Provider:*
- Leverage EHR
    a. Electronic/telemedicine consult/referral to clinical pharmacist for CCM Services
    b. Staff message referral to clinical pharmacist "pool" for CCM services
- Documentation in EHR by CCM Eligible Provider followed by telephonic communication to notify pharmacist of referral for CCM Services

Note: It is important to collaborate with facility's informatics team to identify eligible CCM patients and then approach CCM Eligible Provider to increase patient volume

H. Ensure *documentation in EHR is appropriate for level of care and the time spent on encounter* (review Section 5 under documentation): A written or electronic copy of the care plan must be provided to the patient and/or caregiver.

I. *Communication of plan to CCM furnishing provider*:
- Route clinical documentation (within EHR), fax, or secure message CCM referring provider (to meet general supervision requirement)

Resources and References:

1) American College of Physicians. Chronic Care Management Toolkit: What Practices Need to Do to Implement and Bill CCM Codes. 2015.
2) American Osteopathic Association. Chronic Care Management FAQ
3) Noridian Healthcare Solutions. Evaluation and Management Questions and Answers
4) CMS CCM Services Guide
5) Pharmacy Times CCM: The New Player
6) NASPA CCM
7) CMS CCM Tool Kit
8) West Healthcare Step-by-Step Guide To Implementing CCM for CPT 99490
9) Virginia Pharmacists Association Guide to CCM Services

5. What are the required elements of documentation?

- Documentation of the discussion with the patient that explains and offers the CCM service, with notation of the patient's consent to accept or refusal of the service, is required. One must also

include authorization for the electronic communication of medical information with other treating providers.

- For CMS auditing purposes, we strongly recommend documentation of time spent within the EHR. Note: The monthly clinical staff time requirement can include professional communication regarding the patient's care coordination between healthcare providers (electronic or telephonic) who are providing care for the patient.

- *Structured recording of patient health is required* using certified EHR technology to record the patient's demographics, problems, medications, medication allergies, and creating structured clinical summary records.

  EHR requirements: For some elements of CCM (i.e. structured recording of patient health and documentation of provision of care plan to patient), CMS requires the use of a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year (referred to as "CCM certified technology"). For more information, visit the CMS website.

  For other elements of CCM services (such as the clinical summaries), CMS does not require the use of certified EHR technology at this time, allowing for broader electronic capabilities.

- The "Comprehensive Care Plan" is a "person-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources." A copy of the care plan must be provided to the patient/caregiver. Additionally, it should be readily accessible and available to other providers involved in the care of the patient.

- Documentation of the provision of a care plan to the patient and ensure the electronic availability of the care plan to anyone within the practice providing CCM. A comprehensive care plan includes, but is not limited to, the following elements:

Problem list	Expected outcome and prognosis	Measurable treatment goals
Symptom management	Planned interventions and identification of the individuals responsible for each intervention (i.e. pharmacist)	Medication management
Community/social services ordered	Description of how services of agencies outside the practice will be directed/coordinated	Schedule for periodic review and, when applicable, revision of the plan

All communication to and from home and community-based providers regarding the patient's psychosocial needs and functional deficits must be documented in the medical record.

Resources and References:

1) Institute for Healthcare Improvement (IHI) My Shared Care Plan
2) CCM Services
3) PFS and OPPS Frequently Asked Questions on CCM
4) Chronic Conditions
5) American College of Physicians Chronic Care Management Tool Kit

6. Opportunities and Challenges related to CCM:

Reimbursement Opportunities

- The 2018 average reimbursement per patient per month for CCM CPT codes are listed below, and varies slightly based on geographic location:

CPT Code	Approximate reimbursement
99490	$42.84
99487	$94.68
99489	$47.16
G0506	$64.44
E/M Initiating Visit charge	$44-209

