Connecting the Dots: Diabetes and Chronic Care Management

2023
Trails to Collaboration
Diabetes & Healthcare Conference
April 14-15
Laramie, WY

UNIVERSITY OF WYOMING

Wyoming Center on Aging

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Disclosures to Participants

Notice of Requirements for Successful Completion:

Learners must participate in the full activity and complete the evaluation in order to claim continuing education credit/hours.

Presenter has No - Conflicts of Interest/Financial Relationships Disclosures:

Kevin J Franke

Disclosure of Relevant Financial Relationships and Mechanism to Identify and Mitigate Conflicts of Interest: No conflicts of interest

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Off-label Use: None

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OBJECTIVES

- Understand the elements of Chronic Care Management Services, including patient and practice eligibility.
- Describe how a team-based Chronic Care Management program has been implemented into clinical practice.
- Describe benefits to the patient and the clinic, both in better care and reimbursement.

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UNIVERSITY OF WYOMING

Wyoming Center on Aging

The mission of the Wyoming Center on Aging is to optimize the health and well-being of Wyoming's older residents and their caregivers through interagency partnerships, basic and applied research, community education, and clinical training and services

https://youtu.be/nXsGc_fC0T8

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Partnership for Solution

A Project of Johns Hopkins University and The Robert Wood Johnson Foundation

"People with chronic conditions are getting services, but those services are not necessarily in sync with one another, ……to maintain health and functioning."

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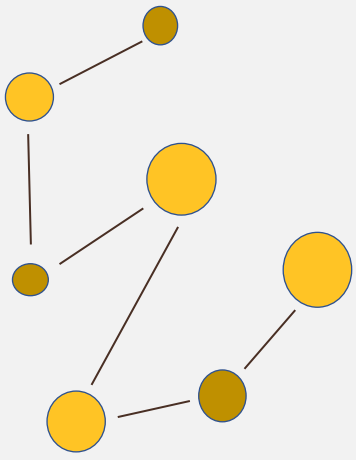
Care Coordination



- Chronic Care Management (CCM)
- Transitional Care Management (TCM)
- Behavior Health Integration (BHI)
- Collaborative Care Management (CoCM)
- Remote Physiologic Monitoring (RPM)
- Principal Care Management (PCM)
- Welcome to Medicare (IPPE)
- Annual Wellness Visit (AWV)
- Advance Care Planning (ACP)

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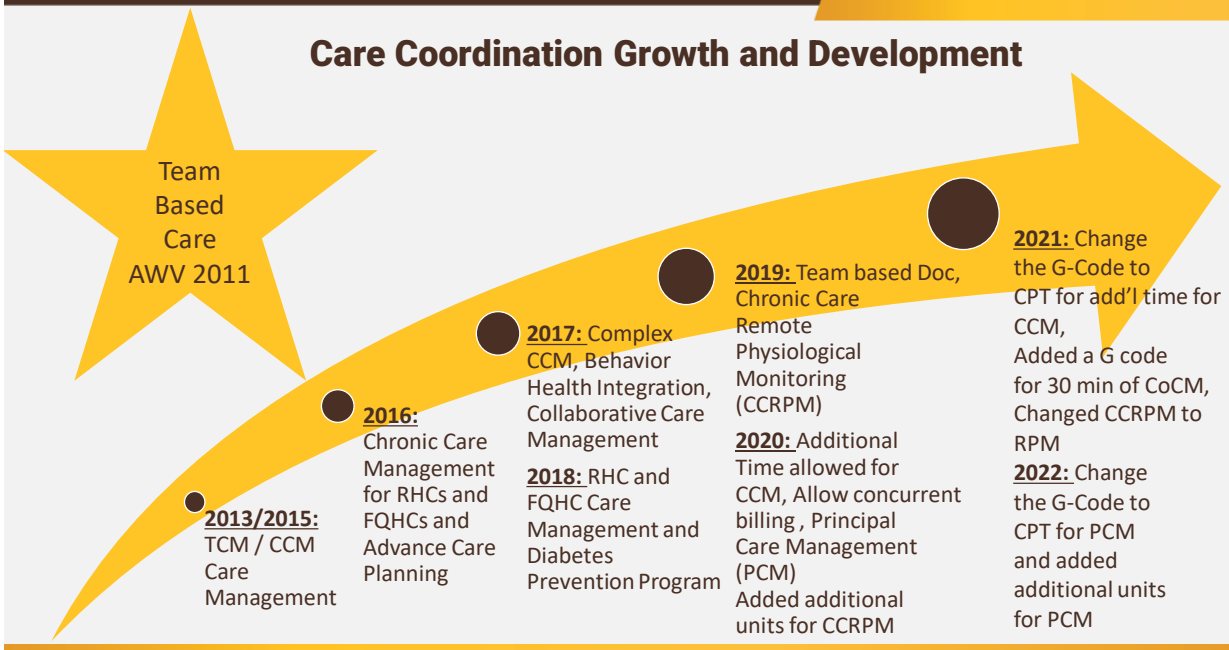
Care Coordination Growth and Development



