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Chronic Care Management:

Introduction to Provision and Payment in 5 Minutes!

A White Paper – January 2015

WHAT'S THE NEWS?



Effective January 1, 2015, Medicare will reimburse 20 minutes of non-encounter (not face to face) Chronic Care Management every 30 days!

Non-encounter based care includes qualified interactions via:

- Electronic communication (e-mail or phone)
- Patient outreach/engagement application(s)

Chronic Care Management is “contact initiated”, and could include:

- Doctor to Patient
- Patient to Doctor
- Lab to Doctor
- Doctor to Pharmacy, etc...

The average reimbursement for each 30 day period is **\$42.60** (adjusted by geography)

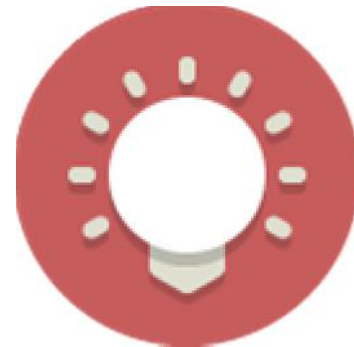
HOW DOES THIS IMPACT YOUR PRACTICE?

Patients receive more consistent care and enjoy potentially improved health outcomes

Providers are able to offer more patient-centered health care management

Providers are able to get paid for work that they are doing for free today!

| Hypothetical Revenue Impact of Chronic Care Management | |
|--|-----------------------------|
| 100 | Qualifying Patients |
| \$ 42.60 | Monthly CCM Payment |
| \$ 4,260.00 | Monthly CCM Income |
| 12 | Months / Year |
| \$51,120.00 | Gross Annual Revenue |



WHAT PATIENTS ARE ELIGIBLE?

Fee-for-service Medicare patients with at least two chronic conditions that are expected to last 12 months or more

There is no definition of “chronic care” but there is the following guidance:

From the 2015 Medicare Physician Fee Schedule Final Rules:
“Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.”

There is a list of established chronic condition categories, but additional conditions will be added to as the program matures. The list of current conditions may be accessed at:

<https://www.cwdata.org/web/guest/condition-categories>



WHICH PROVIDERS ARE ELIGIBLE?

Chronic Care Management billing clinicians

Generally the Primary Care Physician (MD, PA, NP)

Only one provider may bill for a patient per billing period.

Chronic Care Management may be provided by the PCP or clinical staff

Clinical staff may include, but is not limited to:

APRN

CMA

LPN

LSCSW

RN



HOW TO INITIATE CHRONIC CARE MANAGEMENT

Inform and obtain **signed** permission from the patient for the treatment.

The patient permission agreement must specify:



That only one practitioner may provide (be paid for) service per billing cycle

The types of services available and to be provided

How to access the Chronic Care Management services

How the patient's data will be shared with other providers for care coordination

That a Medicare co-insurance payment (typically around \$8.00) will be due per 30 day period of service

That the patient may terminate service at any time

This agreement must become part of the patient's medical record.

CHRONIC CARE MANAGEMENT DELIVERY REQUIREMENTS



A patient centered Electronic Care Plan (documentation to be provided to the patient).

This care plan must include:

- Systemic assessment of patients' needs (physical, mental, cognitive, and environmental)
- Systemic trigger and capture of preventative care services
- Medication management, adherence, and oversight
- Continuity of care with a designated care giver (not necessarily the PCP)

Enhanced Communication:

- Provide means for 24/7 asynchronous communication (e.g.: email / instant message).
- Accessible by all care team members and the patient



Managed and Coordinated Care:

- Accessible by all providers and locations
- Must allow for documentation of the communication with each provider
- Coordination may be conducted by a member of the care team other than the billing physician.

CHRONIC CARE MANAGEMENT INFRASTRUCTURE REQUIREMENTS



A provider must use “CCM certified technology” to provide CCM related services, but does not need to meet individual meaningful use requirements.

CCM certified technology is a EHR that satisfies either 2011 or 2014 EHR Incentive Program criteria

Other required CCM technology capabilities are:

Structured patient data consistent with 45 CFR 170.314(a)(3)-(7)

- demographics

- problems

- Medications / medication allergies

Creation of summary care record consistent with 45 CFR 170.314(e)(2)

Ability to digitally transmit the above records



CHRONIC CARE MANAGEMENT SERVICE LEVEL REQUIREMENTS

At least 20 minutes of non-encounter based chronic care per 30 day period

24/7 access to the Chronic Care Management system

See the [State Plan Amendment Matrix](#) if you practice in the following states:

Alabama

New York

Idaho

North Carolina

Iowa

Ohio

Maine

Oregon

Maryland

Rhode Island

Missouri

South Dakota



<http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/hh-spa-at-a-glance-3-19-14.pdf>

HOW TO BILL

Verify that:

The patient agreement is on file

20 minutes of non-encounter care were rendered

Chronic Care Management has not already been billed this cycle

Only one claim is allowed per 30 days

None of the mutually exclusive billing codes have been billed in the same billing cycle

If all the criteria above has been met, bill using **CPT Code 99490**



MUTUALLY EXCLUSIVE BILLING CODES

| Title | CPT / HCPCS Code |
|-----------------------------|------------------|
| Transition Care Management | 99495 & 99496 |
| Home Healthcare Supervision | G0181 |
| Hospice Care Supervision | G9182 |
| Certain ESRD services | 90951 & 90970 |

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Estenda Solutions is a software development and consulting firm located in the Philadelphia metro region, focused on advancing healthcare, research and medical informatics. Working with large organizations, startups, research institutions and the individual researcher, we enjoy the challenge of helping our client's ideas flourish, improving the health and well-being of patients around the world.

Since 2003, our unwavering focus on exceeding expectations has produced a long list of innovative and successful projects - both grant funded and commercial - all delivered on-time and within budget. We have a rich history of work in disease management/chronic care coordination, registries, screening programs, data warehousing, population health, PCMH and ACO, clinical research program conception and grant writing, clinical study management, telemedicine, and data integration (HL7 and DICOM).

Estenda has the desire, capabilities, and experience to help you design, develop, and deploy your project. Please call us today to find out how we can work together.

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