Resource: Physician Fee Schedule Search here for your geographic region

- Patient co-pays are charged monthly. This can benefit the patient if CCM is able to take the place of some office visits, and improve patient convenience as the service is provided telephonically.
- Proactive scheduling of CCM phone visits at an established date/time slot (30 minute phone call appointment, perhaps) would likely result in an opportunity to bill for the larger reimbursable amount, as the phone visit would be prepared for (multiple items covered such as medication reconciliation, insulin titration, influenza status, annual eye exam, etc.)
- Co-pays exceeding primary coverage may be picked up by dual eligible or secondary co-insurance, if applicable. To determine patient cost, CCM coverage by your state's Medicaid or Medi-Gap insurer should be investigated.
- Much of the work entailed in CCM represents work already being done by clinicians that is not currently being reimbursed. As a result, CCM may represent an opportunity to capture reimbursement for services already being provided. Work must simply be organized and documented in a different manner to qualify for CCM reimbursement.
- Find an example of reimbursement here: Providing and Billing Medicare for Chronic Care Management

Potential Challenges

- Patients must opt-in for CCM services. CMS requires that the patient be informed by the provider of the availability of CCM services and obtain written consent to participate. This may require health care providers to actively recruit patients to the services which may generate resistance from staff if it results in disruptions in workflow.
- The utility and value of CCM may be difficult to communicate to patients as many of the services included in CCM are already currently being provided at no cost.
- Patients are required to pay a monthly co-pay if no secondary coverage exists.
- Ensuring all of the services and documentation requirements for CCM are met may be time-consuming. Efforts will need to be made by a practice to automate and streamline the process in order to make documentation efficient (especially if multiple and different clinical staff members are providing services throughout the month).
- One may consider deploying medical assistants, pharmacy residents or technicians to assist in the phone call effort for CCM billing. Pharmacy students may not assist in provision of these services as they are not considered clinical staff and would not meet the incident to requirement rules. Practices wishing to deploy CCM should refer to the CPT Coding Handbook and state scope of practice regulations for decision making around which personnel should or should not be including in CCM services.
- The organization must have the ability to conduct CCM services within 30-day payment period.
- There are some codes that cannot be billed in the same month as CCM (see #1 for more details)
- State scope of practice and collaborative practice agreement definitions will determine CCM service provision by pharmacists. Please consult state laws as applicable.

*In some specific scenarios, CCM may be billed in the same month as TCM. See resource below for further information.

Resources and References:

1) CY 2017 Physician Fee Schedule Final Rule. Accessed February 23, 2018.
2) PFS Care Management Page. Accessed February 23, 2018.
3) CCM Services Fact Sheet. Accessed February 23, 2018.
4) Changes to CCM Services for 2017 Fact Sheet. Accessed February 23, 2018.

7. CCM Service Examples by ASHP Pharmacists'

ASHP pharmacists attending a fall 2017 CCM Continuing Education webinar polled that only 18% are currently utilizing the CCM billing codes.