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New for 2023

Medicare Chronic Pain Management

- **G3002:** Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using G3002, 30 minutes must be met or exceeded.)
- **G3003:** Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for G3002. When using G3003, 15 minutes must be met or exceeded.)

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Changing Model

"We acknowledged that the care coordination included in services such as office visits does not always describe adequately the non-face-to-face care management work involved in primary care and may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries"

CMS CFR 7-15-2015

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How Well is Care Coordination Working?

"…CMS estimated that approximately 3 million unique beneficiaries (9% of the Medicare FFS pop) received [care coordination] services annually, with a higher use of CCM, TCM and advance care planning services"

Noted outcomes:

"reduced readmission rates, lower mortality, and decrease health care costs"

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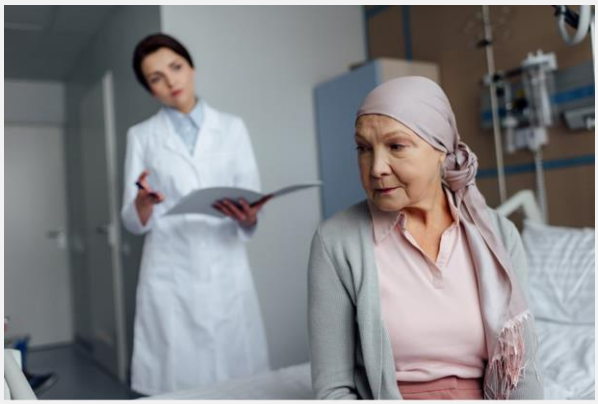
We need to focus on to “WHOM” not “WHERE” when discharging patients.



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Transitional Care Management (TCM)

To improve the coordination of care for Medicare patients between the acute care setting and community setting, the Centers for Medicare & Medicaid Services created two billing codes for Transitional Care Management (TCM). The goal of TCM is for a provider to “oversee management and coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support.” TCM requires initial contact with the patient within two business days after discharge, a face-to-face visit within a specified period of time, and moderate or high medical decision making during the 30-day service period.

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Transitional Care Management (TCM)

The goal of TCM is for a provider to "oversee management and coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support."

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Transitional Care Management (TCM)

Required patient transitional care management (TCM) services include:

- Supporting a patient's transition to a community setting
- Health care professionals who accept patients at the time of post-facility discharge, without a service gap
- Health care professionals taking responsibility for a patient's care
- Moderate or high complexity medical decision making for patients with medical or psychosocial problems

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2023 - Care Coordination CPT Codes
The National Average represents the average Medicare allowable (excluding RHCs and FQHCs for billing Medicare)

Transitional Care Management (TCM)

- **Post Hospital Office visit within 7 days**
  - **CPT Code 99496 National Average Reimbursement ~$271.43**
- **Post Hospital Office visit within 14 days**
  - **CPT Code 99495 National Average Reimbursement ~$200.35**

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Chronic Care Management (CCM)

Chronic care management (CCM) is a critical component of primary care that contributes to better outcomes and higher satisfaction for patients and providers. The Centers for Medicare & Medicaid Services (CMS) recognizes CCM takes time and effort. CMS established separate payment under billing codes for the additional time and resources you spend to provide the between-appointment help many of your Medicare and dual-eligible (Medicare and Medicaid) patients need to stay on track with their treatments and health plans.

