GETTING STARTED WITH



Agenda

- What is ChronicCareIQ?
- Chronic Care Management & Remote Patient Monitoring Overview
- Program Components
- Coding/Billing Information
- How It Works
- Introduction to System Navigation



What is ChronicCareIQ?



CLOUD-BASED REMOTE PATIENT CARE

ChronicCareIQ is a remote care management solution that helps doctors monitor and manage patients with chronic conditions while tracking billing eligibility for Chronic Care Management & Remote Patient Monitoring programs.

Our simple-to-use, turnkey solution empowers physicians and their staff to connect with their patients by utilizing technology patients already have, including smartphones, tablets, computers and even landlines.

Chronic Care Management

CHRONIC CARE MANAGEMENT SERVICES, AT LEAST 20 MINUTES OF CLINICAL STAFF TIME 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.



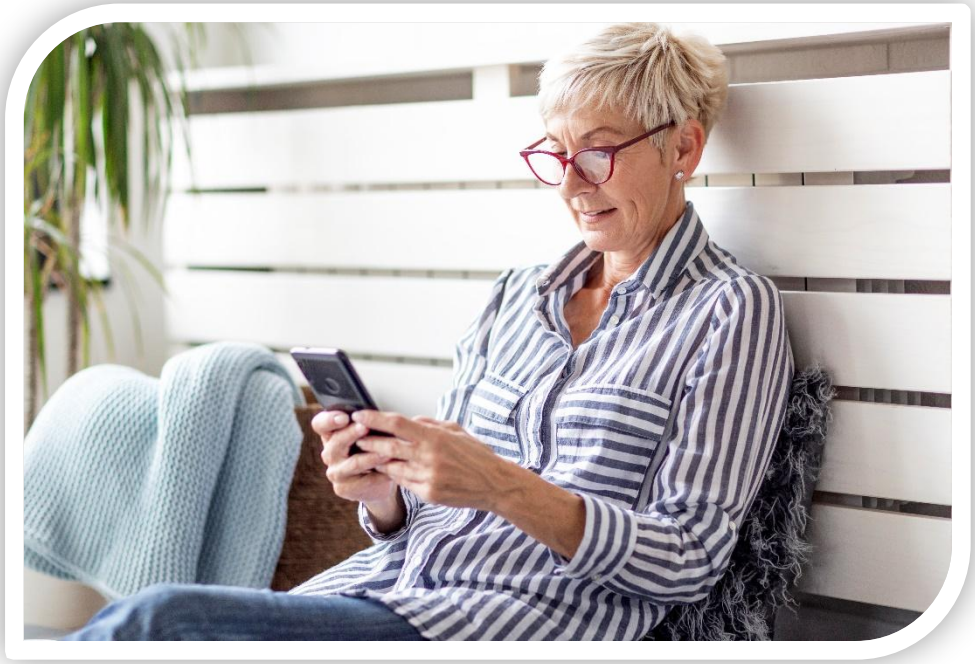
CCM INVOLVES NON-FACE-TO-FACE CLINICAL STAFF TIME THAT IS PERFORMED OUTSIDE THE REGULAR OFFICE VISIT.

Non-Face-To-Face Activities

- Clinical Chart Review
- Provider Lab/Imaging Order or Review
- Care Coordination
- Referral/Prior Auth’s
- Rx Refills/ ePrescribe
- Messaging
- Care Plan Reconciliation
- Phone Calls
- Patient Health Record Updates
- Patient Forms

Remote Physiologic Monitoring

CHRONIC REMOTE PHYSIOLOGIC MONITORING (RPM) IS A CARE MANAGEMENT SERVICE THAT ALLOWS CARE PROVIDERS AND THEIR STAFF TO MONITOR PATIENT-REPORTED PHYSIOLOGICAL DATA THROUGH INTERACTIVE COMMUNICATION WITH THE PATIENT OR CAREGIVER.



RPM INVOLVES MANAGING AND DOCUMENTING CLINICAL STAFF TIME FOR REVIEW AND MANAGEMENT OF VITAL PATIENT REPORTED DATA

Physiological Data Points

- Blood Pressure
- Weight
- Glucose Readings
- Pulse Ox
- Temperature

REIMBURSEMENT

Both services are reimbursable when at least 20 minutes of monitoring treatment or clinical non-face-to-face time has been documented in a calendar month.



