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Chronic Care Management Services & COVID-19

June 25, 2020

Logistics

To ask a question, click on the **Q&A** icon**.**
Raise your hand if you want to verbally ask a question.

Resources from today's session will be posted in **Chat.**

You may adjust your audio by clicking **Audio Settings**.
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CCM Services & COVID-19

Presenters

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Disclaimer

The following presentation is for informational purposes only. The best practices and strategies shared are not formal recommendations from Health Quality Innovators (HQI) on the medical management of patients. Nor does HQI endorse any of the products, applications or resources mentioned in this presentation.

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Polling Question

Are you or your practice currently providing Chronic Care Management Services?

1. Yes
2. Planning to
3. No
4. Not Sure

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Today's Agenda

1. CCM Services Overview
2. Benefits of CCM
3. CCM Service Elements
4. Providers of CCM
5. Implementation Strategy
6. Coding and Billing
7. Success Stories
8. Resources and Q&A

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What is Chronic Care Management (CCM)?

Non-face-to-face care coordination service for at least 20 minutes a month provided outside of a regular office visit for patients with the following:

1. **Two or more chronic conditions** expected to last at least **12 months** or until death

2. At **significant risk of death**, acute exacerbation/decompensation or functional decline

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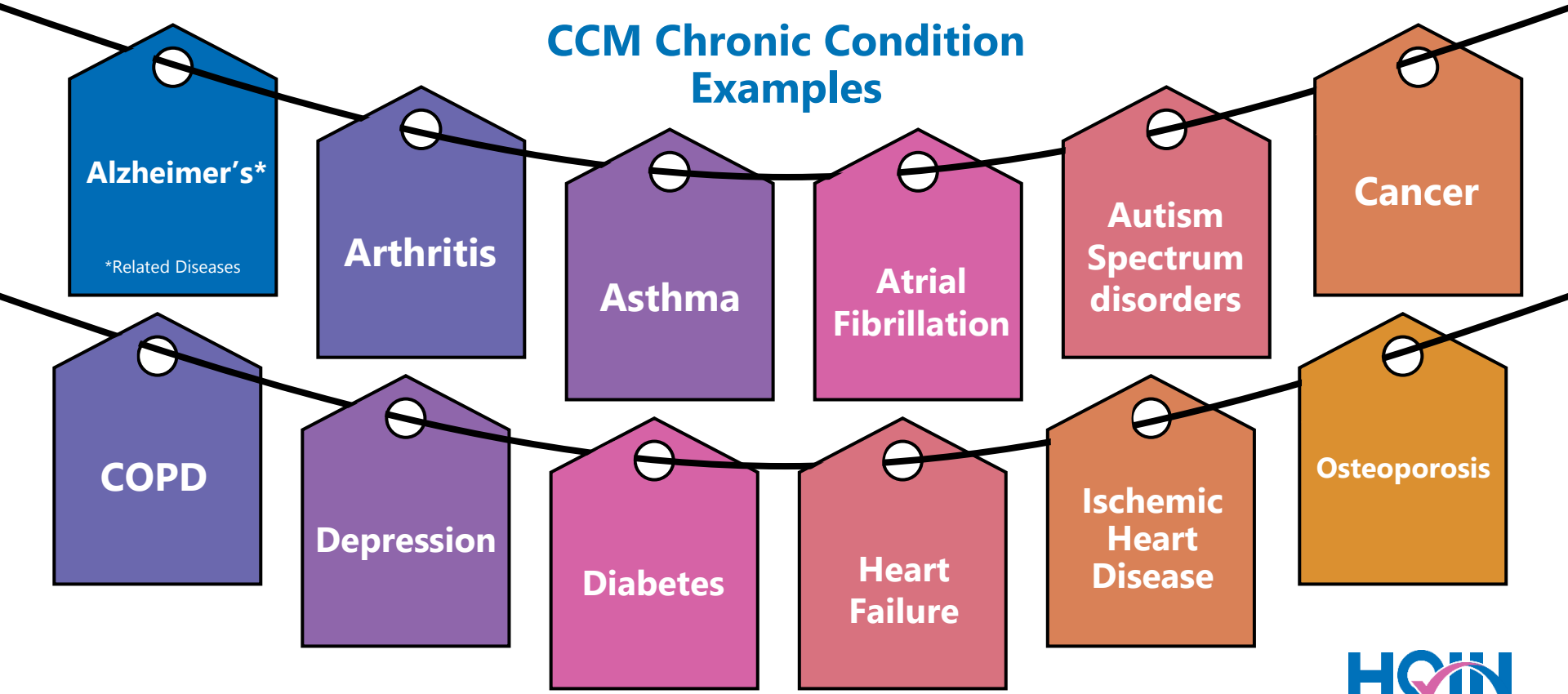

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CCM Services Rationale

CMS estimates that approximately two-thirds of Medicare beneficiaries meet the requirement for CCM Services.