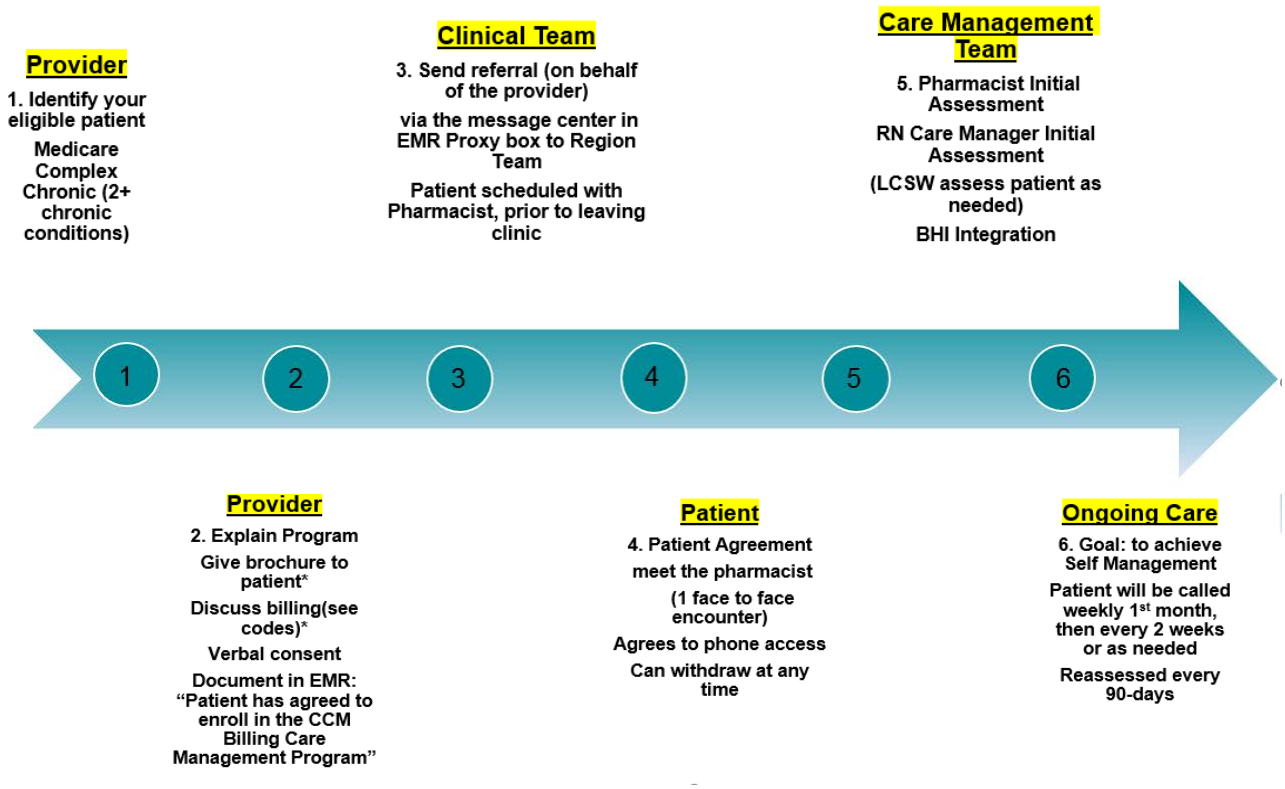
Due to the low adoption of these codes, legislation has tasked the Federal Office of Rural Health Policy (FORHP) at Health Resources & Services Administration (HRSA) and the CMS Office of Minority Health (OMH) to provide an outreach and education campaign to inform healthcare providers and consumers of CCM service benefits. These Connected Care resources are designed to encourage participation for racial and ethnic minority and rural populations.

Successful adoption of pharmacist CCM Billing examples:

1. **Atrium HealthCare** (formerly Carolinas HealthCare System) utilizes CCM billing for Population Health management. Medicare patients with uncontrolled chronic conditions and frequent admissions/utilizations are candidates for CCM billing. The time spent on the telephone by the pharmacist and nurse care manager counts towards the monthly billing time calculation.

These 8 regional Care teams consist of an Amb-Care pharmacist (CPP in state of NC), nurse care navigator, and health advocate/social worker. The team utilizes the electronic health record to document a care plan, pharmacist notes, updated med lists, time for communication events and other pharmacist functions.

Atrium CCM Referral Process:



In review of CCM billing at Atrium Health, 25% of CCM billing patients qualified for complex CCM billing (or higher charges). Physician champions have been identified and increased referrals for the billing service. The Care Team outcomes include a reduction in admissions and associated costs for patients with heart disease (25%), diabetes (45%), and COPD (45%).