Program Components:



- Practitioner Eligibility
- Supervision
- Patient Eligibility
- Initiating Visit
- Patient Consent
- Service Elements

Practitioner Eligibility:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Certified Nurse Midwives
- Clinical Nurse Specialists

NOTE: Only one practitioner may be paid *in each* calendar month.

Supervision:

Assigned **general supervision** under the Medicare PFS. General supervision means when the service is not personally performed by the billing practitioner, it is performed under their overall direction and control although his or her physical presence is not required.

Patient Eligibility:

Patients with chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline are eligible for services.

CCM requires multiple (2+) chronic medical conditions for patients to qualify for the service.

RPM requires only 1 chronic or acute medical condition for patients to qualify for the service.

Examples of chronic conditions include, but are not limited to the following:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes (type 1 and 2)
- Hypertension

Initiating Visit:

A face-to-face visit with a patient that gives consent to participate in CCM/RPM services.

Examples:

- **Annual Wellness Visit (AWE)**
- **Initial Preventive Physical Exam (IPPE)**
- **Transitional Care Exam (TCM)**
- **Most standard E/M visits**

Only required for new patients or patients not seen within the last 12 months.

Initiating Visit:

CCM Care Planning

*Practitioners who furnish a **CCM** initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code **G0506,** which is reportable once per CCM billing practitioner, in conjunction with CCM initiation.*

Please Note:** This code is billed as an add-on code to the initiating visit – same date of service with no modifier needed. **It's recommended to bill this code the same day as the E/M visit.

CCIQ TIP: This code is **not time based** and should be billed at the point of service.
It's recommended to consider this when creating the billing workflow.

Patient Consent:

Advance patient consent must be obtained prior to commencing and billing for CCM/RPM services. Patient must be informed of the following:

- **Availability of services and applicable cost-sharing**
- **Only one practitioner may furnish services during a calendar month**
- **Knowledge they can revoke CCM/RPM services at any time (effective at the end of the calendar month)**

PLEASE NOTE:
Consent can be either verbal or written, but must be documented in the patient's medical record

Check out CCIQ University for sample patient consent forms!

CCM Service Elements:

Service Elements
Structured Recording of Patient Health Information
Comprehensive Care Plan
Access to Care & Care Continuity
Comprehensive Care Management
Management of Care Transitions
Home & Community Based Care Coordination
Enhanced Communication Opportunities

Structured Recording of Patient Health Information



Record the patient's demographics, problems, medications, and medication allergies using certified Electronic Health Record (EHR) technology.

Comprehensive Care Plan

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 are directed/coordinated**
- **Schedule for periodic review and, when applicable, revision of the care plan**

- ✔ **A person-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with a focus on the chronic conditions being managed)**
- ✔ **Provide the patient and/or caregiver with a copy of the care plan**
- ✔ **Ensure the electronic care plan is available and shared timely within and outside the billing practice to individuals involved in the patient's 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
- Ensure continuity of care with a designated member of the care team with whom the patient can schedule successive routine appointments
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care by telephone and through secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods (for example, email or secure electronic patient portal)

Comprehensive Care Management

- Systematic assessment of the 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
- Coordinating care with home and community-based clinical service providers

Transitional Care Management

- Manage transitions between and among health care providers and settings, including referrals to other clinicians, follow-up after an emergency department visit, or facility discharge
- Timely create and exchange/transmit continuity of care document(s) with other practitioners and providers

CCM Coding & Billing:

Billing Code	2022 National Rate	Clinical Staff Time	Description
99490	$62	20+ minutes	**Non-Complex CCM** • Low complexity medical decision making • Care planning
G2058 (99439 in 2021)	$47	40, 60 minutes	**Non-Complex CCM** Each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional
99491	$84	30 minutes	**CCM – Physician or QHCP** Provided personally by a physician or other qualified health care professional
99487	$130	60+ minutes	**Complex CCM** • Moderate to high medical decision making • Care planning
99489	$68	Each add. 30 minutes	**Complex CCM** Add-on code listed separately in addition to 99487
G0506	$64	n/a	**Care Planning** Practitioner performs care planning outside the normal effort described by the CCM initiating visit
99437	$59	Each add. 30 minutes	**CCM – Physician or QHCP** Each additional time 30 minutes provided personally by a physician or other qualified health care professional