- Contributes to better health outcomes and higher patient satisfaction
- Practices are already coordinating care – get reimbursed for your time and effort
- Due to COVID-19, patients at higher risk of death

40% decrease in treatment for severe heart attacks

Estimated **150,000** missed cancer diagnoses

600% increase in suicide hotline calls

Chronic Care Management can be a solution

Source:; https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2015-02-18-CCM-Transcript.pdf **and** https://www.forbes.com/sites/gracemarieturner/2020/05/22/600-physicians-say-lockdowns-are-a-mass-casualty-incident/#b636dd350fa5

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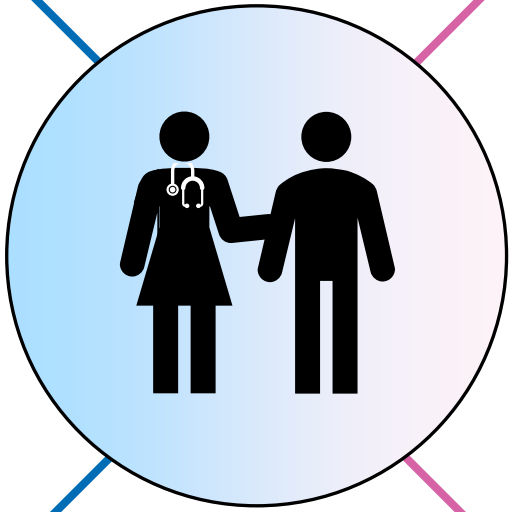
Benefits of Participation

Practice Benefits

- Improved care coordination
- Better patient compliance
- Patient loyalty and trust
- Enhanced office visit efficiency
- Additional revenue stream
- MIPS: Improvement Activity



Patient Benefits

- 24/7 access to care team
- Personalized, comprehensive care plan
- Support between visits to stay on track and engage in treatment plan
- Personal assistance with referrals and coordination of care

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Polling Question

Which of the benefits of Chronic Care Management are you most interested in?

1. Increased patient engagement
2. Improved patient outcomes
3. Additional source of revenue for the practice
4. All the above
5. None of these
6. Other (please type into chat)

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CCM Service Elements

Structured recording of patient health information in a certified EHR	Comprehensive care plan	24/7 access to care team and continuity of care	Comprehensive care management	Transitional care management
• Demographics • Problems • Medications • Allergies	• Person-centered • Electronic • Multifaceted assessment (physical, mental, cognitive, psychosocial, functional and environmental) • Inventory of resources	• To address urgent needs regardless of time of day or day of week • Designated care team member • Provide enhanced opportunities for communication	• Systematic assessment of medical, functional and psychosocial needs • Timely receipt of preventive care services • Medication reconciliation • Oversight of patient self-management • Coordination of care	• Between and among providers and settings, including referrals and follow-up • Timely creation and exchange of continuity of care documents

