

Medicare (CMS) Chronic Care Management Webinar

June 2017

Today's Presenter



Janice Morrow, CPC, Associate Clinical Director

Janice Morrow, CPC, brings more than 20 years of health care experience to her role as an Advisory Board Associate Clinical Director. In this role, Ms. Morrow is responsible for physician practice operations and positioning physician practices for successful growth and long-term stability. This includes enhancing practice efficiencies and strengthening the overall practice management team and supporting developing strategies and decision-making processes.

During her time at the Advisory Board, Ms. Morrow served as Project Manager for ICD-10 provider education for a health system in the West, where she created a project plan for the transition; delivered provider education; provided reports from compass; worked with the program director to create educational fliers to announce upcoming training sessions; and collaborated with the organization's internal corporate trainer to create the initial outline for provider education. Ms. Morrow was also responsible for auditing records for a large, multispecialty pediatric health care system in the south where she provides both statistical and educational feedback based on educational content she created. Additionally, Ms. Morrow presented ICD-10 educational seminars to providers in a large multi-specialty health system in Western North Carolina; audited records and provided feedback for large healthcare system in New Jersey, assisted with onsite support for newly implemented front end revenue cycle policy and procedures at a large healthcare system in Philadelphia, is providing subject matter expertise for a healthcare system in South Dakota on centralization of their coding department and in New Jersey to assess their Provider Medical Group coding operations

Prior to joining the Advisory Board, Ms. Morrow served in multiple positions for Accenture in Albany and New York City, N.Y. In her most recent role as Consulting Manager, Ms. Morrow provided subject-matter expertise for medical record and practice management systems validation, training and implementation. In this position, she focused mainly on medical coding, medical terminology and revenue cycle. Additionally, Ms. Morrow served as an Assessment Manager for a large, teaching health system, focused on inpatient and outpatient ICD-10 remediation, as well as leading and supervising assessment teams to determine client readiness for ICD-10 transformation.

Previously, Ms. Morrow served as a Project Manager / System Trainer for Etransmedia Technology in Troy, N.Y. In this position, she successfully managed Allscripts MyWay medical record and practice management implementation projects, provided system training, and oversaw a five-person training and project management staff. Additionally, Ms. Morrow delivered physician and staff web-based and on-site training, as well as designed, developed and deployed project plans for medical record and practice management system training. Ms. Morrow began her career in health care as a Practice Manager for a small pediatric medical group before serving with Prime Care Physicians in Albany, N.Y. During her time at Prime Care Physicians, Ms. Morrow served in a variety of roles such as Practice Administrator where she managed all aspects of physician revenue cycle, medical coding initiatives, budgeting, regulatory requirements, facility management, marketing trends, strategic planning and quality metrics. In addition, Ms. Morrow facilitated staff efficiency and improved revenue and operational workflow through implementation of revamped physician schedules. Ms. Morrow also served as a Corporate Training Manager / System Trainer and a Central Business Office ("CBO") Customer Service Revenue Cycle Team Manager.

Ms. Morrow is a Certified Professional Coder ("CPC") and is a member of the American Association of Professional Coders. Ms. Morrow earned a Bachelor of Science in human development from SUNY Empire State College in Saratoga Springs, N.Y.; an associate degree in applied science in medical secretarial science from Albany Business College located in Albany, N.Y.; and an associate degree in liberal arts from Harriman College in Harriman, N.Y.

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 - 2 Chronic Care Management Components
 - 3 Chronic Care Management Coding and Billing
 - 4 Operational Considerations
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Chronic Care Management (CCM) Services

Care Coordination for Medicare Beneficiaries



Centers for Medicare & Medicaid Services



CPT 99490

**Chronic Care
Management Services
(Non-Complex)**



CPT 99487

**Complex Chronic
Care Management
Services**



CPT 99489

**Each additional 30
minutes of staff
time**

CCM Program Basics



On January 1st, 2015, Chronic Care Management (CCM) services (CPT 99490) became reimbursable via Medicare.

Patients with 2+ chronic conditions must be provided 20 minutes or more of non-face-to-face CCM services within a 30 day period.



Qualifying Conditions

- ✓ Expected to last at least 12 months, or until death of patient
- ✓ Place patient at significant risk of death, acute exacerbation/ decompensation, or functional decline



Qualifying Services

- ✓ Phone calls and emails with patient
- ✓ Coordination of care (by phone or other electronic communication, but not fax) with other clinicians, facilities, community resources, and caregivers
- ✓ Time spent on prescription management and medication reconciliation
- ✓ Time spent reviewing physiologic data from patient monitoring devices (provided it is not billed elsewhere)



Qualifying Providers

- ✓ Physicians
- ✓ Certified Nurse Midwives
- ✓ Clinical Nurse Specialists
- ✓ Nurse Practitioners
- ✓ Physician Assistants
- ✓ ...and only one practitioner may be paid for the CCM service for a given calendar month

CCM and Complex CCM Basics

What

- ▶ CCM or non-complex, and Complex CCM services share common service elements but differ in the amount of clinical service staff time provided; the involvement and work of the billing practitioner; and the extent of care planning performed

- ▶ The CCM service is extensive and includes:
 - ✓ structured recording of patient health information
 - ✓ requires an EHR for a comprehensive electronic care plan
 - ✓ managing transitions of care and other care management services coordinating and sharing patient health information timely within and outside the practice

CCM and Complex CCM Basics

Who

The following health care professionals may furnish CCM services:



- ✓ Physicians - Generally Primary Care
- ✓ Non Physician Providers (NPPs*):
 - ✓ Certified Nurse Midwife
 - ✓ Clinical Nurse Specialists
 - ✓ Nurse Practitioner
 - ✓ Physician Assistants

Supervision

- ✓ CCM codes are assigned as General Supervision under Medicare PFS
- ✓ When service is not provided by the billing practitioner, it is performed under his/her overall direction and control
- ✓ Physical presence is not required

Additional Eligibility Requirements

- ✓ Certain circumstances - specialty practitioners may provide and bill CCM
- ✓ Out of practice scope – limited license physicians i.e. clinical psychologists, dentists, podiatrists
- ✓ CCM services not provided personally by the billing practitioner are provided by the clinical staff employed by and under the direction of the billing practitioner on “incident to” basis

*Applicable to state law, scope of practice, “incident to” rules and regulations. The staff are either employees or working under contract to the billing provider whom MCR directly pays for CCM services

CCM and Complex CCM Basics

When

- ▶ CCM services are typically provided **outside of face-to-face patient visits**
 - ✓ Focus on characteristics of advanced primary care such as a continuous relationship with a designated member of the care team
 - ✓ Patient support for chronic diseases to achieve health goals
 - ✓ 24/7 patient access to care and health information
 - ✓ Receipt of preventive care
 - ✓ Patient and caregiver engagement
 - ✓ Timely sharing and use of health information

CCM and Complex CCM Basics

Patient Eligibility

1

Requirements

- ✓ Multiple chronic conditions (2 or more)
- ✓ Expected to last 12 months or till the death of the patient
- ✓ Places the patient at significant risk of:
 - Death
 - Acute exacerbation/ decomposition
 - Functional decline

2

Identifying Patients

- ✓ Use criteria suggested by CPT
 - # of illnesses
 - # of medications
 - Repeat admissions or ER visits
 - Identify & engage subpopulations to help reduce disparities in geographical and racial/ethnic arenas

3

Examples of Chronic Illnesses

- ✓ 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
- ✓ Infectious diseases i.e. HIV/ AIDS

*Illnesses not limited to those identified

1

Chronic Care Management Basics

2

Chronic Care Management Components

3

Chronic Care Management Coding and Billing

4

Operational Considerations



CCM Components

CCM services can be billed using code **99490**.

Code	Description	Elements
99490	Minimum 20 minutes of clinical staff time, directed by a physician or other qualified health care professional per calendar month	<p>Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient</p> <ul style="list-style-type: none">• Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline• Comprehensive care plan established, implemented, revised, or monitored

Complex CCM Components

Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report **99489** in conjunction with **99487**. Do not report **99489** for care management services of less than 30 minutes, additional to the first 60 minutes of complex CCM services during a calendar month.

Code	Description	Elements
99487	Complex Chronic Care Management	<p>Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient</p> <ul style="list-style-type: none"> • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Establishment or substantial revision of a comprehensive care plan • Moderate or high complexity medical decision making • 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	

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CCM Documentation

Patient Consent

- ✓ A practitioner **must obtain patient consent** before furnishing or billing CCM
 - ✓ Consent may be verbal or written but must be documented in the medical record, and includes informing each patient of the following:
 - The availability of CCM services and applicable cost-sharing
 - That only one practitioner can furnish and be paid for CCM services during a calendar month: identify the name of the provider responsible
 - The right to stop CCM services at any time (effective at the end of the calendar month)
 - Provide a written or electronic copy of the plan to the patient and keep one in the patient's electronic record
 - Document in the patient's medical record that all elements of CCM were explained and offered to the beneficiary and document the patient's decision
- ✓ Informed patient consent need only be obtained once prior to furnishing CCM, or if the patient chooses to change the practitioner who will furnish and bill CCM
 - ✓ Consideration may be given to renewing the consent on a yearly basis, or if the patient has not received services for several months.



Cost sharing will apply. Supplemental insurance, for patients who subscribe, will assist in the cost.

CCM Documentation Con't.

Structured Recording and the Comprehensive Care Plan

Practices should establish documentation processes for CCM patients that includes:

- ✓ **Patient consent** (includes the date of beneficiary's decision and signed agreement)

- ✓ **Detailed accounting of the time** (at least 20 minutes per calendar month) spent furnishing non-face-to-face services, including the performing clinical staff and details of time spent providing care

- ✓ Patient's **demographics, problems, medications, and allergies**

- ✓ **A Comprehensive Care Plan:**
 - Problem List
 - Expected outcomes and prognosis
 - Measureable treatment goals
 - Symptom Management
 - Medication Management
 - Community social services ordered
 - Planned interventions – including the identification of the individuals responsible for each intervention
 - Description of how agency services and specialists outside of the practice will be directed and/or coordinated
 - Scheduled periodic review and plan revision as necessary

CCM Documentation Con't.

Documentation by other Clinicians

- ✓ If after hours care is provided by a clinician who is not part of the practice, such as for call coverage, that individual must have access to the electronic care plan (other than by facsimile).
 - ✓ The care plan may be accessed via a secure portal, a hospital platform, a web-based care management application, a health information exchange, or an EHR to EHR interface.

- ✓ Contracted clinicians, such as covering clinicians or locum tenens, count as long as they have access 24/7 to the patient's electronic record and are under the general supervision of the CCM physician or "eligible practitioner."

CCM Billing

The requirements for billing CCM include:

- ✓ Minimum of 20 minutes per calendar month
 - ✓ If other E&M procedural services are provided, services should be billed as appropriate and **cannot be counted** toward the 20 minutes
 - ✓ Time, i.e. from a phone call, that leads to an office visit (OV) resulting in an E&M charge is considered part of the billed OV and **cannot be counted** toward the 20 minutes
- ✓ The billing practitioner cannot report both complex and regular (non-complex) CCM for a given patient for a given calendar month.
 - ✓ A given patient receives either complex or non-complex CCM during a given service period, not both.
- ✓ New patients or patients not seen within one year prior to the commencement of CCM Medicare require initiation of CCM services during a face-to-face visit with the billing practitioner
 - ✓ Annual Wellness Visit [AWV]
 - ✓ Initial Preventive Physical Exam [IPPE]
 - ✓ Other face-to-face visit with the billing practitioner
 - ✓ This initiating visit is not part of the CCM service and is separately billed



CMS does not prohibit the use of recurring billing but advises practices to **use caution** to ensure billing does not occur in months when the CCM service requirements are not met

CCM Billing Con't.

- ✓ Practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code G0506
 - ✓ Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring CCM services [billed separately from monthly care management services]
 - ✓ Add-on code, list separately in addition to primary service
 - ✓ G0506 is reportable once per CCM billing practitioner, in conjunction with CCM initiation
- ✓ Per CPT: Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient.
 - ✓ Do not count any clinical staff time on a day when the physician or qualified healthcare professional reports an E&M service

CCM Billing Con't.