RPM Coding & Billing:

Billing Code	National Rate	Clinical Staff Time	Description
99457	$48	20+ minutes	**Remote Patient Monitoring** Remote physiologic monitoring treatment management services, requiring interactive communication with the patient/caregiver during the month
99458	$39	40, 60 minutes (limit to 2 units)	**Remote Patient Monitoring** Each additional 20 minutes, remote physiologic monitoring treatment management services
99091	$54	30 minutes	Remote Patient Monitoring – Provider or QHCP Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
99453	$18	Device	**RPM** Initial, setup and patient education on use of equipment (must report at least 16 days in the calendar month)
99454	$54	PE, Device	**RPM** Initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days (must report at least 16 days in the calendar month)

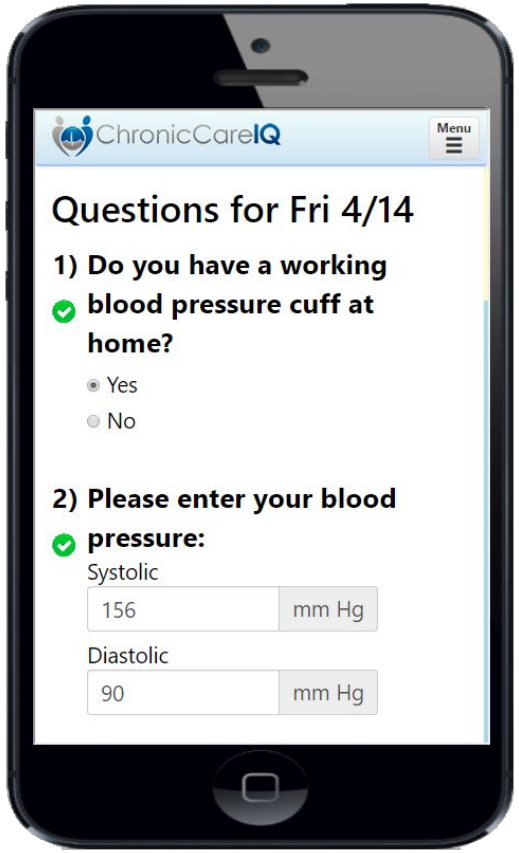
Concurrent Billing

CCM & RPM can be billed in the same calendar month, however, time spent managing the patient cannot be counted towards the required time for both programs.