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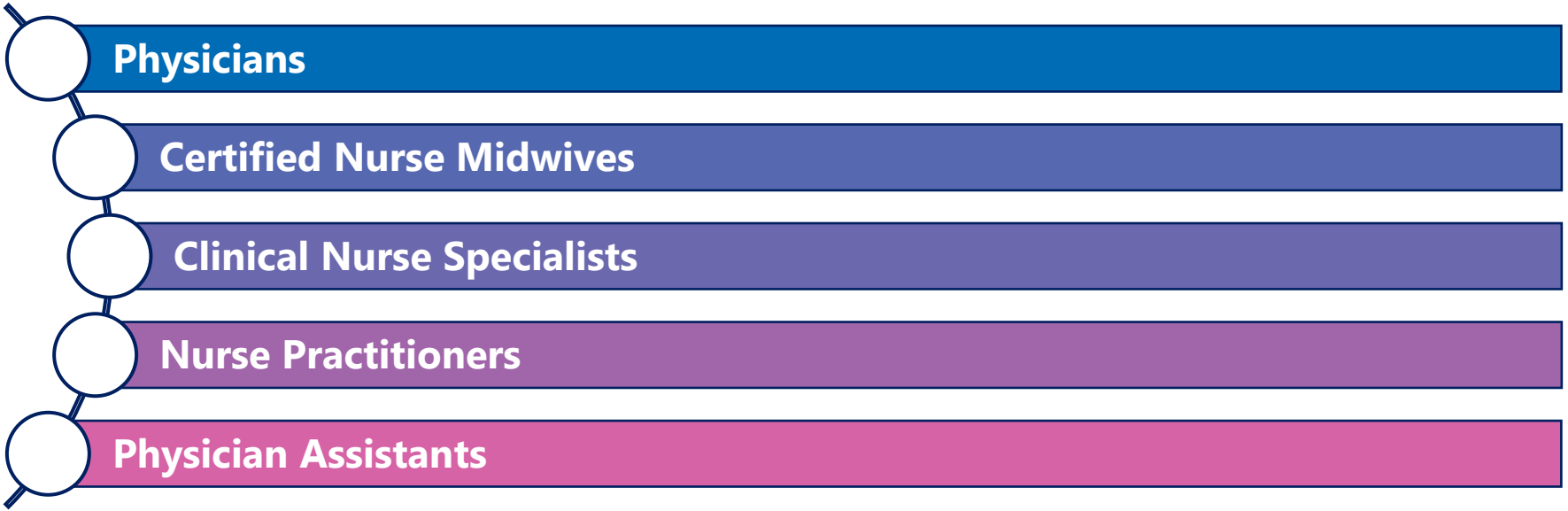
CCM Service Providers – Physicians and Other Qualified Healthcare Professionals



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

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CCM Service Care Team – Clinical Staff

Clinical staff, as defined by AMA CPT, are allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service. These individuals can provide CCM services but cannot bill CMS directly; they can provide the service as incident to any of the CCM eligible practitioners.

Examples: Nurse (RN/LPN), Social Worker, or Pharmacist. Typical CCM responsibilities may include:

- **Review labs, referral notes, x-ray reports**
- **Coordinate care between patients**
- **Review chart for completeness of health maintenance items**
- **Medication reconciliation**
- **Follow up after ER visits and hospital discharges**
- **Patient education**

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Polling Question

Do you currently work directly with a Social Worker, Pharmacist, or Community Pharmacy? (either contracted or employed)

1. Yes
2. Planning to
3. No
4. Not Sure

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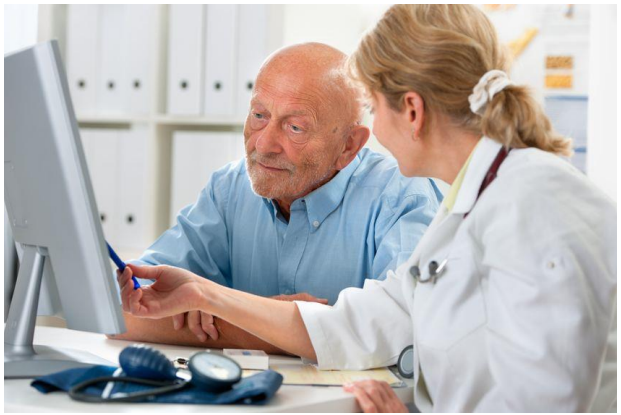
CCM Implementation Steps

- ☑ Develop an Operations Plan for CCM
- ☑ Identify CCM eligible Patients
- ☑ Marketing and education to enroll patients
- ☑ Deliver CCM Services
- ☑ Documentation, Coding and Billing
- ☑ Monitor Quality and Effectiveness



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Develop an Operations Plan for CCM

1. Designate care team roles and responsibilities
   - Care Manager (nurse, social worker, pharmacist)
   - Support roles for outreach, enrollment, scheduling, etc.
2. Develop a patient tracking system in the EHR and for billing
3. Ensure **24/7 access** to a qualified health care professional who has access to the EHR to address any urgent needs after hours
4. Establish workflows for enrollment and subsequent outreach
5. Ease into CCM by testing your process with one clinician and 3-5 patients

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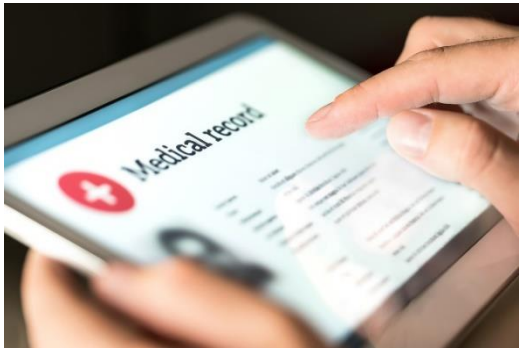
Identify CCM Eligible Patients

- ☑ Leverage EHR to identify initial list of patients
- ☑ Focus on high risk, comorbidity patients
- ☑ Review patient list and edit based on care team feedback
- ☑ Activate decision support rules in EHR to support ongoing identification of potential patients
- ☑ Utilize Annual Wellness Visits (AWVs) and Transitional Care Management (TCM) to identify potential CCM patients



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Marketing and Patient Education

Outreach campaign

- Invite to participate through patient portal, email, and/or letter
- Make follow up phone calls to encourage enrollment and answer questions
- Review the day's schedule and flag eligible patients to discuss CCM participation during office visits
- Utilize CMS *Connected Care* patient education resources (at no cost)

Educational Poster
(available in English and Spanish)

Postcard
(available in English and Spanish)

Animated Video

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Patient & Family Education & Engagement

- Develop standardized messaging points around:
  - Frequency of contact
  - Care coordination activities
  - Consent and financial responsibility
- Embrace person and family centered engagement techniques such as shared-decision making and the teach back method
- Utilize culturally appropriate educational resources to supplement and reinforce coaching
- Stress the importance of being honest about barriers to compliance and lack of understanding
- Assess for health literacy, including comprehension of written information as well as math skills
- Educate on and engage patients through the EHR patient portal

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Deliver CCM Services

1. Use a template to document the comprehensive care plan
2. Share the care plan with patient through the portal
3. Follow the plan and provide on-going care management services
   - Routine assessment of medical, functional and psychosocial needs
   - Ensure patient receives applicable preventive services
   - Patient education/motivational interviewing
   - Perform medication reconciliation
4. Periodically review and update care plan with the patient
5. Document time spent on CCM activities
6. Provide continuity of care through a designated care team member who is regularly in touch with the patient (referral management, coordination of care with other providers)

CCM Care Plan Elements

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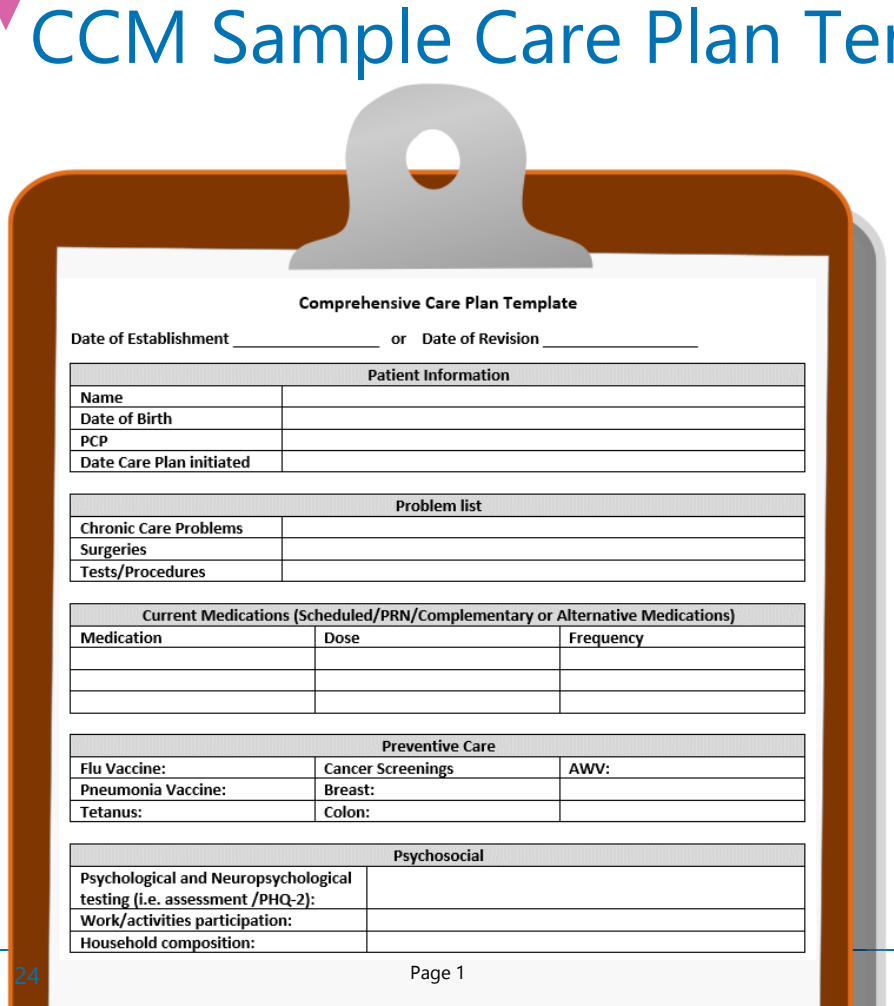
CCM Sample Care Plan Template



Comprehensive Care Plan Template

Date of Establishment _____ or Date of Revision _____

Patient Information	
Name	
Date of Birth	
PCP	
Date Care Plan initiated	

Problem list	
Chronic Care Problems	
Surgeries	
Tests/Procedures	

Current Medications (Scheduled/PRN/Complementary or Alternative Medications)		
Medication	Dose	Frequency

Preventive Care		
Flu Vaccine:	Cancer Screenings	AWV:
Pneumonia Vaccine:	Breast:	
Tetanus:	Colon:	

Psychosocial	
Psychological and Neuropsychological testing (i.e. assessment /PHQ-2):	
Work/activities participation:	
Household composition:	

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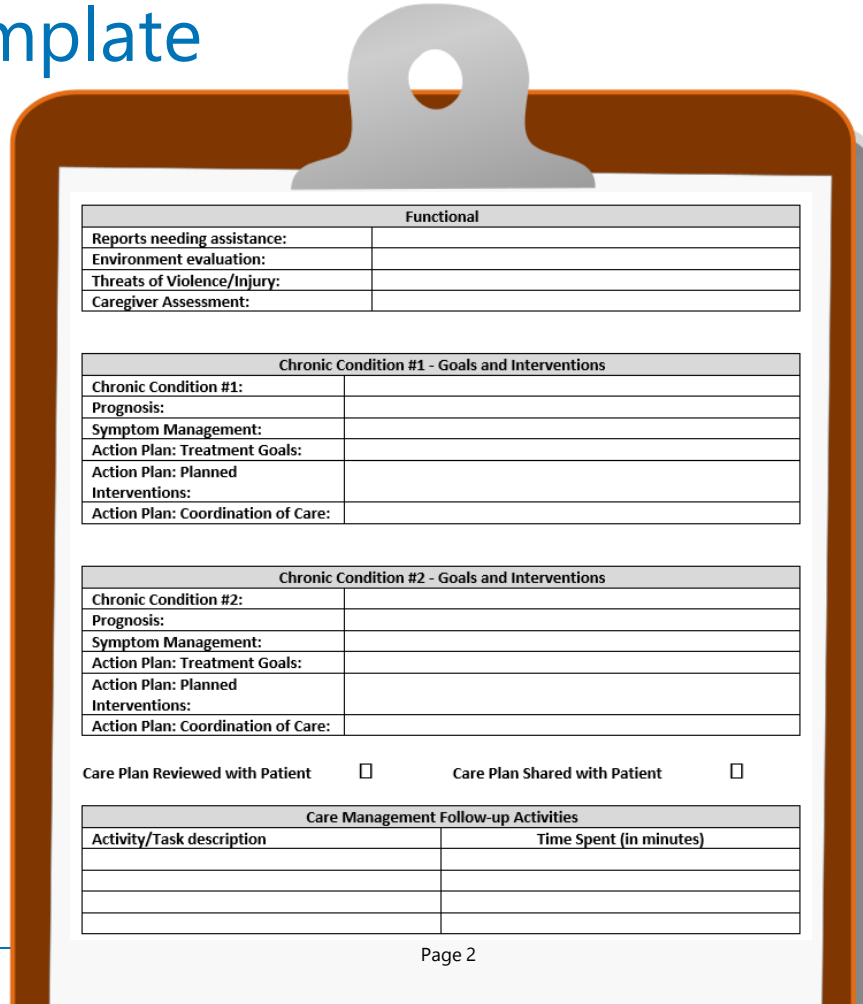

Functional	
Reports needing assistance:	
Environment evaluation:	
Threats of Violence/Injury:	
Caregiver Assessment:	

Chronic Condition #1 - Goals and Interventions	
Chronic Condition #1:	
Prognosis:	
Symptom Management:	
Action Plan: Treatment Goals:	
Action Plan: Planned Interventions:	
Action Plan: Coordination of Care:	

Chronic Condition #2 - Goals and Interventions	
Chronic Condition #2:	
Prognosis:	
Symptom Management:	
Action Plan: Treatment Goals:	
Action Plan: Planned Interventions:	
Action Plan: Coordination of Care:	

Care Plan Reviewed with Patient ☐ Care Plan Shared with Patient ☐

Care Management Follow-up Activities	
Activity/Task description	Time Spent (in minutes)

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Documentation, Billing, and Coding

- Calculate time spent each month on CCM activities for each patient
- Ensure documentation supports time billed
- Ensure no other conflicting codes have been billed during the month. Examples include:
  - Home health care supervision
  - Hospice care supervision
  - End stage renal disease services
- Complex and non-complex CCM services **cannot** be billed in the same month for the same patient
- Patient coinsurance and deductible do apply

CCM Coding and Billing

CCM Type	CPT Code	Time	Oversight/ Delivery of Care	Billing Limitations	Required Elements	Transitional Care Mgt	Reimburse-ment
Non-Complex	**99490**	At least **20** minutes	Directed by a physician or other qualified healthcare professional	**Once** per calendar month	- Two or more chronic conditions expected to last at least 12 months or until death - Patient at significant risk of death, acute exacerbation/decompensation, or functional decline - Comprehensive care plan established, implemented, revised, or monitored	Can bill concurrently ☑	**$42.22**
	G2058 (add on code for 99490)	Each additional **20** minutes	Directed by a physician or other qualified healthcare professional	**Up to twice** per calendar month			**$37.89**
	99491	At least **30** minutes	**Provided directly by** a physician or other qualified healthcare professional	**Once** per calendar month			**$84.09**
Complex	**99487**	At least **60** minutes	Directed by a physician or other qualified healthcare professional	**Once** per calendar month	- Two or more chronic conditions expected to last at least 12 months or until death - 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	Can **NOT** bill concurrently ☒	**$92.39**
	99489 (add on code for 99487)	Each additional **30** minutes	Directed by a physician or other qualified healthcare professional	**Once** per calendar month			**$44.75**

Source:; https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

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FQHCs and RHCs

- CCM service can be billed using the general care management code **G0511**, either alone or with other payable services
- If CCM services are billed on the same claim as an office visit, both will be paid
- 2020 payment rate is **$66.77**
- Patient coinsurance and deductibles do apply
- *Special rules apply.* Consult the FQHC/RHC Care Management FAQ document for more information.

New and Expanded Flexibilities for COVID-19

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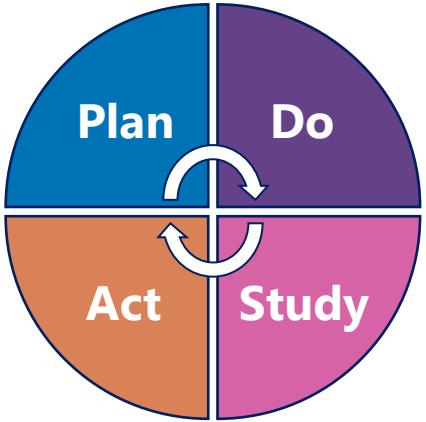
Monitor Quality & Efficiency

- Review CCM outcomes relative to initial goals
- Evaluate performance of your CCM services
  - Meeting minimum of 20 minutes of services per CCM patient per month per provider
  - Thoroughness of documentation of CCM services through audit
  - Billing and coding accuracy
- Obtain regular feedback from patients and providers
  - Obtain patients feedback/recommendations for improvement
  - Evaluate provider feedback about processes, workflows and clinical outcomes
- Test and implement changes that improve CCM services

  (**P**lan, **D**o, **S**tudy, **A**ct)



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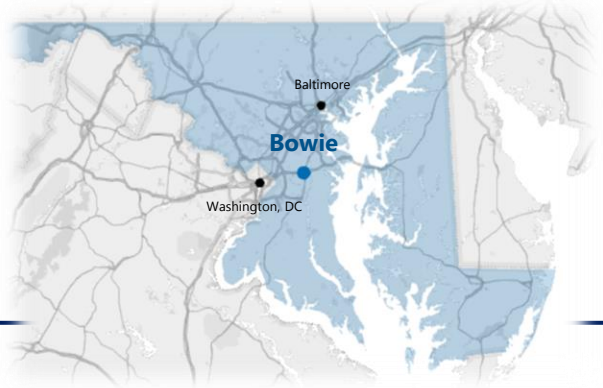
CCM Success Stories

- Practice in **Prince George, Virginia**
- Seven clinicians
- Internal case manager – EMR module



- Practice in **Bowie, Maryland**
- Six clinicians
- Care Team – CCM program integrated with EMR

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Successful Rural CCM Trial in Virginia

Practice Role

- Recruits eligible patients
- Collaboratively creates a care plan with the pharmacist
- Submits Medicare claims
- Reimburses pharmacy for CCM services
- Follows up with pharmacist as needed

In 2017, Emporia ranked **133rd** (last) in the Commonwealth of Virginia for health outcomes.

