How to Create a Successful CCM Care Plan

Savvy Jane Health Solutions

Our Background

Jill Hewett

Jill Hewett's career in health care spans over 25 years. Starting as an MA, Jill spent 17 years working for a private practice and helped it to become the first in Missouri to achieve Primary Care Medical Home (PCMH) status.

In 2016 Jill began working for a bi-state health system and developed the CCM program to reach over 1,500 patients. Jill has actively been involved in DEI (Diversity, Equity, and Inclusion), and finds fulfillment in supporting others to foster a positive and inclusive work environment.

Today, Jill serves as the CCM Consultant for Savvy Jane Health Solutions, where she assists practices nationwide in enhancing their CCM programs and improving patient health outcomes.

Jessica Schroeder, MBA

Jessica Schroeder has worked in the field of healthcare analytics for over 10 years. Starting her career in physician compensation analysis and accounting, Jessica helped develop methodologies and software solutions to enhance financial outcomes.

In 2017, she began working in population health management, helping transform care delivery models and empowering clinical teams with real-time reporting tools and dashboards that identify potential CCM enrollees, patient care gaps, and other insights to drive patient health improvements.

Today, Jessica serves as the Data Analytics Consultant for Savvy Jane, helping clients leverage their data to boost business outcomes.

Ozarks Community Hospital

- 25-bed CAH
- Swing-Bed Program
- 12 RHCs and 2 Fee For Service Clinics
- 14 Chronic Care Managers (CCMs)
- 1,550 CCMs Billed Monthly

1550 monthly CCM’s

14 Fulltime CCMs

1) Fill in when short staffed
2) Assist with PAs and referrals
3) Prep all MWV regardless of enrollment status
4) Boost value-based care

Chronic Care Management CPT Codes

G0511 (RHC)

99490 (FFS) 99439 additional 20 minutes

Rules will be changing for 2025

- G0511 will sunset grace period until July 2025
- FQHC, FFS, and RHCs will use 99490

2025 Advanced Care Management

- **Advanced Primary Care Management (APCM) codes**
  - Three new HCPCS G-codes:
    - G0556
    - G0557
    - G0558
  - These bundle care management and communication technology services. These codes are stratified into three levels based on the patient's number of chronic conditions and status as a Qualified Medicare Beneficiary.

G0506

HCPCS code used to describe the work of a billing practitioner in chronic care management (CCM).

Is an add-on code to the CCM initiating visit that accounts for the billing practitioner's additional work in performing a comprehensive assessment and care plan.

Is an add-on code to the standard E&M code (99212-99215), AWV, or IPPE initiating visit.

When is the Initiating visit required?

- Initiating Visit Before CCM services can start, we require an initiating visit for new patients or patients who the billing practitioner hasn't seen within the previous 1 year.
- The initiating visit can happen during a comprehensive face-to-face evaluation and management (E/M) visit, annual wellness visit (AWV), or initial preventive physical exam (IPPE).
- If the practitioner doesn't discuss CCM during an E/M visit, AWV, or IPPE, it cannot count as the initiating visit.
- A face-to-face initiating visit isn't part of CCM and can be separately billed. Practitioners who personally provide extensive assessment and care planning outside the usual effort described by the initiating visit and CCM codes may also bill HCPCS code G0506 once, as part of an initiating visit. MLN909188 May 2024

12 Components of a Care Plan

1. **Problem list (chronic conditions)**
2. **Expected outcome and prognosis**
3. **Measurable treatment goals**
4. **Cognitive and functional assessment**
5. **Symptom management**
6. **Planned interventions**
7. **Medication Management**
8. **Environmental evaluation**
9. **Caregiver assessment**
10. **Interaction and coordination with outside resources, practitioners, and providers**
11. **Requirements for periodic review**
12. **When applicable, revision of the care plan**

Current Chronic Conditions

Expected to last at least 12 months or until the patient's death

List ALL chronic conditions

Diagnosis should be to the highest specificity.

Patient Goal

PCMH REQUIREMENT IN MISSOURI

THIS SHOULD BE A PERSONAL GOAL FOR THE PATIENT.

Patient Concerns/Barriers to Care

What are the patient's health concerns?

- Would like to lose weight
- Better blood pressure control
- Lower A1C

Barriers- What is keeping the patient from their health goals?

- Weight loss- Bad knees
- Blood pressure control- weight gain and limited mobility have caused blood pressure to increase
- Lower A1C- Late night snacks

Achieving Care Plan Goals

Weight loss- Patient will visit local YMCA and inquire about water therapy

Blood pressure control- Patient will take daily blood one time per day and bring log into next appointment.

Lowering A1C- Patient will try and eliminate late night snacks. Will think about going to see diabetic educator. Diabetic diet and healthy snack list mailed to patient.

Provider Guided Goals

These are things the provider has indicated in their Plan.

