Chronic Care Management:

GETTING PAID FOR WHAT WE DO BEST!

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Dr. Bailey, originally from Texas, is a graduate of Houston Baptist University and Baylor College of Medicine. She did her family medicine residency at Eglin Airforce Base Regional Hospital and after serving at Tyndall Airforce Base and in Saudi Arabia during Operation Desert Storm, she opened a solo private practice in the small Florida Panhandle town of Bonifay, Florida.

She and her husband James raised their family in Bonifay where she has been in practice for over 20 years. She enjoys practicing the full spectrum of family medicine including pediatrics, obstetrics, geriatrics, and emergency medicine. She also enjoys teaching the many medical students that rotate through her office from FSU and The University of Florida.

While Dr. Bailey has done Chronic Care Management for years, she has over the last two years instituted a formal Chronic Care management program in her office. Whenever possible, she enjoys sharing the success the program has brought her practice with other physicians.

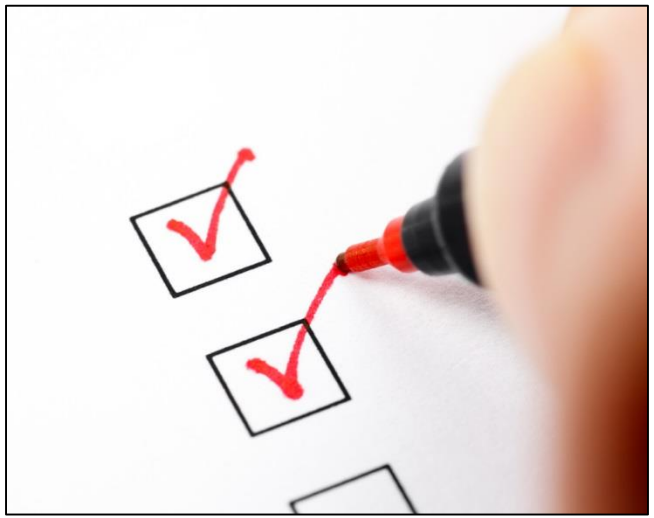
Learning Objectives

1. Review CMS Chronic Care Management (CCM) requirements and summarize visit elements.
2. Identify how CCM can manage chronic conditions to close care gaps and engage patients.
3. Assess financial and quality implications of incorporating CCM as a means of practice improvement.
4. Recognize the importance of CCM in relation to value-based payment.

Chronic Care Management Basics

1. Requirements for CCM
2. Implementing CCM
3. Barriers to CCM
4. Benefits of CCM

Chronic Care Management Requirements



1. Who is eligible?
2. What is required of us in order to bill for services?
3. When do we document our time and whose time counts?
4. How do we get paid and avoid billing pitfalls?

Who is Eligible?

- Medicare patients with at least 2 chronic medical problems that:
  - are expected to last at least 12 months or until the death of the patient; OR,
  - place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
- Residents of nursing homes and assisted living facilities (ALF) that receive monetary compensation from Medicare are NOT eligible for Chronic Care Payment

Chronic Condition Examples

- Alzheimer's and Related Dementia
- Arthritis
- Asthma
- Autism Spectrum Disorders
- Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Ischemic Heart Disease
- Osteoporosis

***Not limited to these conditions*

What is Required in Order to Bill?

1. Provide 24/7 access by telephone and secure email
2. Coordinate referrals and transitions
3. Provide timely appointments, as needed
4. Medication reconciliations, preventive services (immunizations, screenings, etc.)
5. Must provide wellness visit, welcome to Medicare visit, or comprehensive office visit prior to initiating Chronic Care (unless seen in the last year-2017 change)

What is Required in Order to Bill? (cont)

6. Consent from the beneficiary to initiate services
7. Comprehensive personalized chronic care plan created, revised, and updated, as needed
8. All members of chronic care team must be able to access the care plan in a timely manner
9. Provide patient copy of chronic care plan
10. Use of certified electronic health record technology (CEHRT), ability to share care plans (via fax or CEHRT), ability to communicate with patients by phone or secure e-mail.
11. At least 20 MINUTES non-face-to-face time monthly (99490)

Documenting Time

What Time Counts?