Pharmacy Role

- Meets monthly with patient (phone or visit)
- Implements the care plan
- Coaches patients, reviews medications
- Coordinates with practice

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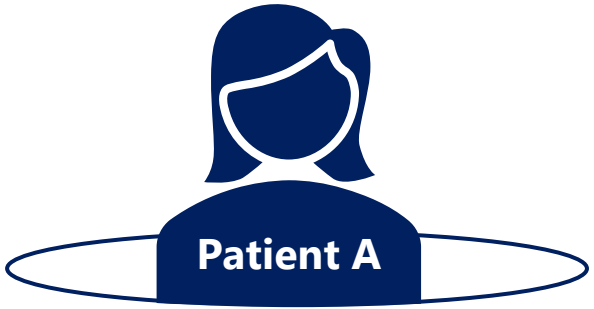
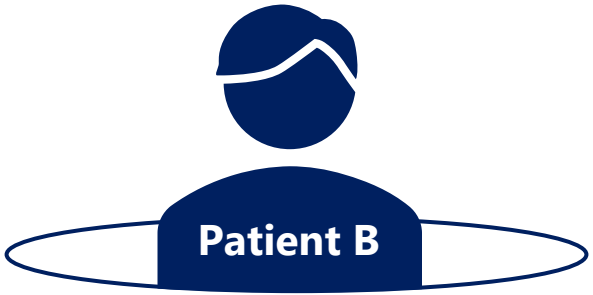
Successful Rural CCM Trial in Virginia

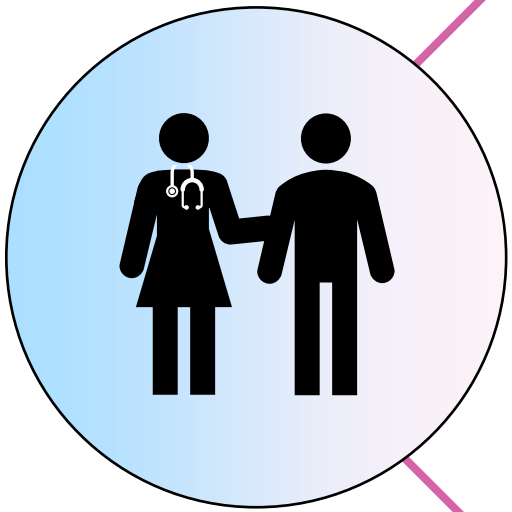


- Did not know it was necessary to refrigerate insulin
- Was not maintaining a healthy weight
- Required multiple hospital stays



- Used the same lancet for one year to test his blood sugar
- Did not consistently follow the meal plan outlined for him
- Did not maintain frequent communication with his physician

Successful Rural CCM Trial in Virginia



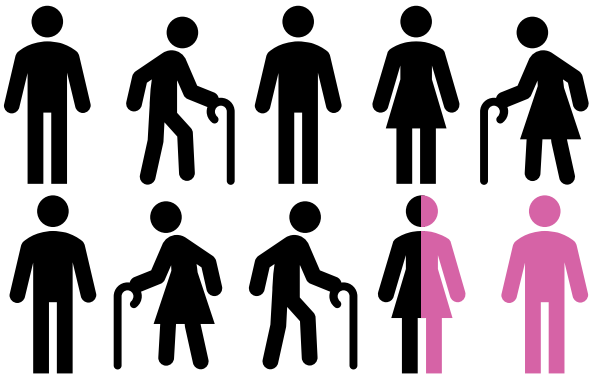
Patient Benefits

- Monthly contact with the pharmacist
- Medication reconciliation and Rx synchronization
- Guidance for eating healthy and getting active
- Tools for tracking blood glucose levels, blood pressure monitoring and medication schedule
- Time to ask questions

Successful Rural CCM Trial in Virginia

100% of patients reported improvement after dieting and exercising

85% of patients kept their CCM monthly appointments



Practice showed improvement in related quality measures

8% increase in Clinical Medication Reconciliation

6% increase in Chronic Care Management

11% increase in Tobacco Cessation

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Patient Impact

Blood Glucose Self-Monitoring and Level Improvement

Issues Identified

- Majority of patients not recording BG levels
- At least **10%** incorrect use of meter
- **>10%** incorrect insulin storage

Improvements Gained

- **100%** received BG self-monitoring guidance
- **68%** showed BG level improvements

Medication Reconciliation and Increased Adherence

Issues Identified

- Incorrect use of medications, wrong dosage/wrong time
- At least **10%** had expired medications

Improvements Gained

- **100%** received medication reconciliation guidance
- **81%** showed improved medication adherence

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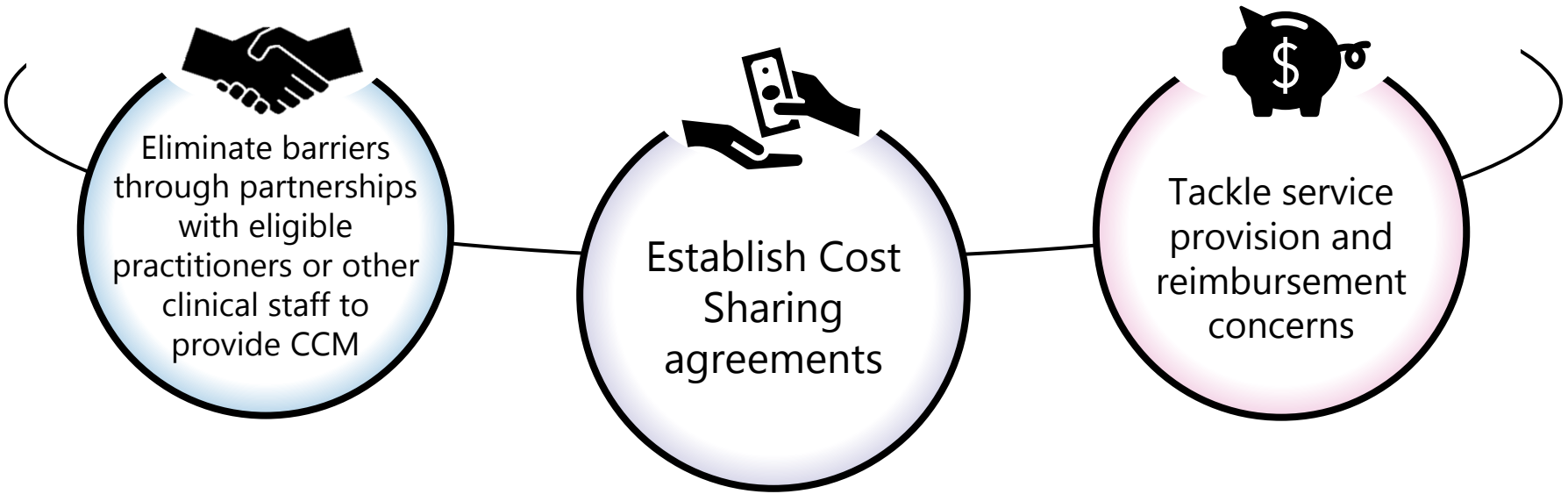
Cost Sharing



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Final Thoughts and Key Takeaways

- Don’t let perfection get in the way of progress
- Environmental scanning
- Learn from your peers
- Community partnerships
- Communicate and Outreach
- Post COVID-19 care model strategies

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Clinical Resources

1. AAFP/FPM CCM Coding Updates for 2020
2. CMS Connected Care Toolkit CCM Resources
3. CMS Care Management Resources
4. CMS Chronic Care Management Services
5. Navigating Cancer: CCM 2020 CMS Changes
6. CMS MLN Summary of Policies CY 2020
7. CMS Medicare Claims Processing
8. Chronic Care Management Services
9. Chronic Care Management (CCM): An Overview for Pharmacists
10. MLN Connects Chronic Care Management Transcript
11. CMS QPP MIPS 2020 Improvement Activities
12. Forbes.com Mass Casualty Event Article
13. CMS Care Management Services: FQHC/RHC 2019
14. CMS FQHC/RHC COVID-19 Flexibilities

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Patient & Family Resources

1. AHRQ Blood Thinner Pills Safety Guide
2. AHRQ Spanish Blood Thinner Pills Safety Guide
3. AHRQ Patient & Consumer Information
4. AHRQ Managing Type 2 Diabetes
5. CMS CCM Patient Resources
6. CDC Blood Pressure Resources
7. CDC Heart Disease Resources
8. CDC How to Monitor Your Blood Sugar
9. USDA Choosemyplate-Eating Healthy
10. CDC COPD Self Management
11. NAMI-Helpline
12. ADAA Anxiety & Depression Brochures
13. NIH Osteoporosis National Resource Center
14. NIH Safe Use of Medication for Older Adults
15. BeMedWise.org Think It Through Brochure

Q&A

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