SOUTH CAROLINA OFFICE OF
RURAL HEALTH
Investment. Opportunity. Health.

Care Management: The Whole Picture

Shannon Chambers

The Stats

- 3 out of 4 American adults have at least one chronic condition, and over half have two or more chronic conditions.
- 40% of Americans have 2+ chronic conditions
- People with chronic conditions account for around 90% of all health care spending
- Chronic diseases are the leading cause of illness, disability, and death in America.

https://www.cdc.gov/chronic-disease/data-research/facts-stats/index.html

Key Components of Chronic Care Model

Informed, Activated Patient

Productive Interactions with Prepared, Proactive Practice Team

Decision Support

Clinical Information Systems

Delivery System Redesign

Self-Management Support

Requirements

- Initiating visit- new patients or patients who haven't been seen within the previous 1 year.
- Care Management must be discussed during an E/M, AWV or IPPE visit. If not, then it doesn't count as the initiating visit.
- Patient consent- must be written or verbal and documented in the patient record. Explanation of cost sharing must be discussed. Patient can stop CCM at anytime.
- Only one practitioner can provide during a calendar month.
- Comprehensive Care Plan, 24/7 access to care and care continuity.

COMPREHENSIVE PATIENT- CENTERED CARE PLAN

ACCORDING TO CMS

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.

Access to Care & Care Continuity

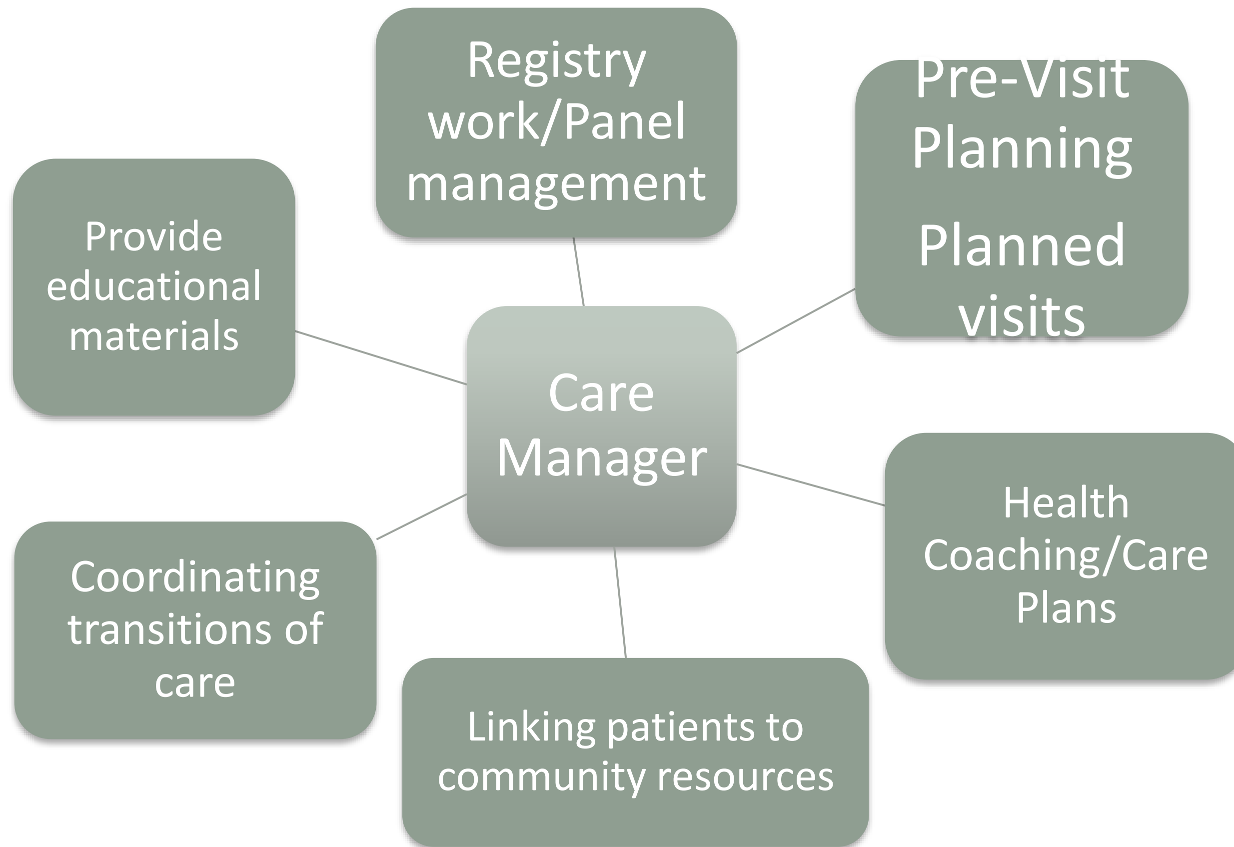
- Provide 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified health care professionals or clinical staff, including providing patients (and caregivers as appropriate) with a means to make contact with health care professionals in the practice to address urgent needs regardless 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:
  - Answering service
  - Call center system
  - Recording that directs the caller to another number to reach the PCP or PCP-authorized medical practitioner
  - System that automatically transfers the call to another telephone line answered by a person who will contact the PCP

Care Team

- CCM Care team members can be classified based on their profession and roles on the team.
  - Qualified Healthcare Professionals- Physicians, NPs, PAs, Clinical Nurse Specialists, Certified Nurse Midwives.
  - Clinical Staff- Pharmacists, Nurses, Social Workers and Certified Medical Assistants
  - Clinical Pharmacist
  - Community Health Worker, Community Paramedic, Peer Support Specialist
  - Non-Clinical Staff- Referral Coordinator, Front Desk, etc

Care Manager Role in CCM



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

Insurer’s Definition of Who Can Benefit

- Risk Adjustment Scoring
- Nurse Care Manager contacts
- Gaps in Care Lists
- Portal or Paper Based Registries
- Medication Non-Adherence
- “Frequent Flyer” in ER or Hospital
- Post Hospitalization trigger

Care Management Services

- Care management includes the following services:
  - Transitional Care Management (TCM)
  - Principal Care Management (PCM)
  - Chronic Care Management (CCM)
  - Advanced Primary Care Management (APCM)
  - Community Health Integration (CHI)
  - Principal Illness Navigation (PIN)
  - Remote Patient Monitoring (RPM)
  - Remote Therapeutic Monitoring (RTM)
  - Behavioral Health

TCM

- TCM is a comprehensive set of services designed to make sure patients get coordinated and continuous care as the transition from an inpatient care setting back to their community.
- Only one practitioner can bill for this service.
- 30 day period begins on the day of discharge and continues for the next 29 days.
- Service date should be the face-to-face visit date.
- TCM is billed as 99495 (Moderate) or 99496 (High) to an RHC Claim, either alone or with other payable services.
- If it is the only medical service provided on that day then it is paid as a stand-alone visit.
- Can be billed concurrently with CCM services.
- 2026 Reimbursement paid at all inclusive rate.

PCM

- Focuses on a single, high-risk condition expected to last at least 3 months that could result in hospitalization, exacerbation of the condition, functional decline or death.
- PCM is monthly if the patient needs it.
- Requires at least 30 minutes of providing PCM to bill.
- Reimbursement:
  - **99424- PCM Physician 1st 30 mins- $84.27**
  - **99425- PCM Physician each additional 30 mins-$59.15 (add on code)**
  - **99426- PCM Staff 1st 30 mins-$ 65.02**
  - **99427- PCM Staff each additional 30 mins. -$51.68 (add on code)**

CCM Breakdown

Code	Care Type	Staff Type	Time	Payment
99490	CCM	Clinical Staff	First 20 min	$63.47
99439	CCM	Clinical Staff	Each add'l 20 mins	$48.26
99491	CCM	Provider	First 30 min	$85.99
99437	CCM	Provider	Each add'l 30 mins	$60.70
99487	Complex CCM	Clinical Staff	First 60 mins	$137.60
99489	Complex CCM	Clinical Staff	Each add'l 30 mins	$74.58
G3002	Pain Management	Provider	First 30 min	$83.01
G3003	Pain Management	Provider	Each add'l 15 mins	$30.46

Ability to Log Time

Categories	Clinician	Date	Time
Telephone Call with Patient	Dr A/ Nurse	03-12-2025	12:10p-12:14p (4)
Medication Review	Dr A/ Nurse	03-16-2025	3:19p-3:23p (4)
Referral Tracking	Dr A/Referral Coordinator	03-16-2025	4:22p-4:26p (4)
Referral Review	Dr A	03-18-2025	8:20a-8:25a (5)
Telephone Call with Patient	Dr A/Nurse	03-18-2025	11:17a-11:22a (5)
		TOTAL TIME	22 Minutes

APCM

Code	Staff	Conditions	Payment
G0556	Provider	0-1	$15.71
G0557	Provider	2 or more	$51.52
G0558	Provider	2 or more and QMB.	$112.27

Advanced Primary Care Management services combine elements of PCM, TCM, and CCM. ***There is no time requirement***. This was established since patients can go back and forth between care management services. Essentially, it's a bundled payment.

CHI

- Community Health Integration is for patients with unmet social needs that affect diagnosis/treatment of their medical problems by connecting them with clinical/social support and resources.
- Can be billed Monthly (must be medically necessary)
- Must follow an E/M services where you find SDOH
- Community Health Workers, Care Navigators, Peer Support Specialists, Community Paramedics and other auxiliary personnel if the provider completes the required supervision.
- Reimbursement:
  - **G0019- 60 mins- $81.99**
  - **G0022- Each additional 30 mins- $51.65**

Principal Illness Navigation

- Principal illness navigation is a type of care management that helps patients understand their medical condition or diagnosis and guides them through the health care system.
- Condition must be serious, at least 3 months, significant risk for hospitalization, exacerbation, functional decline, or death.
- Provider or staff can provide services or other trained personnel including patient navigators or peer support specialists.
- Reimbursement:
  - **G0023- 60 mins- $82.92**
  - **G0024- Each additional 30 mins- $51.96**

RPM

- 3 main components- Education and set-up, Device Supply, and Treatment and Management.
- Must be for a medically necessary diagnosis.

Code	Descrition	Payment
99453	RPM Set up	$20.01
99454	RPM Device	$48.12
99457	RPM monitoring 1st 20 mins	$49.29
99458	RPM each add'l 20 mins	$39.72

RTM

- Technology to track non-physiological data- Blood Sugar, Blood Pressure, Heartbeat, and Oxygen Levels.
- Must be for a medically necessary diagnosis.

Code	Descrition	Payment
98975	RTM Set up	$20.01
98976	RTM Device Resp	$48.12
98977	RTM Device mscskl	$47.50
98980	RTM monitoring 1st 20 mins	$51.50
98981	RTM each add’l 20 mins	$39.74

Behavioral Health

- **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.

99484-$55.30

Return on Investment

Type	# of patients enrolled	Reimburseme nt	Total Revenue	**Total Annual Revenue**
PCM (Provider)	50	$84.27	$4,213.50	$50,562.00
CCM (Provider)	50	$85.99	$4,299.50	$51,594.00
APCM Level 2	50	$51.52	$2,576.00	$30,912.00
CHI	50	$81.99	$4,099.50	$49,194.00
RPM (setup, device, and 1st month)	50	$117.42 ($20.01,$48.12 and $47.50)	$5871.00	$70,452.00

Questions

SOUTH CAROLINA OFFICE OF

RURAL HEALTH

Investment. Opportunity. Health.

CONTACT US

Shannon Chambers, CPC
Sr. Director of Provider Solutions
Chambers@scorh.net

Social:

Website:
scorh.net

Address:
107 Saluda Pointe Drive
Lexington, SC 29072

Phone:
803-454-3850

Text SCRURALHEALTH to 66866 to subscribe to our "Rural Focus" newsletter!