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Meet the Presenter…

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On the topic:
Chronic Care Management: New Revenue Possibilities
New Revenue Possibilities with Care Management Services

Presented by:
Rhonda Granja
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Boost Your Revenue

• Under the new Chronic Care Management program authorized by CMS as of 1-1-15, you can get paid for the work you are probably already doing.

• Many of your senior patients likely have two or more chronic conditions.
Boost Your Revenue

In the Final Rule, CMS has adopted CPT 99490 for Medicare CCM services, which is defined in the CPT Professional Codebook as follows:

“Chronic care management services, at least 20 minutes of clinical staff 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.”

The Stats…

2/3 of Medicare beneficiaries had 2 or more chronic conditions

1/3 had 4 or more chronic conditions

Source:
http://www.cdc.gov/pcd/issues/2013/12_0137.htm
What Is the Reimbursement for CCM?

For the first quarter of 2015, the national average reimbursement will be $40.39 per beneficiary per calendar month. This amount is subject to change thereafter based on Congressional action on the Sustainable Growth Rate (SGR) formula.

Example for GBA region $41.35.

What Is the Reimbursement for CCM?

To find payment information for a specific geographic location, access the Medicare PFS Look-Up tool at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup) on the CMS website.
New Guidance

Two new resource documents have been issued per CMS:

http://go.cms.gov/1A47UO1
http://go.cms.gov/17MzZNa

There is now more clarity and some changes to the rules. Be sure to add to your rule book!

*This was issued 05/2015

New Guidance

For example: The new FAQ says: “When the 20 minute threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month.”

CMS also says providers can bill CCM to Part B on hospital or SNF patients “if the patient is not an inpatient the entire month.”
Practitioner Eligibility

Physicians and the following non-physician practitioners may bill the new CCM service:

* Certified Nurse Midwives
* Clinical Nurse Specialists
* Nurse Practitioners
* Physician Assistants

New Opportunities

• In 2013, the Centers for Medicare & Medicaid Services (CMS) acknowledged the additional work involved in managing a patient following a hospital discharge was not covered by existing reimbursement. CMS, therefore, created a new payment for transitional care management, or TCM.
New Opportunities

• A physician who furnishes specified services for a Medicare beneficiary over a 30-day post-discharge period receives payment roughly equal to the highest payment for a new patient office visit.

How Do I Start?

• Identify those patients in which the physician or other qualified health care professional has determined that they have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
How Do I Start?

• Inform the patient that you will be providing them with this service and obtain their signed permission on an agreement that you make part of the medical record.

How Do I Start?

• Provide 20 minutes or more of chronic care management services per patient per 30 days. The 20 minutes cannot be time spent during a routine encounter.
Supervision

• CMS provided an exception under Medicare’s “incident to” rules that permits clinical staff to provide the CCM service incident to the services of the billing physician (or other appropriate practitioner) under the **general supervision** (rather the direct supervision) of a physician (or other appropriate practitioner).

Patient Consent Agreement for Chronic Care Services

• Medicare now offers a new benefit for patients with multiple chronic diseases, and by consenting to this Agreement, you designate your provider, (Provider Name) ___________________ “Provider,” to provide chronic care management (CCM) services per the new rule.

• Only patients with more than one chronic condition are eligible for this benefit and your provider agrees not to bill Medicare for this service if you don't have more than one chronic condition. Medicare defines a chronic condition as one that is expected to last at least 12 months, and that increases the risk of death, acute exacerbation of disease, or a decline in function.
Provider Chronic Care Services

• As part of this new benefit, your Provider agrees to make available the following services:
  • 24/7 access to a healthcare provider to address your acute chronic care needs
  • Use of certified EFIR software to document your care
  • Provide a written or electronic version of your care plan
  • Perform medication reviews and oversight
  • Assist in the management of transitions of care from one provider to another

Provider Chronic Care Services

• In connection with this new benefit, your provider agrees to bill Medicare just one time per each 30-day billing cycle and if you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation.
Beneficiary Consent Terms

By signing this Agreement, you agree to the following terms required by Medicare:

You consent to your Provider providing CCM services to you.
You acknowledge that only one practitioner can furnish CCM Services to you during a thirty (30)-day period.
You authorize electronic communication of your medical information with other treating providers to facilitate the coordination of your care.
You understand that the Medicare Co-Insurance amount applies to CCM Services.
You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty 30-day period of services by notifying our practice in writing.

Beneficiary or Caregiver
Signature __________________ Print Name __________________ Date ____________

How Do I Start?