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Elements for Chronic Care Management (CCM)

Practice Eligibility

- Qualified EMR
- Availability of electronic communication with patient and caregiver
- Collaboration and communication with community resources & referrals
- After hours coverage
- Care Plan Access
- Primary Care Provider supervision of clinical staff

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Elements for Chronic Care Management (CCM)

Patient Eligibility

- Medicare Patient (Part B Service)
- Two or more chronic conditions expected to last at least 12 months or until the death of the patient
- At significant risk of death, acute exacerbation, decompensation, or functional decline without management
- Patient Consent
- CCM initiated by the primary care provider

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2023 - Care Coordination CPT Codes
The National Average represents the average Medicare allowable (excluding RHCs and FQHCs for billing Medicare)

Chronic Care Management (CCM)

- Billed per calendar month for 20 min of care coordination

  CPT Code 99490 - National Average Reimbursement ~$61.16
- Billed with 99490 for each additional 20 min of care coordination – Max of 2

  CPT Code 99439 - National Average Reimbursement ~$46.28
- Billed per calendar month for 60 plus minutes of Complex Chronic Care Management

  CPT Code 99487 - National Average Reimbursement ~$129.93
- Billed with 99487 for additional 30 min per calendar month for Complex Chronic Care Management

  CPT Code 99489 - National Average Reimbursement ~$68.77

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Principal Care Management (PCM)

Designed to address those patients who have "significant resources involved in care management for a single high-risk disease or complex chronic condition"

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CMS INTENT

"We anticipate that in the majority of instances, PCM services will be billed when a single condition is of such complexity that it cannot be managed as effectively in the primary care setting, and instead requires management by another, more specialized, practitioner."

"Although we did not propose any restrictions on the specialties that could bill for PCM, we expect that most of these services will be billed by specialists who are focused on managing patients with a single complex chronic condition requiring substantial care management."

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Element of Principal Care Management (PCM)

Patient Eligibility

- Medicare Patient
- One serious chronic condition
- Condition will typically be expected to last between 3 months and 1 year or until the death of the patient
- May have led to a recent hospitalization and or place the patient at significant risk of death, acute exacerbation/decompensation or functional decline
- Patient Consent
- PCM initiated by the provider

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Element of Principal Care Management (PCM)

Practice Eligibility

- Qualified EMR
- Availability of electronic communication with patient and care giver
- Collaboration and communication with community resources & referrals
- After hours coverage
- Care Plan Access
- Provider supervision of clinical staff

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	Chronic Care Management	Principal Care Management
Time Requirement (services furnished by clinical staff under general supervision)	20 minutes/month	30 minutes/month
Number of Chronic Conditions	2 or more	1
Billing Practitioner (most cases)	Primary care provider	Specialist
Scope	Manage total patient care	Manage disease-specific care
Likely Utilization	General need for care coordination, communication	Exacerbation of condition or hospitalization
Intended Length of Time	Longer-term, as needed	Shorter-term, until condition is stabilized

PCM (Principal Care Management) vs CCM (Chronic Care Management)

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2023 - Care Coordination CPT Codes
The National Average represents the average Medicare allowable (excluding RHCs and FQHCs for billing Medicare)

Principal Care Management

- **Billed per calendar month for 30 min of care coordination by clinical staff**

  CPT Code 99426 RVU 1.0 National Average Reimbursement ~$59.84

- **Billed with 99426 for additional 30 min per calendar month of care coordination by clinical staff**

  CPT Code 99427 RVU .71 National Average Reimbursement ~$46.28

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Remote Physiologic Monitoring

- Must have patient consent / agreement for the service
- Must be ordered by a Provider
  - For specific reason
  - Treatment plan
- Device used must meet the FDA definition of Medical device
  - …"intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease…"
- Data must be wirelessly synced where it can be evaluated
- Device must be supplied for at least 16 days to be applied to the billing period

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2023 - Care Coordination CPT Codes
The National Average represents the average Medicare allowable (excluding RHCs and FQHCs for billing Medicare)

Remote Physiologic Monitoring

- Billed per calendar month for at least 20 minutes of patient and or care giver interaction related to remote physiologic monitoring treatment management services

  CPT Code 99457 National Average Reimbursement ~$47.61

- Billed with 99457 for additional 20 min of physiologic monitoring management services with the patient and or care giver in the month

  CPT Code 99458 National Average Reimbursement ~$38.68

- Billed on initiation for initial set-up and patient education of the monitor and service

  CPT Code 99453 National Average Reimbursement ~$18.84

- Billed each 30 days of supplying the device with daily recording ability

  CPT Code 99454 National Average Reimbursement ~$48.93

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2023 - Care Coordination Codes and Reimbursements for RHCs and FQHCs for Medicare billing

Care Management Services

- Care Management Services includes any of the following:
  - Chronic Care Management
  - Behavioral Health Integration
  - Principal Care Management

- Billed per calendar month for 20 plus minutes of care coordination and can only be billed once per month no matter what program you are doing care coordination under

  CPT Code G0511 RVU 1.23 National Average Allowable ~$76.04

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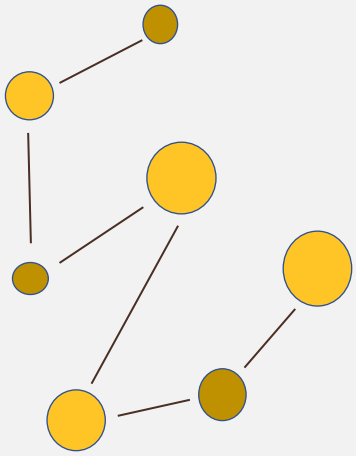
Care Coordination



Care Management Codes can be billed

CONCURRENTLY

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This is a **Team Approach**

People with serious and/or complicated medical needs will need care service from many different medical professionals (and caregivers) in multiple settings.

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Care Delivery Models

"…new and evolving care delivery models, which feature an increased role for non-physician practitioners (often as care coordination facilitators or in team-based care) have been shown to improve patient outcomes while reducing costs, both of which are important Department goals as we move further toward quality- and value-based purchasing of health care services in the Medicare program and the health care system as a whole."

Vol. 80 Wednesday, No. 135 July 15, 2015, P 226

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"This is GREAT information Kevin, but……

How does this help me and my diabetes program?"

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CMS is declaring its intended investment in the future of chronic care management services, indicating the agency views the services as an integral component of its overall long-term patient care strategy.

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CMS has significantly increased reimbursements for the time spent on chronic care management services.

CCM is *"consistent with our goals of ensuring continued and consistent access to these crucial care management services and acknowledges our longstanding concern about undervaluation of care management under the physician fee schedule."*