Per MCR Guidelines, CCM cannot be billed during the same service period as:

- ✓ HCPCS codes - G0181/G0182 (home health care supervision, hospice care supervision)
- ✓ CPT codes – 90951-90970 (certain end stage renal disease services)
- ✓ CPT codes - 99495, 99496 (should not be reported during the 30 day transitional care management period)
- ✓ Complex CCM and prolonged Evaluation and Management (E&M) services cannot be reported the same calendar month
- ✓ Consult CPT instructions for additional codes that cannot be billed concurrent with CCM. Additional restrictions on billing for practitioners participating in a CMS sponsored model or demonstration program may apply.
- ✓ Time that is reported under or counted towards the reporting of a CCM service code cannot also be counted towards any other billed code

CCM Payment

- ✓ Medicare pays for CCM services separately under Medicare FFS
- ✓ Medicare will not make duplicative payments for the same or similar services for patients with chronic conditions already paid for under the various CMS advanced primary care demonstration and other initiatives, such as the Comprehensive Primary Care (CPC) Initiative

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CCM Roadmap

Three Elements of Successful CCM Implementation

1

Start with the “Why”

Why should they participate?

- Develop messaging for patients around benefits of participation
- Define incentives for physicians and Care Team

2

Simplify the process

Make it easy to be involved

- Automate data capture and billing as much as possible
- Clearly define responsibilities and expectations for all Care Team members
- Provide training on new workflow and data capture/documentation tools

3

Manage performance

Maintain quality of program

- Leverage reporting to track outcomes over time
- Provide consistent feedback and support to Care Team
- Develop program for on-going optimization of patient activation

CCM Roadmap

Summary Implementation Roadmap



Clearly define requirements and workflow for each program participant/care team member

- Define staffing needs, including roles, responsibilities, and expectations
- Include ancillary services (behavioral health, social worker, dietician, pharmacist, etc.)
- Provide training and scripts for **enrollment** and **maintenance**

Leverage available features in EHR to streamline/automate workflows

- Time tracking across encounters
- CCM Registry
- Integrate CCM, TCM and HCC data for enhanced patient tracking and management

Increase number of included diagnoses

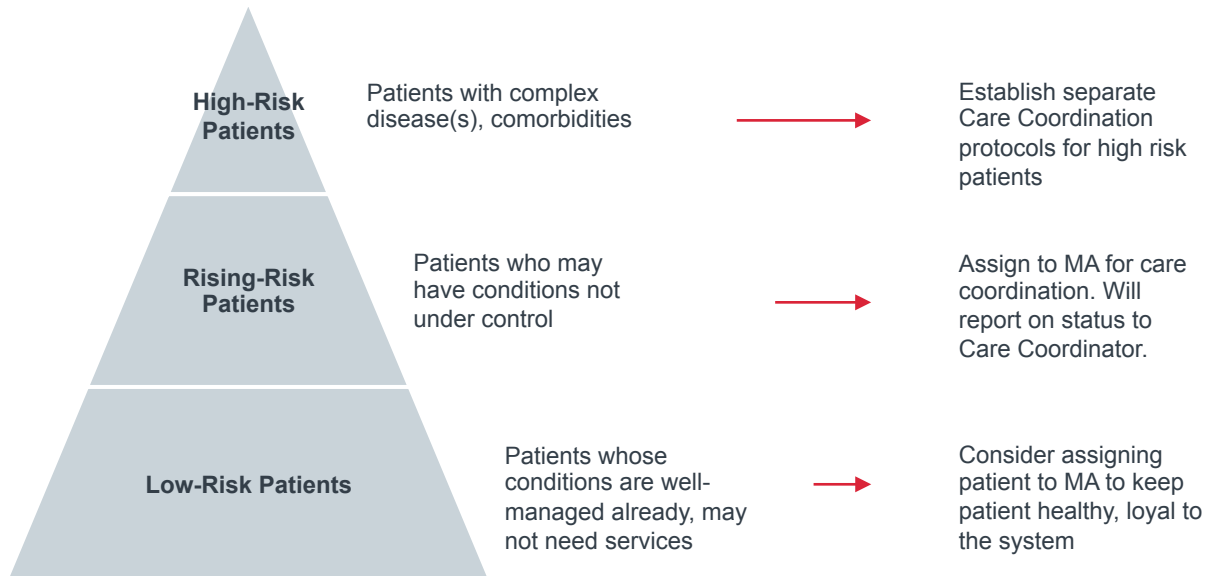
- Expand pool of CCM-eligible patients by including additional diagnoses in CCM Registry

