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The Business Case for Chronic Care Management in the Ambulatory Care Practice

Debbie Rozanski, CMC
Practice Transformation Coach

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Objectives

- >> Describe Chronic Care Management (CCM) services and its impact in the ambulatory care practice
- >> Learn strategies for proper billing and coding CCM services
- >> Learn how to identify your patient population for CCM services
- >> Understand the opportunity for increased revenue

What is Chronic Care Management?

>> Services provided when medical and/or psychosocial needs of the patient requires establishing, implementing, revising, documenting or monitoring a plan of care

CCM Service Requirements

>> Two or more chronic conditions expected to last at least 12 months or until the death of the patient

>> Chronic condition places the patient at significant risk of death, acute exacerbation/decompensation, or functional decline

>> The beneficiary's agreement to receive CCM services from the Rural Health Center

>> Development of a comprehensive care plan - implemented, established, revised and monitored

>> Management of care transitions and coordination of care with other providers

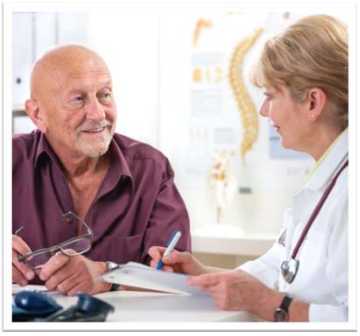
>> Secure messaging capabilities and health IT requirements

>> All CCM requirements must be met for payment

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9234.pdf Source: AMA CPT

Practitioner Requirements for Reporting

- Furnish one of the following:
  - A comprehensive Evaluation and Management (E/M) visit
  - Annual Wellness Visit (AWV)
  - Initial Preventive Physical Examination (IPPE)
- Must initiate CCM service as part of the visit



Additional Reporting Requirements

- Written consent and the beneficiary must acknowledge in writing the practitioner has explained the following:
  - Nature of CCM
  - How CCM may be accessed
  - One practitioner at a time can furnish CCM for the beneficiary
  - Beneficiary's health information will be shared with other practitioners for care coordination purposes
  - Beneficiary may stop CCM at any time by revoking consent, effective at end of current calendar month
  - Beneficiary will be responsible for any associated co-payment/co-insurance/deductible

Care Management Elements

1. Access to care management services 24/7
2. Continuity of care for routine appointments
3. Care management for chronic conditions
4. Documented and comprehensive plan of care that is patient-centric
5. Management of care transitions between health care providers and settings
6. Coordination with home and community-based clinical services providers
7. Enhanced communication opportunities for the patient and caregiver
8. Electronic sharing of care plan information on a 24/7 basis

Documentation & Reporting Requirements

>> Electronic Health Record (EHR) certification

>> Provide 24/7 access to physician

>> Care plan via EHR to include the following assessments/reassessments of the beneficiary's needs:

- Physical
- Mental
- Cognitive
- Psychosocial
- Functional
- Environmental

Documentation & Reporting Requirements

- >> Coordinating and sharing patient information with practitioners outside of practice
- >> Availability for continuation of care/successive visits
- >> Discussion must be substantive and focused on coordinating service within the medical neighborhood
- >> Includes providers or agencies pertinent to care plan and goals
- >> Availability for continuation of care/successive visits

Who Can Bill for CCM?

- >> Physicians and the following non-physician practitioners:
  - Nurse Practitioners
  - Physician Assistants
  - Certified Nurse Midwives
  - Clinical Nurse Specialists

- >> CMS permits “clinical staff” to provide CCM services under general supervision and AFTER the initial face-to-face

  Includes:
  - Clinical pharmacist
  - Social worker
  - Psychologist
  - Auxiliary staff

Care Management Clinical Staff Time

- >> Communication
  - – Patient
  - – Family
  - – Caregiver
  - – Other professionals
  - – Agencies
- >> Care Plan
  - – Implementation
  - – Documentation
  - – Revision
- >> Teach Self-Management

CCM & 99490

- >> The primary intent of CCM is to allow physicians and qualified health care professionals to report the work and time they spend on a patient's care, including the non-face-to-face elements

99490 used to report physician or qualifying non-physician practitioner care management services for a patient

Conditions of Payment & Quantity Limitations

- >> Billed once per month by one practitioner with a minimum of 20 minutes of CCM service required
- >> CCM takes place of Transitional Care Management (TCM) service
  - Unless the TCM period was concluded prior to the end of that calendar month and the minimum of 20 minutes of CCM service is furnished between that time and the end of that month
- >> Ancillary staff can be used (no overlapping intervals)
- >> Other codes that cannot be billed with 99490: (CPT 99495, 99496), (HCPCS G018), (HCPCS G0182), (Certain ESRD CPT 90951-90970)
- >> Cannot bill for CCM until the practitioner secures the beneficiary's written consent at a face-to-face visit because the patient is responsible for any copayments of deductibles
- >> The face-to-face visit is not a component of the CCM service and may be billed separate

Payors

- >> Medicare
- >> Medicare Advantage plans
- >> Blue Cross Blue Shield of Michigan
- >> Priority Health
- >> Other

Note: Verify eligibility under each contract prior to performing services

How to Identify Your Population

>> EMR and/or registry – 2 or more conditions
>> Focus on small number of specific diagnoses with more prevalence, e.g., diabetes, HTN, COPD, etc.
>> Patient empanelment
>> Create tracking log

DIABETES														
Patient name	Gender	DOB	Health Plan	PCP First Name	PCP Last Name	Phone #	Systolic Blood Pressure	Diastolic Blood Pressure	ACE/ARB Completion	HBA1C Level	HBA1C date	Retinal Exam Date	Foot / Neuropathy Exam Date	Nephropathy Screening Date
John Doe	Male	4/5/1962	Medicare	Richard	Brown	555-555-0000	145	100	yes	10	8/4/16	5/3/14	3/1/15	1/2/16
Jane Doe	Female	8/7/1965	United	Richard	Brown	444-444-1111	140	90	no	8	8/5/16	3/5/15	4/5/16	1/3/16
Rosalie Crush	Female	1/5/1990	Medicare	Richard	Brown	444-444-1112	130	82	no	7.2	8/6/16	7/3/16	11/2/15	1/4/16
George Merck	Male	2/18/1972	BCN	Kevin	Smith	444-444-1113	124	70	yes	6.9	8/7/16	3/6/16	11/18/15	1/5/16

Potential Revenue

>> About $40 per 99490
>> Number of patients the practice can effectively manage is about 100 per full time employee
>> (CCM eligible patients) x (reimbursement amount) = (reimbursement per month) x (number of months reported per calendar year) = **additional annual revenue**

Example

100 CCM patients x $40 Per patient = **$4,000** per month x 12 months = **$48,000** additional annual revenue

Summary

- Centers for Medicare and Medicaid Services recognizes care management as one of the critical components of primary care that contributes to better health and care for individuals, as well as reduced spending
- Identify at-risk patients that can benefit from CCM
- Utilize your resources and build a robust care management program
- Report your services to the health plan and get reimbursed for the work that you are already doing

Contact

Debbie Rozanski, CMC
Practice Transformation Coach
Medical Advantage Group
drozanski@medadvgrp.com
517-324-2531

Resources

CMS

- >> https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- >> https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf
- >> https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9234.pdf
- >> https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-02-18-Chronic-Care-Presentation.pdf

AAFP FAQ Toolkit

- >> http://www.aafp.org/practice-management/payment/coding/chronic-care.html

ACPonline – FAQ Toolkits

- >> https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf