Jumpstart Your Chronic Care Management Program

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Objectives

At the end of this session the learner will be able to…

- Identify key components of CCM
- Present rationale for starting a CCM program
  1)Patient Care 2)Resource Optimization
- Produce an implementation plan for CCM

CCM Underlying Theme

- Reduce hospitalizations
- Reduce emergency visits
- Care team gets paid for services delivered

- **Improved CARE**

Questions to Ponder

Does your clinic provide Chronic Care Management Services?

- If so, how many patients are being served in the clinic? Share a success story with your neighbor.
- If not, share your rationale of why you haven't implemented a CCM program or why you have stopped the program.

CCM Overview

- Provides non-face to face team care
- Requires a consent
- Requires a care plan in place
- Requires 2 chronic diseases
- Requires at least 20 minutes in one month
- Work performed by anyone on clinical team

Complex CCM

- Same as CCM
- Requires 60+ minutes in calendar month
- Care plan change or creation
- Requires moderate decision making
- Involves Qualified Healthcare Professional (QHP)

Who is clinical staff?

"a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service; but who does not individually report that professional service."

CPT Professional 2019 p xii

"Incident to" rules

- Service doesn't have to be in-house
- "Incident to" exception – provider needs to be accessible
- What about outsourcing?

Outsourcing

- May streamline expansion of clinical team
- May not clearly achieve team CCM goals
- Billing provider responsible in audit, etc.
- Perform litmus test with comparison to next slide statements

"All CCM service codes are valued to include ongoing oversight, management, collaboration and reassessment by the billing practitioner consistent with the included service elements. This work cannot be delegated or subcontracted to any other individual."

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

"If there is little oversight by the billing practitioner or a lack of clinical integration between a third party providing CCM and the billing practitioner, we do not believe CCM could actually be furnished and therefore the practitioner should not bill for CCM."

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

How is time calculated?

- 10 minute discussion of case between two clinical staff is 10 minutes, not 20 minutes
- Not subject to 50% rule

Services Provided

- CMS expects all scope of service elements to be provided
- Exception: not medically indicated or necessary
- Perform all parts of the code descriptor

Appropriate CCM Activities

- Create or update care plans
- Just about anything in support of care plan
- Mine consult notes – chart, address, follow-up
- Medication management / reconciliation / PAs
- Family phone calls
- Administrative tasks by clinical staff

Inappropriate Activities to Bill

- Work overlapping with other E/M services
- Work by non clinical staff
- Work if no consent or no care plan

Other CCM Pearls

- No phone call required
- Billing not required every month
- Time does not carry over
- Count any task consistent with care plan
- Much of work is work already being performed
- Administrative time (i.e. charting) counts

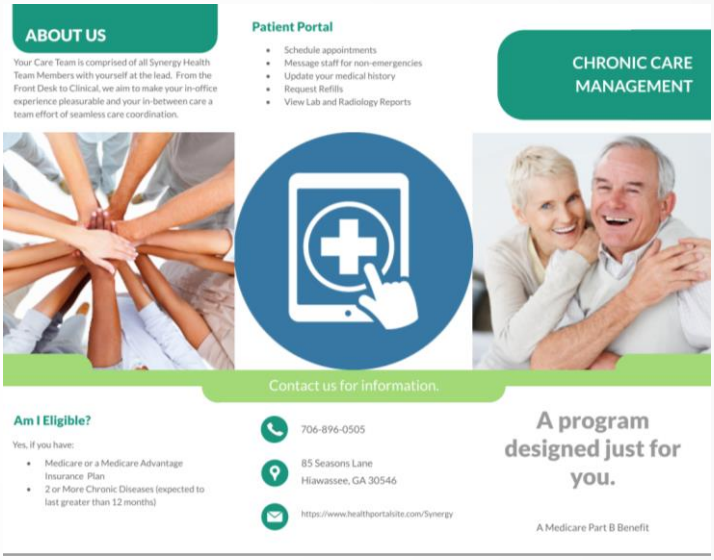
CCM in Action

- Need QHP and staff champions
- Understand care goals and underlying theme
- Have time tracking process
- Work up to implementation and start new staff communication

Early Analysis – Do The Math

500 Medicare patients… 2/3 estimated to be eligible	= 335 patients
Medicare payment = $41.58 …	$41.00
Monthly income	= $13,735
Yearly income	= $164,820

Develop a Custom Brochure



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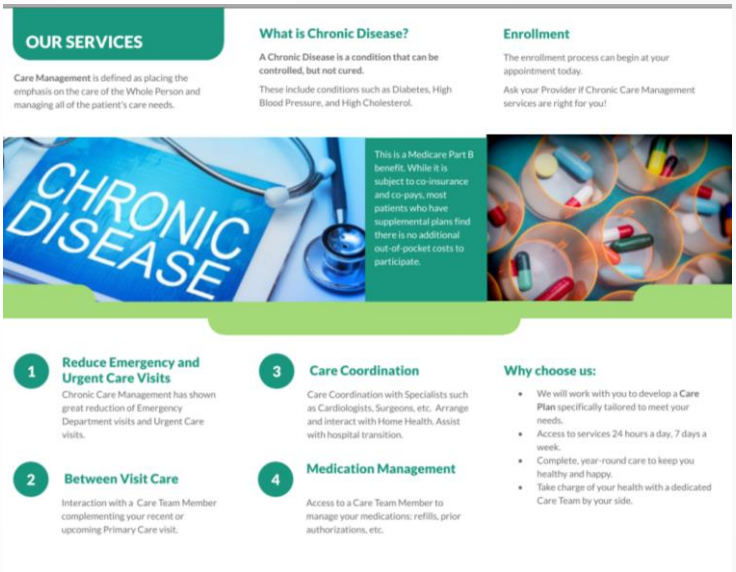

Slow Rollout

- Doesn't have to be perfect
- Identify appropriate patient TYPE
- QHP and staff identifies patients to enroll
- Be excited… invite, enroll, change culture
- Transition from episodic care to team care

First Steps

- Spend time on care plans *
- Show value to patients early

  E.g. – schedule a nurse call to review BP logs in a few weeks in lieu of an office visit – a win-win!
- Explain payment clearly

  $41, subject to co-insurance (20%)

Work Groups

- Best Practices/Challenges – Staffing
- Best Practices/Challenges – Workflow
- Implementation Barriers

Review of Workgroup Ideas

Video

Questions?

&

Answers

(hopefully)

Resources

Chronic Care Management Services
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Porter, Sheri. "Utilize CCM Codes to Maximize Patient Care, Payment." *AAFP Home*, 30 Nov. 2018, www.aafp.org/news/practice-professional-issues/20181130ccmcoding.html.

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