CMS CFR 11-19-2021

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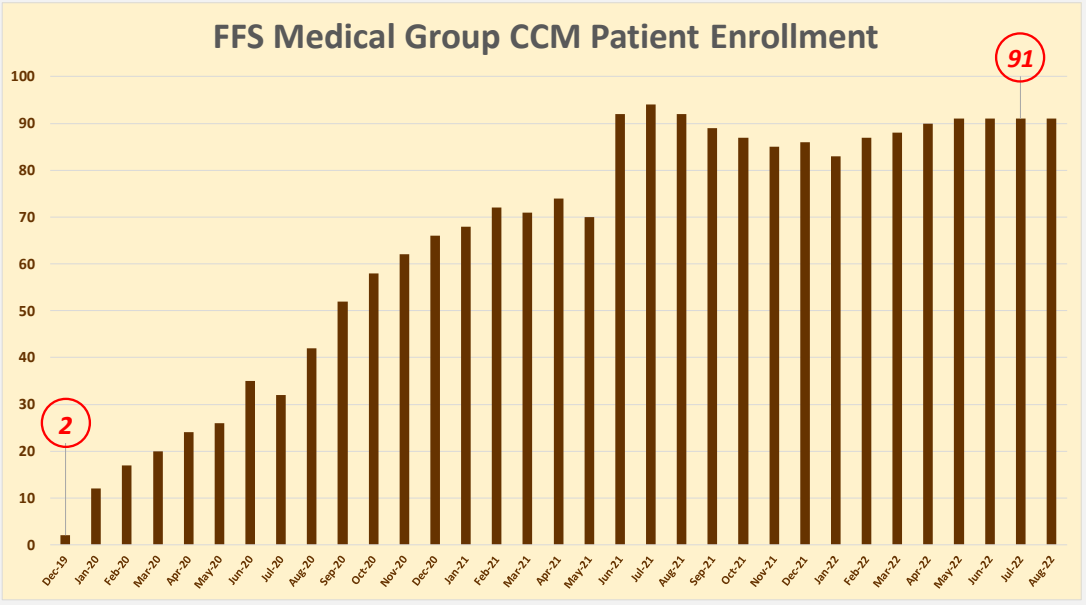
FFS Medical Group CCM Patient Enrollment
91
2
100
90
80
70
60
50
40
30
20
10
0
Dec-19
Jan-20
Feb-20
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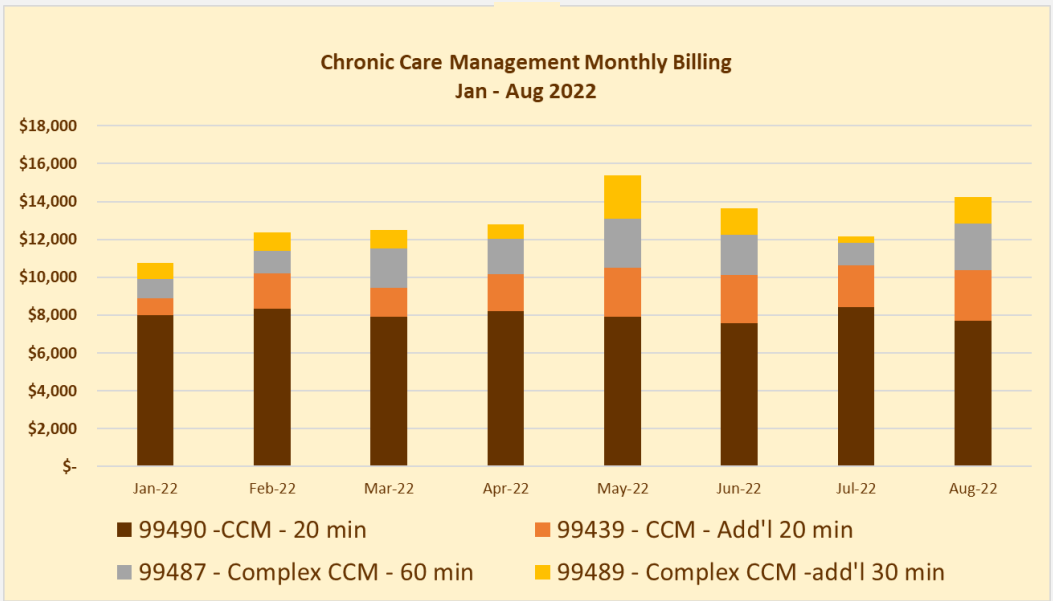
Chronic Care Management Monthly Billing
Jan - Aug 2022
$18,000
$16,000
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$-
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
99490 -CCM - 20 min
99439 - CCM - Add'l 20 min
99487 - Complex CCM - 60 min
99489 - Complex CCM -add'l 30 min

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Questions?

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Thank You

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