• Provide access to chronic care management services 24/7

• Give patients a way to make timely contact with health care providers to address urgent chronic care needs.
What You Need to Do

• Ensure the patient has continuity of care with a designated practitioner or member of the care team, and is able to get successive appointments with them. The designated member of the care team does not need to be a DO or MD.

What You Need to Do

• Provide care management of chronic conditions that includes:
  • Systematic assessment of patient’s medical, functional, and psychosocial needs.
  • System-based approaches to ensure timely receipt of all recommended preventive care services.
  • Medication reconciliation with review of adherence and potential interactions.
  • Oversight of patient self-management of medications.
What You Need to Do

• Create a patient-centered care plan document to assure care is provided in a way that is compatible with patient choices and values and provide a written or electronic copy of the care plan to the patient.

What You Need to Do

• Manage care transitions between and among health care providers and settings.

• Coordinate with home and community-based clinical service providers as appropriate.
The Patient Agreement Must Explain…

• That only one practitioner can furnish and be paid for these services during a 30-day period.

The Patient Agreement Must Explain…

• That the patient can terminate the agreement verbally or in writing at any time.
The Patient Agreement Must Explain...

- That Medicare co-insurance payments apply and that a co-insurance payment of approximately $8 per month will be billed for each 30-day period that your practice bills for the service.

Which Practitioners Are Eligible to Bill Medicare for CCM?

- Physicians (regardless of specialty) advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse midwives (or the provider to which such individual has reassigned his/her billing rights) are eligible to bill Medicare for CCM.

- Other non-physician practitioners and limited-license practitioners (e.g., clinical psychologists, social workers) are not eligible.
What About a Rural Health Clinic?

- For now, CMS has not recognized CCM as an RHC or RQHC service; thus, these providers will not be reimbursed at their all-inclusive rate for CCM services.
  - An RHC or FQHC may have the opportunity to bill for CCM on the Medicare Physician Fee Schedule, provided it satisfies the applicable requirements to bill for non-RHC/non-FQHC services.

What Do We Use for a Date of Service?

- CMS hasn't addressed this particular question. Code 99490 is intended to encompass a calendar month's worth of work. Box 24 on the CMS-1500 claim form does allow a “From” and “To” date, so consider putting the first date of the month in “From” and the last day as “To” as a line item. Since code 99490 spans the entire month, I would refrain from billing until the last day of the month.
  - *Refer to new guidance links given in this presentation.
Examples of Chronic Conditions

- Cancer
- Diabetes
- Hypertension
- Stroke
- Heart disease
- Pulmonary conditions
- Mental illness including addictions
- Asthma
- Obesity
- Depression
- COPD

Examples of Chronic Conditions

- Alzheimer’s disease
- Arthritis (osteoarthritis and rheumatoid)
- Autism spectrum disorders
- Osteoporosis
Comprehensive Care Plan

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialists outside the practice will be directed
- Periodic review and when applicable, revision of the care plan

How Do I Compile the Care Plan?

- “Tell me about the health conditions that you have…”

- “What do you know about your <health conditions> …?”

- “What might happen to you if you do not keep your <health condition> under control?”
How Do I Compile the Care Plan?

- “What prevents you from making or attending your medical appointments?”
- “How comfortable are you talking with your doctor/nurse about your medical conditions?”

How Do I Compile the Care Plan?

- “Tell me about the symptoms you experience / how you keep track of them / how you manage them…”
- “What do you do to keep yourself as healthy as possible?”
How Do I Compile the Care Plan?

• “Tell me how and why you take your medications…”

• “What are some other treatments that you are using now, or have tried in the past?”

• “What side effects have you experienced from taking your medications?”

How Do I Compile the Care Plan?

• “How well do you understand your health condition(s) and treatment(s)?”

• “How well do you communicate with your family and your health care providers about your health condition?”

• “How does your health condition change your life - Physically? Emotionally? Socially?”
How Do I Compile the Care Plan?

- Be sure to set goals from the patient's perspective as well as the physician.

- Determine who is responsible for the intervention (patient or provider).

Note:

- While the code was designed primarily to help primary care providers to be paid for chronic care management, specialists can also bill under this code if they are providing chronic care management.
  - However, if the patient's primary care physician is one of your main referral sources and you expect they may want to bill for CCM, you may want to defer to the primary for this service, as it will preclude their claim.
Tips, Tools, and Techniques

1. CCM and TCM codes are worth capturing.

2. Explain to patients their rights and responsibilities.


Questions?

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Thank you for your attendance!