Develop a strategy for patient enrollment

- Stratify patient population by risk and assign patients accordingly
- Determine appropriate length of participation in program

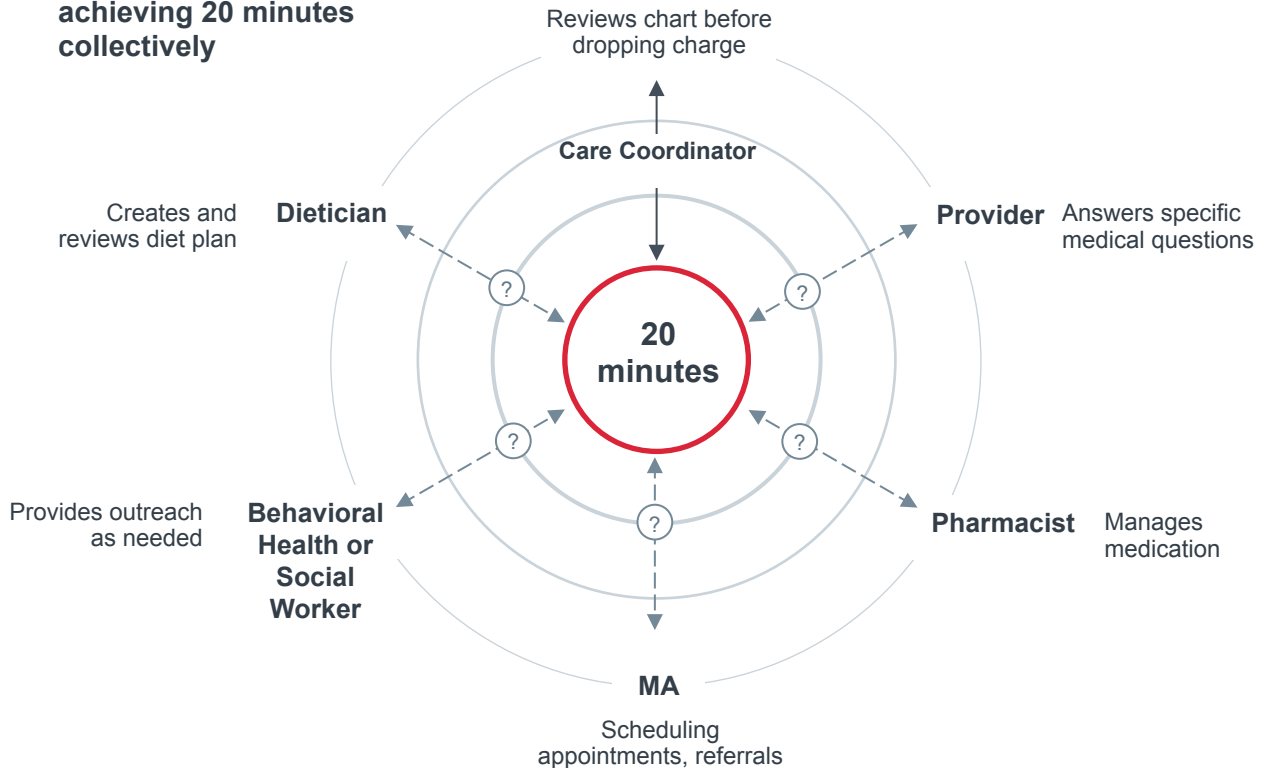
Addressing CCM Challenges: Identifying patients for enrollment