2. **UNC Health Care** utilizes CCM Billing for population health management. A team service is utilized and those making the initial phone calls consist of registered nurses, licensed clinical social workers, registered dieticians, and care assistants. These disciplines are precepted and the calls reviewed by embedded APPs (Advanced Practice Providers). APPs include clinical pharmacists, physician assistants, and nurse practitioners. The enrolling provider then signs the notes and the CCM charges

are put in the patient's enrolling provider's name at the end of the month. UNC tracks process measure outcomes such as call volume and total time spent, etc. Complex CCM Billing is utilized when the requirements are met.

Appendix:
Definition of Complex Chronic Management CCM

For Complex Chronic Care Management (CCM) an additional requirement above standard CCM is Medical Decision Making (MDM) of Moderate to High Complexity. The complexity of MDM is determined by three separate subcategories: Number of Diagnoses/Management Options; Amount and/or Complexity of Data Reviewed; and Level of Risk. The amount of work within each subcategory is added up to determine what level of MDM was made (a process called leveling).

The first subcategory, Number of Diagnoses/Management Options (Table 1), quantifies the number and severity of diagnoses being managed by the healthcare provider. More points are awarded for new diagnoses being worked-up or established diagnoses that have worsened. Each diagnosis is required to have a status qualifier such as worsening, stable, improved, acute, or chronic. As pharmacists are not formally trained in physical examination and diagnostic work-up it is likely prudent for status qualifiers to be restricted to acute or chronic. To determine the level of this subcategory the number of diagnoses being actively managed should be totaled by adding the points for each level (Table 1). Only those diagnoses being actively managed or having a direct influence on the disease state(s) being managed should be included. For example, if a patient with a history of atrial fibrillation, gastrointestinal (GI) bleeding, and hyperlipidemia (HLD) is being seen for follow-up for anticoagulation a history of GI bleeding may be an included diagnosis as it may influence treatment decisions related to the patient's anticoagulation therapy. However, HLD, if not directly addressed, should not be listed as a diagnosis for the encounter as it was not addressed or directly considered in the decision making of the patient's anticoagulation. For Moderate Complexity MDM at least 3 chronic stable diagnoses would need to be managed and for High Complexity at least 4 chronic stable diagnoses would be needed. If physicians are involved, which is required for Complex CCM, the physician may make the determination on the status of the disease state and if it is worsening a fewer number of disease states will be required.

The second subcategory, Amount and/or Complexity of Data Reviewed (Table 3), quantifies the amount and type of data reviewed and or gathered by a healthcare provider. It is important to note that regardless of the amount of data reviewed within a given category only 1 point is awarded (e.g., if a complete blood count [CBC], basic metabolic panel [BMP], and liver function test [LFT] are reviewed only 1 point is awarded). While categories exist for review of radiology tests, medicine tests (e.g. heart catheterization), and independent visualization of an image, tracing, or specimen, these are likely not applicable to most pharmacists. While some pharmacists have the skills and experience to accurately read and interpret many of these images or tests, as these skills are not part of our training or Scope of

Practice our profession will likely have a difficult time substantiating a clear ability to perform these functions.

The last subcategory, Risk, has three different categories to make the determination on the level of Risk. The first category, Presenting Problem(s) (Table 4), awards higher levels of risk for problems with more serious consequences, worse disease status, or more problems being managed. The second category, Diagnostic Procedure(s) Ordered, quantifies risk by how much work-up, or the type of work-up, required to manage a given disease state. More work-up and more extensive work-up, such as surgery, indicates a higher level of risk. The last category is Management Options Selected; higher risk coincides with treatment options that are more invasive or carry higher risk. To determine the Level of Risk any of the 3 categories may be utilized and the highest risk from an individual category may be used to make the final determination. For example, if one stable chronic disease state is being managed (Presenting Problem, Low Risk), a BMP is ordered (Diagnostic Procedure Ordered, Minimal Risk), and a prescription drug is continued (Management Options, Moderate Risk) then the Level of Risk would be classified as Moderate as the highest risk comes from the prescription drug management within the Management Options category.