- Reviewing labs, x-rays, and consultant notes
- Arranging referrals, speaking to home health nurses, etc.
- Answering patient phone calls/emails about chronic conditions
- Any telephone education that is done that month
- DO NOT INCLUDE TIME SPENT ON THE SAME DAY AS AN OFFICE VISIT.

Whose time counts?

- All members of the CLINICAL TEAM (ex. doctors, ARNPs, PAs, nurses, medical assistants).
- CLERICAL TIME DOES NOT COUNT (ex. receptionist).

How Do We Get Paid?

Procedure codes:

99490 (basic) 99487 & 99489 (complex), G0506

Diagnoses codes:

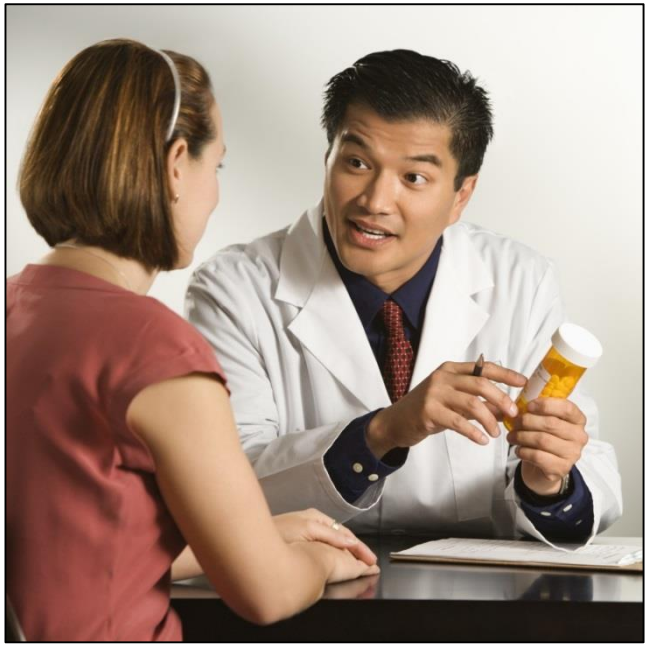
List at least 2 chronic conditions

Bill at the end of the month!

When Can We NOT Bill?

- When transitional care management (TCM) services overlap CCM services
- Billing for hospice oversight or home health oversight services
- Patients in nursing homes or ALFs receiving compensation from Medicare
- Do NOT document at least 20 mins of CHRONIC CARE SERVICES in a month

Implementing CCM in a Small or Rural Practice



1. Patient sign-up/selling the program
2. The personalized chronic care plan
3. The designated chronic care nurse

Patient Sign-up

1. Sign up everyone (only bill if they qualify).
2. Physician/ARNP explains CCM to patient and answers questions (nurse/MA could do this also).
3. Patient fills out “health concerns questionnaire” and consent form with the assistance of staff if necessary.
4. Physician/ARNP reviews questionnaire and initiates care plan (this step only necessary if billing G code).
5. Tag qualified enrollees in medical record and complete care plan.

Selling Chronic Care to Patients

1. NEW PROGRAM designed to help KEEP YOU OUT OF HOSPITAL
2. Allows time to take BETTER CARE of you.
3. Provides 24 HOUR ACCESS to your health care team.
4. Provides MORE TELEPHONE MEDICINE when possible, visits when you need/want.
5. CCM may DECREASE frequency of regular visits, if you would like.
6. If you have supplemental insurance it may be FREE or have a small copay. Fewer visits and hospitalizations make up for the copay.

Characteristics of Personalized Chronic Care Plan

1. May be created by physician/ARNP/PA or chronic care nurse (2017)
2. Problem list, specific measurable goals for specific chronic problems
3. Patient-populated personal goals
4. Other providers, community resources, etc.
5. Care gaps identified and addressed
6. Symptom and medication management addressed
7. Mailed to patient with Welcome to Chronic Care Letter (must receive plan before billing for services)

The Chronic Care Nurse

1. Answers patient phone calls during office hours
2. Reviews labs, referral notes, and x-ray reports
3. Coordinates care between other providers
4. Reviews patient charts for completeness of health maintenance items
5. Periodically does telephone medication reconciliation

The Chronic Care Nurse, cont.

6. Follow-ups after emergency room visits and hospital discharges (TCM)
7. Call backs, as requested by physicians
8. Telephone patient education, when indicated
9. Carefully documents time spent for each of the above
10. Tallies time spent at the end of the month and submits for billing

Filling the Time

Question:

- What happens when you have less than 20 minutes of documented chronic care in a particular month?

Answer:

- Go the extra mile…chronic care nurse calls patient, does patient education specifically for one or more of their chronic problems and addresses any health maintenance issues not documented.

Provider Conflict

Question:

- What do you do if you discover your patient has been signed up for chronic care by a specialist you have referred them to?

Answer:

- Tell them nicely - “Get your dirty paws off my patients!”

1. Sign up early, sign up everyone
2. Sign up as soon as they turn 65 or enroll in Medicare
3. Explain to specialists/patients, as your patient’s family physician, you are best suited to coordinate care
4. If necessary, remind them we usually get to choose who we refer to

What's New for 2017

New Codes, less requirements!

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Additional CCM Codes

- 99490 - original CCM code, requires 20 min. of non-face-to-face time, $43
- 99487- complex CCM, requires 60 min., moderate complexity and decision making and creation or revision of care plan, $94
- 99489 - add-on code for each additional 30 min., $47 (99490 cannot be billed during same month as 99487 & 99489)

New Procedure Code

- G0506 Initiating Chronic Care

Comprehensive assessment and care planning provided by physician/ARNP/PA during office visit or wellness visit during which chronic care management is initiated. This is an add-on procedure code to the visit they are already receiving and requires the development of the care plan. This code can only be billed once, but 99490 can also be billed during the same month. $64

Relaxed Requirements in 2017

- Written consent not required (but still must document at least verbal consent).
- Requirement for electronic transmission of care plans no longer necessary. Faxes are now allowable. After hours access to electronic medical record not required.
- Initiating visit not necessary if patient has been seen within the last year.
- Care plan requirements are not as detailed and specific.

Barriers to Chronic Care Management

Technology

- 24/7 phone and secure e-mail access
- CEHRT
- All other technology requirements such as electronic transmission of care plans have been relaxed for 2017.

Staff

- Lack of experience
- Insufficient time for anymore paperwork and phone calls
- Payment concerns
- Potential disruption to workflow trying to enroll patients

Patient

- Copays
- Not wanting to answer the phone
- Distrust of a new program

Benefits of a Chronic Care Program

Patient Satisfaction

1. 24 hour access
2. Timely appointments
3. Less frequent appointments
4. Feel “special” and well-cared for

Physician Satisfaction

1. Health maintenance being done better
2. Less hospitalizations, less early morning rounds
3. More staffing
4. Freeing up more appointment slots
5. Financial rewards and/or extra time off

Financial Rewards

	# Patients	Revenue per month
	$43+* per month per patient	
1.	50 patients	$1,500 - $2,000 per month
2.	100 patients	$3,000 - $4,000 per month
3.	200 patients	$6,000 - $8,000 per month

* Amount could vary based on location of practice and represents basic CCM.

Unexpected Rewards

- Chronic Care spilling over to ALL patients, not just Medicare patients
- Not really any more trouble for chronic care nurse to provide same services for other patients
- Better health maintenance done for EVERYONE
- Ideal model for my OB patients
- Chronic care nurse “pays for herself” and provides services for other patients at the same time

Best benefit of all:

Time off for important stuff!!

Chronic Care Management Resources

CCM Toolkit from AAFP

http://www.aafp.org/ccm-toolkit

CMS: Chronic Care Management Services

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf

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