Patient advised to lose 10lbs

Smoking Cessation

Low sodium diet

Keep blood pressure log

Keep blood sugar log

Lab & Clinic Appointments

- Office appointments due:
- 1-2 months pain medication appointments- UDS due per controlled medication contract
- 3-4 months diabetic appointment and A1C
- 6 months appointment Lipids (fasting)
- 12 months- Medicare wellness due / yearly labs– Medicare pays for this visit one time per year. MWV scheduled:

Resources and Support

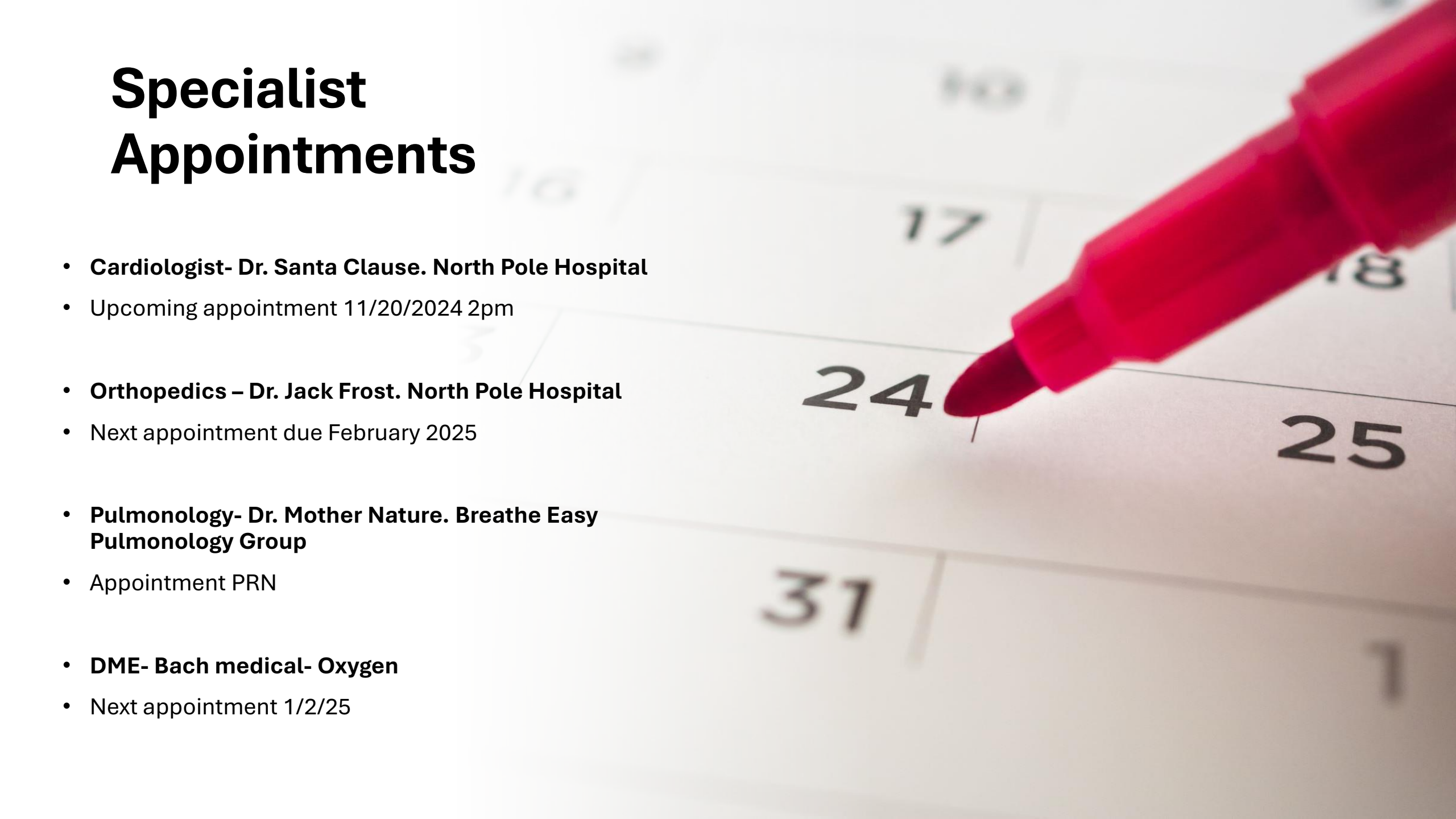
Besides your healthcare team who would you turn to for health- related problems?

- Family members
- Friends
- Neighbors
- Church family

Specialists (other providers involved in care)

- Cardiologist
- Orthopedist
- Pulmnologist
- DME supplier

Specialist Appointments



- **Cardiologist- Dr. Santa Clause. North Pole Hospital**
- Upcoming appointment 11/20/2024 2pm

- **Orthopedics – Dr. Jack Frost. North Pole Hospital**
- Next appointment due February 2025

- **Pulmonology- Dr. Mother Nature. Breathe Easy Pulmonology Group**
- Appointment PRN

- **DME- Bach medical- Oxygen**
- Next appointment 1/2/25

Preventative/ Immunizations

- Medicare Wellness due after 6/26/2025
- Next Colonoscopy due 2028
- Mammogram /Bone Density due August 2025

- **Due now-**
  - Flu
  - Zoster
  - Pneuovax 23

Treatment Goals (Provider Guided)

- These are mutually agreed upon, measurable goals to help me improve or control my medical conditions or manage their symptoms (for example, LDL cholesterol <100, BP<150/90, weight of 150 pounds, 7 hours of uninterrupted sleep, average pain level of 5, ability to walk to my mailbox daily):

Current Medication List

- List current medication list with dosage and sig.

- Patient should always be encouraged to review their medication list and report any changes or discrepancies.

Comprehensive Care Plan

Create, revise, and monitor (per code descriptors) a person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports

Provide patients and caregivers with a copy of the care plan

Electronically capture the care plan information, and make it available promptly both within and outside the billing practice with people involved in the patient's care, as appropriate

Thank you!

Feel free to reach out with questions:

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