Chronic Care Management
Shannon Chambers
The Case for Chronic Care Model

To deliver high-quality chronic care to all our patients in a way that a busy clinic can manage, we need to rethink how we deliver the care.

The Chronic Care Model provides us with a framework for thinking about this, and essential tools to help improve our processes.

In particular, a focus on care teams and use of registries can help you get started on redesigning your care delivery to better meet the needs of chronically ill patients.
Current Care Management Rates

Effective January 1, 2023, care management services furnished in RHCs include chronic care management (CCM), principal care management (PCM), chronic pain management (CPM), and general behavioral health integration (BHI) services.

- Paid at the average of the national non-facility PFS payment rates, either alone or with other payable services
- Use general care management HCPCS code G0511
- 2023 rate for G0511 is $77.94
Current Care Management Rates cont.

Psychiatric CoCM services furnished on or after January 1, 2019

Paid at the average of the national non-facility PFS payment rates, either alone or with other payable services

Use general care management HCPCS code G0512

2023 rate for G0512 is $146.73
Current Care Management Rates cont.

Transitional Care Management services furnished on or after January 1, 2019

• Paid at the RHCs All Inclusive Rate
• Use CPT code 99495 (Face to Face visit occurs within 14 days of discharge for moderate complexity decision making)
• Use CPT code 99496 (Face to Face visit occurs within 7 days of discharge for high complexity decision making)
• Only one TCM visit can be billed per patient during 30 day post-discharge period
• If billed on the same day as another RHC billable visit RHC will only receive the AIR rate once
Key Components of Chronic Care Model

1. Informed, Activated Patient
2. Productive Interactions with Prepared, Proactive Practice Team
3. Decision Support
4. Clinical Information Systems
5. Delivery System Redesign
6. Self-Management Support
What is the ROI?

If a clinic has 50 Medicare patients enrolled in CCM:
- 20 Minutes spent on each patient would only be 16.6 hours per month.
- 50 patients at $77.94 = $3,897
- For 12 months at this volume, it would be $46,764 a year.

If a clinic has 100 Medicare patients enrolled in CCM:
- 20 minutes spent on each patient would only be 33.3 hours per month
- 100 patients at $77.94 = $7794.00
- For 12 months at this volume, it would be $93,528 a year.

If a clinic has 150 Medicare patients enrolled in CCM:
- 20 minutes spent on each patient would only be 50 hours per month.
- 150 patients at $77.94 = $11,691
- For 12 months at this volume, it would be $140,292 a year.
Non-Face-To-Face Activities

- Monthly Clinical Chart Review
- Telephone Call With Patient, Caregiver or family
- Physician Review of labs/test
- Physician Review of Care Plan
- Discussions with Other Providers
- Scheduling Appointments/Services
- Referrals
- Prescription Refills
- Portal Messaging
- ePrescribe
- Home Health / Hospice Orders
- Care Plan Reconciliation
- Medico-Legal Coordination

- Telephone Call with Provider
- Telephone Call with Facility
- Updating Patient Health Record
- Lab/Radiology Orders
- Patient/Facility Forms
- Physician Review of Consult Notes
- Physical Review of hospital/Facility Records
- Initial Patient-Centered Care Plan
- Letter to Patient
- Letter to Provider
- Preauthorization
- Discussion With Patient’s Family or Caregiver
Care Management Services

- Transitional Care Management (TCM)
- Principal Care Management (PCM)
- Chronic Care Management (CCM)
- Chronic Pain Management (CPM)
- General Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)
<table>
<thead>
<tr>
<th>TCM</th>
<th>Communication (direct) must be within 2 business days of discharge.</th>
<th>30 day period begins on the day of discharge and continues for the next 29 days.</th>
<th>Service date should be the face-to-face visit date.</th>
</tr>
</thead>
<tbody>
<tr>
<td>99495 –Moderate Complexity. Visit must be completed within 14 days of discharge.</td>
<td>99496-High Complexity. Visit must be completed within 7 days of discharge.</td>
<td>Only service- Paid as Stand alone. Same day- another visit, then only 1 visit is paid.</td>
<td></td>
</tr>
</tbody>
</table>
PCM

- Minimum of 30 minutes of qualifying PCM services for the calendar month.
- A single complex chronic condition lasting at least 3 months, which is the focus of the care plan.
- The condition is sufficient severity to place the patient at risk of hospitalization or have been the cause of a recent hospitalization.
- The condition requires development or revision of disease-specific care plan.
- The condition requires frequent adjustments in medication.
- The condition is unusually complex due to comorbidities.
CCM Requirements

**PATIENT**
- 2 or More Chronic Conditions
- Serious Health Risk or at risk of death
- Must Consent to the CCM Service
- May have a Co-pay

**PROVIDER**
- Must use a Certified EHR Technology
- 20 minutes per patient per month
- 24/7 Access to Care Management Services
- Comprehensive Patient-Centered Care Plan
- Documented time spent per patient
- Care Plan available 24/7 to entire staff
- Monthly Reports and Summary of CCM
- Care Plan shared with EMR and other providers

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**SOUTH CAROLINA OFFICE OF RURAL HEALTH**
Chronic Care Management

**Billing:** At least 20 minutes of chronic care management and coordination services each month (G0511)

** Eligibility:** Patients must have 2 chronic conditions- these conditions place the patient at a significant risk of death, acute exacerbation/decompensation, or functional decline (e.g. Diabetes, Heart Failure, Alzheimer’s)

**Requirements:**
- Patient information on EHR, includes demographics, problems, medications, allergies and available electronically outside of RHC if needed.
- Comprehensive care plan is established, implemented, revised or monitored.
- 24/7 access- provides patients with a means to make contact with practice to address urgent needs.
CPM

Minimum of 30 minutes of qualifying non-face-to-face time for the calendar month.

Patient must have multiple chronic conditions that involve chronic pain.

Must have a person-centered plan of care.

Care coordination, medication management and other aspects of pain management are discussed.
CCM, BHI or CoCM

• Requirements:
  o Initiating Visit: A visit within the prior 12 months
  o Beneficiary Consent: Obtained during or after initiating visit and before provision of care coordination, Written or verbal consent document in the medical record.
  o Explanation: Cost sharing, only one practitioner can bill for care coordination, patient has the right to stop care coordination at any time (effective at the end of the calendar month), and the patient has given permission to consult with relevant specialists.
Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list;
- Expected outcome and prognosis;
- Measurable treatment goals;
- Symptom management;
- Planned interventions and identification of the individuals responsible for each intervention;
- Medication management;
- Community/social services ordered;
- A description of how services of agencies and specialists outside the practice will be directed/coordinated; and
- Schedule for periodic review and, when applicable, revision of the care plan.
Comprehensive Care Plan

- Patient Directed, Electronically created
- Copy inside EMR & copy to patient
  - Doesn’t have to be built in HER

- Available to other providers
  - Remote access, fax, messaging
  - Provide in timely manner

- Assess and reassess as needs change (recommend every time CCM is billed). Minimum update is at least yearly
24/7 Access to Care

- Ensure continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.

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- Patient plan of care & info accessible.

- Plan to call members at times where you can be proactive for care – all about learning self care.
Access to Care & Care Continuity

• Provide 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified health care professionals or clinical staff, including providing patients (and caregivers as appropriate) with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week.

• Each PCP is responsible for ensuring resources to provide covered physician services are available as needed 24 hours a day, 365 days a year. PCPs must provide participants with an after-hours telephone number. The after-hours number must connect the participant to at least one of the following:
  o Answering service
  o Call center system
  o Recording that directs the caller to another number to reach the PCP or PCP-authorized medical practitioner
  o System that automatically transfers the call to another telephone line answered by a person who will contact the PCP
CCM Claim Example

| 0521 | G0511 | 100.00 |

The CG Modifier is NOT appended to the G0511. Deductible and Coinsurance apply to CCM.
General BHI

**Billing:** Same as CCM

**Eligibility:** Any behavioral health or psychiatric condition being treated by the RHC including substance use disorder, that, in the judgment of the RHC practitioner, warrants BHI services.

**Requirements:**

- Initial assessment of follow-up monitoring, including the use of applicable validated rating scales,
- Behavioral health care planning in relation to behavioral psychiatric health problems, including the revision of pts who are not progressing or whose status changes,
- Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling/psychiatric consults) AND
- Continuity of care with a designated member of the care team.
Psychiatric CoCM

- **Billing:** At least 70 minutes in the first month and at least 60 minutes in subsequent calendar months. (G0512- $145.96)

- **Eligibility:** Any behavioral health or psychiatric condition being treated by the RHC including substance use disorder, that, in the judgment of the RHC practitioner, warrants BHI services.

- **RHC Provider Requirements:**
  - Direct the behavioral care manager or clinical staff.
  - Oversee the care including prescribing medications, providing treatments for medical conditions and making referrals to specialty care when needed.
  - Remain involved through ongoing oversight, management, collaborations and reassessment.
• Behavioral Health Care Manager requirements:
  • Provide assessment and CM services, including validated rating scales, behavioral health care planning, revision for patients who are not progressing, provision of brief psychosocial intervention, ongoing collaboration with RHC practitioner.
  • Be available to provide services face-to-face with patient
• Psychiatric Consultant requirements:
  • Participate in regular reviews of the clinical status of the patient
  • Advise the RHC practitioner regarding diagnosis, options for resolving issues with patient adherence and tolerance of behavioral health treatment, making adjustments to treatment plans who patients who are not progressing
  • Facilitate referral for direct provision of psychiatric care when clinically indicated.
• CCM Care team members can be classified into three categories based on their profession and roles on the team.
  o Qualified Healthcare Professionals- Physicians, NPs, PAs, Clinical Nurse Specialists, Certified Nurse Midwives.
  o Clinical Staff- Pharmacists, Nurses, Social Workers and Certified Medical Assistants
  o Non-Clinical Staff- Referral Coordinator, Front Desk, etc
Care Manager Role in CCM

- Registry work/Panel management
- Provide educational materials
- Pre-Visit Planning
- Planned visits
- Health Coaching/Care Plans
- Coordinating transitions of care
- Linking patients to community resources
- Care Manager
Patient Consent for Enrollment

• Consent can be verbal or written
• Share required information:
  • Explain services
  • Patient costs: co-pay, etc.
  • Only 1 PCP bills per month
  • Service Months can be non-consecutive
  • Consult/share patient info with others
• Documentation to for audit compliance
<table>
<thead>
<tr>
<th>Categories</th>
<th>Clinician</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone Call with Patient</td>
<td>Dr A/ Nurse</td>
<td>03-12-2023</td>
<td>12:10p-12:14p (4)</td>
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<tr>
<td>Medication Review</td>
<td>Dr A/ Nurse</td>
<td>03-16-2023</td>
<td>3:19p-3:23p (4)</td>
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<tr>
<td>Referral Tracking</td>
<td>Dr A/ Referral Coordinator</td>
<td>03-16-2023</td>
<td>4:22p-4:26p (4)</td>
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<tr>
<td>Referral Review</td>
<td>Dr A</td>
<td>03-18-2023</td>
<td>8:20a-8:25a (5)</td>
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<tr>
<td>Telephone Call with Patient</td>
<td>Dr A/Nurse</td>
<td>03-18-2023</td>
<td>11:17a-11:22a (5)</td>
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</tbody>
</table>

**TOTAL TIME** 22 Minutes
Questions
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