For pharmacists, with regards to Presenting Problems, we are most likely to utilize the number of problems to determine the level of risk for this category as we likely cannot make accurate assessments of the disease status (e.g. worsening) based on our training and State Scope of Practice (although in many circumstances it will be clear whether or not the disease is worsening or not); this will also be related to the overall subcategory of Number of Diagnoses/Management Options. Further, since pharmacists will be working with established patients for established problems, as outlined in a patient's Comprehensive Care Plan, the list of possible disease states will already be defined. For Diagnostic Procedure(s) Ordered pharmacists are certainly able to order laboratory tests in most settings (Minimal Risk) but it would be rare to order more extensive or invasive tests such as endoscopies or imaging studies. Lastly, for Management Options, pharmacists are likely to be involved with Prescription Drug Management. To meet this requirement the actual prescription of a drug is not required; having a patient continue prescription drug therapy or changing the dose of a current prescription drug satisfies this criteria.

To determine the overall level of MDM the totals of all three subcategories (Diagnoses, Data Amount/Complexity, and Risk) are added up and compared (Table 4). Only two of three subcategories are required in order to determine the level, but both of the subcategories used have to meet a given level of MDM to qualify. For example, if two stable chronic diseases are managed (Number of Diagnoses = 2 points), a BMP is reviewed (Amount of Data = 1 point), and a patient is advised to continue prescription drug therapy (Management Options Selected = Moderate Risk [3 points]) then the Level of MDM overall would be Low. To select a level of MDM two categories have to meet the selected Level; as the Amount of Data only totals one point this subcategory is not used. Although the level of Risk is

Moderate this is the only subcategory that meets that Level so it cannot be selected as the final Level (as two subcategories have to meet the Level of MDM selected). Both the Risk and the Number of Diagnoses meet the level of MDM of Low so it would be the final level of MDM that is selected.

Table 1	
Number of Diagnoses/Management Options	**Points**
Self-limited or minor (stable, improved, or worsening) (Max 2 points)	1
Established problem, stable or improved	2
Established problem, worsening	3
New problem, no additional work-up (Max 3 points)	3
New problem, additional work-up	4
Total	

Table 2	
Amount and/or Complexity of Data Reviewed	**Points**
Lab(s) ordered and/or reviewed (regardless of #)	1
Radiology test(s) ordered and/or reviewed (regardless of #)	1
Medicine section test(s) ordered and/or reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old record and/or obtain history from someone other than patient	1
Review and summary of old records and/or obtaining history from someone other than patient and/or discussion with other healthcare provider	2
Independent visualization of an image, tracing, or specimen	2
Total	

Table 3

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options
Minimal	-One self-limited or minor problem (ex: cold, tinea corporis)	-Lab tests requiring venipuncture -Chest x-rays -EKG/EEG -Urinalysis	-Rest -Superficial dressings
Low	-Two or more self-limited minor problems -One stable chronic illness	-Physiologic tests not under stress (ex: PFTs) -Clinical laboratory tests requiring arterial puncture -Skin biopsy	-OTC drugs -Minor surgery with no risk factors -PT -OT -IV fluids without additives
Moderate	-One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment -Two or more stable chronic illnesses	-Physiologic tests under stress -Diagnostic endoscopies with no risk factors	-MInor surgery with risk factors -Prescription drug management -IV fluids with additives
High	-One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment -Acute or chronic illnesses or injuries that post a threat to life or bodily function -Abrupt change in neurologic status (ex: TIA, seizure, weakness, sensory loss)	-CV imaging with contrast with risk factors -Cardiac electrophysiological tests -Diagnostic endoscopies with risk factors	-Emergency major surgery -Parenteral controlled substances -Drug therapy requiring intensive monitoring for toxicity -Decision to not resuscitate or to de-escalate care due to prognosis

Note: not complete list; adjusted to align with Ambulatory Care Pharmacists and Chronic Care Management

Resources and References:
1) CMS Medical Record Documentation Evaluation and Management Services requirements. Accessed May 11, 2018.

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