Stratify and assign coordination responsibilities based on risk



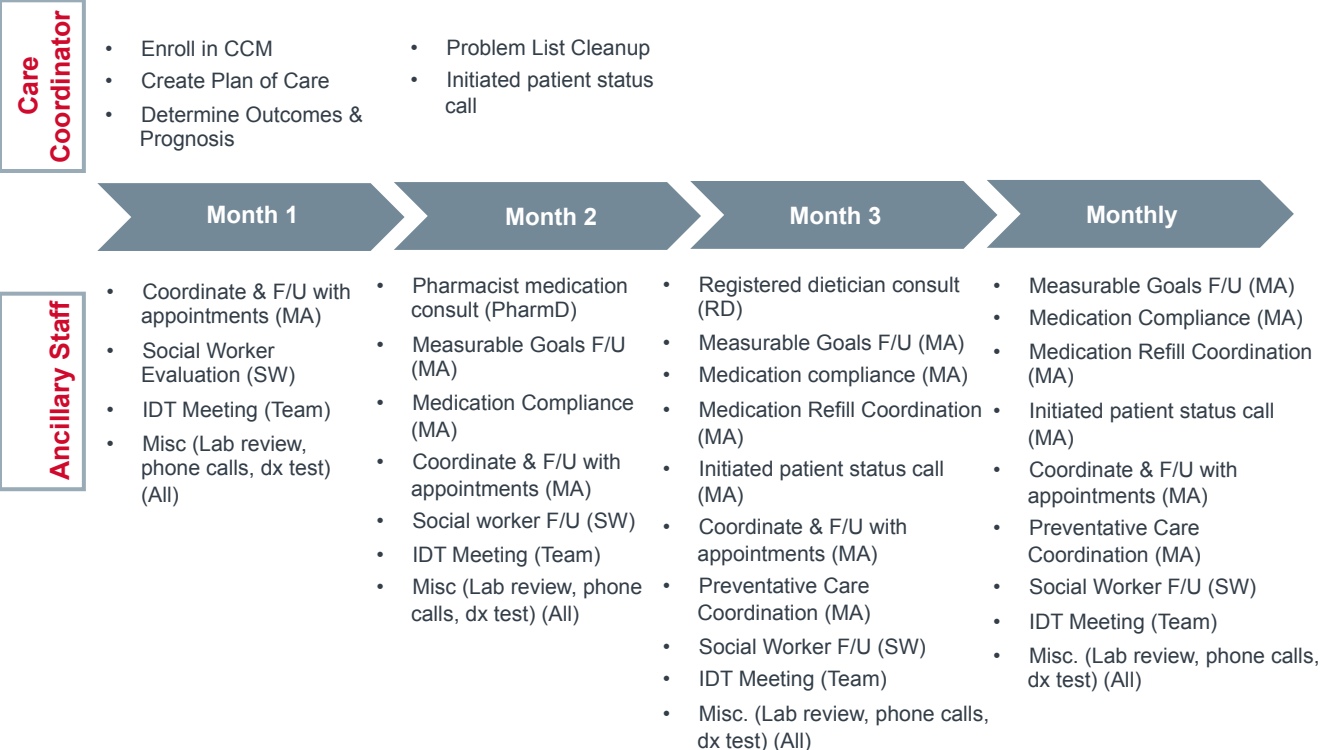
Addressing CCM Challenges: 20 minutes per patient

Emphasize teamwork for achieving 20 minutes collectively



Example Timeline/Roles & Patient Experience

CCM participation across time and care team members



Reporting: Tracking Patients Over Time

Review Data to Maximize Monthly CCM Requirement Completion

Recommended reports to be developed:

A

Monthly report for which patients are no longer or have become eligible

- Identify eligible patients who are new to the health system
- Identify patients who are eligible but don't yet have CCM or physical

B

Monthly report for which patients discontinued participation in CCM

- Who declined participation and why?
- Track reasoning for why patients decline service to identify potential trends/need for modification

C

Monthly report (after submission of billing) for number of CCM enrolled patients who did not meet 20-minute per month requirement

- Discuss reasons for failing to meet the 20 minute requirement
- Determine plan for increasing time for the next month

D

Monthly report (1-2 weeks prior to submission of billing) for CCM-enrolled patients yet to achieve 20 minutes

- Create plan for Care Team to meet 20-minute requirement



Questions for Q&A Hours?
