CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10718	**Date: April 26, 2021**
	Change Request 12247

SUBJECT: Cognitive Assessment & Care Plan Services

I. SUMMARY OF CHANGES: Cognitive Assessment & Care Plan Services Requirements

Section 116 of the Consolidated Appropriations Act, 2020 (P.L. 116-260) requires CMS to conduct provider outreach and education for the Medicare-covered Cognitive Assessment & Care Plan Services (CPT code 99483) to increase awareness of this service and its eligibility requirements.

This Change Request (CR) outlines the requirements for provider outreach and education, including a direct mailing, from the Medicare Administrative Contractors (MACs) to eligible clinicians, including: physicians, nurse practitioners, clinical nurse specialists, and physician assistants; about Medicare-covered Cognitive Assessment & Care Plan Services. The education and mailing will raise general awareness of the benefit and provide information on eligibility and billing.

EFFECTIVE DATE: May 26, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 26, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: Section 116 of the Consolidated Appropriations Act, 2020 (P.L. 116-260) requires CMS to conduct a one-time provider outreach and education campaign for the Medicare-covered Cognitive Assessment & Care Plan Services (Current Procedural Terminology (CPT) code 99483) to increase awareness of this service and its eligibility requirements.

If a physician, or other clinician eligible to bill Evaluation and Management services, finds a patient shows signs of cognitive impairment during a routine visit, Medicare covers a separate visit to more thoroughly assess the patient's cognitive function and develop a care plan. The cognitive assessment includes a detailed history and patient exam. There must be an independent historian for assessments and corresponding care plans provided under CPT code 99483. Clinicians will use information gathered during the cognitive assessment to help create a written care plan. Effective January 1, 2021, Medicare increased payment for these services, added these services to the definition of primary care services in the Medicare Shared Savings Program, and permanently allowed these services to be provided via telehealth.

CMS is working on a comprehensive campaign about this service including a hard copy fact sheet for the MAC direct mailing, webpage, video, and messaging in the Medicare Learning Network (MLN) Connects newsletter. This Change Request (CR) details the MACs' outreach and education responsibilities related to this campaign.

B. Policy: Section 116 of the Consolidated Appropriations Act 2021

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12247.1	MACs shall identify all active physicians (MD and DO), nurse practitioners, clincal nurse specialists, and physician assistants within their jurisdiction and determine the best mailing address on file in accordance with Internet Only Manual Publication		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	(Pub.)100-09, Chapter 6, Section 20.4.2.									
12247.2	In accordance with the instructions in IOM Pub.100-09, Chapter 6, Section 20.4.2, MACs shall send a direct mail package (including a letter and Fact Sheet) to active Medicare providers (identified in business requirement 12247.1) using the best mailing address on file, taking the following actions: 1. Include only the letter and Fact Sheet in the direct mail package. Note: CMS will send the letter and Fact Sheet via the Provider Customer Service Program (PCSP) Contractor User Group (PCUG) electronic mailing list once both are available. For planning purposes, MACs shall assume the letter and Fact Sheet will be no longer than six pages (three page duplex document). 2. Duplicate all required content in hard copy using black ink, not altering the letter or Fact Sheet. 3. Complete the direct mailing no later than 10 business days after receipt of the letter and Fact Sheet, via the PCUG electronic mailing list. 5. Send a single package to groups.		X							
12247.3	In accordance with IOM Pub. 100-09, Chapter 6, Section 80.2.3.12, MACs shall report information about this direct mailing into the Special Initiatives section of the Provider Customer Service Program Contractor Information Database (PCID) by the 10th of the month following the month of the actual completion date.		X							
12247.4	MACs shall add a link on their provider education webpages to the Cognitive Assessment & Care Plan Services page on cms.gov. CMS will send the link to the webpage through the PCUG listserv. MACs shall		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	add the link within two business days after receipt.									
12247.5	MACs shall use the information posted on the Cognitive Assessment & Care Plan Services page to conduct provider education for the provider types identified in business requirement 12247.1.		X							
12247.5.1	MACs shall add this education to already existing educational offerings or they should create a stand-alone educational event.		X							
12247.6	MACs shall report all provider outreach and education done on Cognitive Assessment & Care Plan Services in the Special Initiatives module in PCID no later than the 10th of the month after the education occurred. MACs shall report on education conducted through September 30, 2021.		X							
12247.7	MACs shall use the information posted on the CMS Cognitive Assessment & Care Plan Services page to respond to provider inquiries.		X							
12247.8	MACs shall add the following subcategory under Temporary Issues to their inquiry tracking systems, customer service representative training materials and related resources within seven (7) business days of issuance. **Temprorary Issues/Cognitive Assessment & Care Plan Services (CACP)** Contact is seeking information about the Cognitive Assessessment & Care Plan Services (CPT code 99483). Provider inquiries may include questions about eligibility requirements, coverage-including Medicare Shared Savings program and telehealth, information package from MACs, provider outreach and education initiatives, reference materials, claim documentation, billing and payment matters. Contacts may also ask about requirements for the written care plan, the independent historian for asessments and corresponding care plans, and other related aspects of		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the services and CMS outreach initiative.									
12247.9	MACs shall track all telephone and written inquiries received within 7 business days of issuance and shall report these inquiries in PCID the following month. Tracking and reporting shall continue until notified via the PCUG listserv.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Nicole Cooney, nicole.cooney@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0