ChronicCareIQ

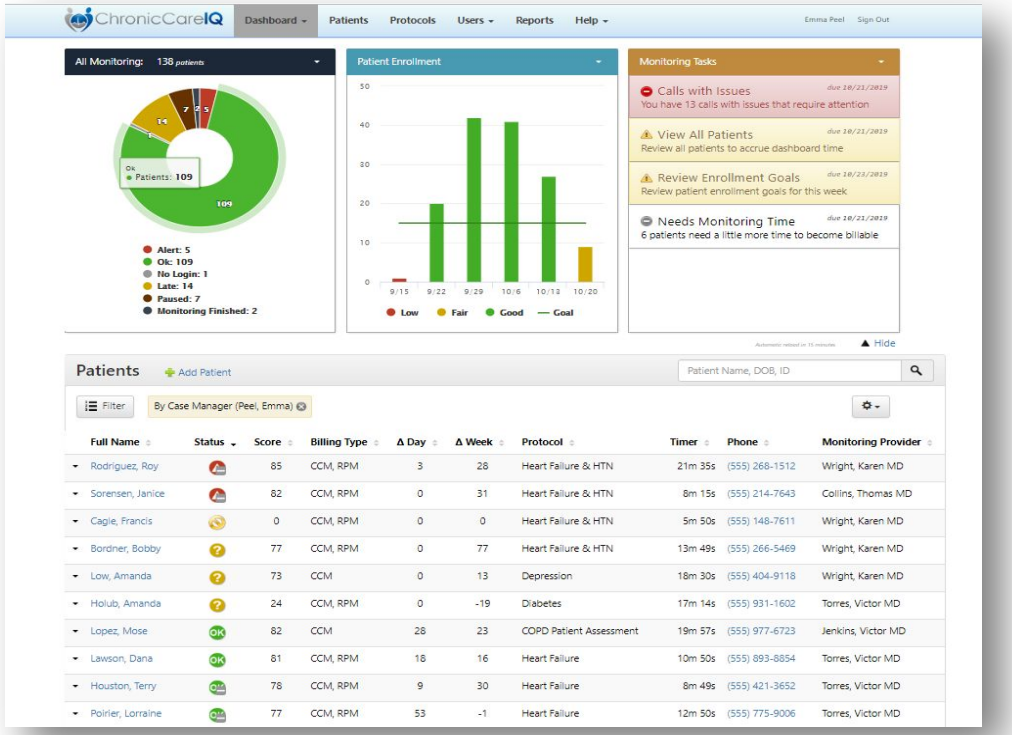
How It Works

Patients are enrolled into the program and are prompted to login at a set frequency using their smartphone app, computer or tablet to answer basic questions about their health status and/or vitals.



ChronicCareIQ

How It Works



The answers are scored using CCIQ's intuitive built-in algorithm and are triaged on the color-coded dashboard.

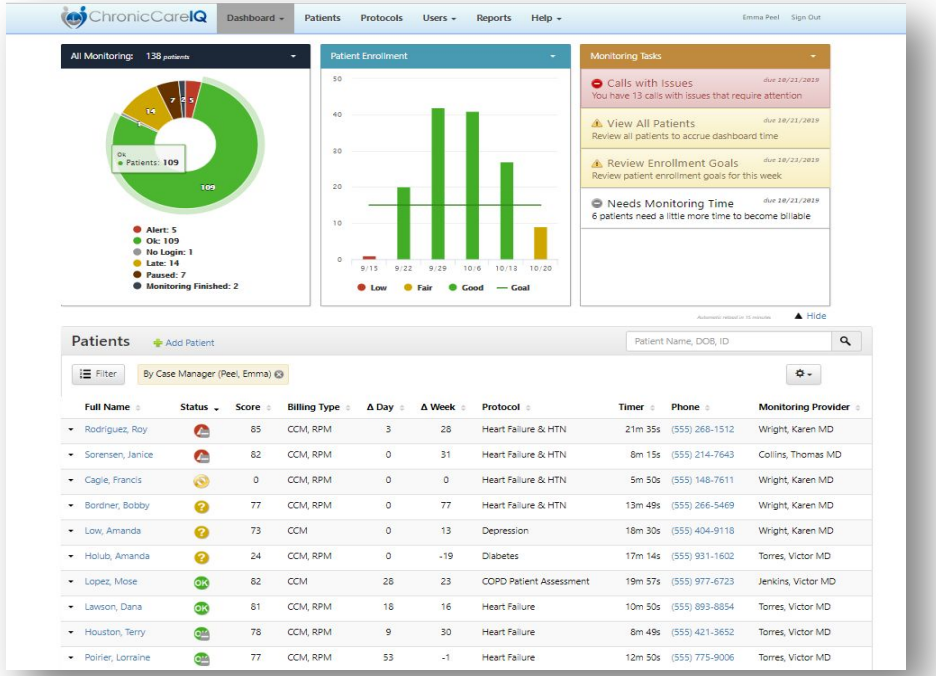
Red | Yellow | Green

Red – At Risk

Yellow – Warning

Green – Within Normal Limits

ChronicCareIQ
How It Works



The Monitoring Dashboard also displays a **Health Score**.

The score ranges from 1-100.

High Scores = Potential Health Risk, Hospitalization (>80)

Low Scores = Responses within normal limits

Full Name	Date of Birth	Patient ID	Status	Score	Billing Type	Δ Day	Δ Week	Protocol	Timer
Vannatta, Anita	5/15/1967	00039HT	⚠	91	PCM	16	69	Heart Failure	11m 33s

ChronicCareIQ

How It Works

- Time Tracking
  - ✔ Dashboard
  - ✔ Chart View
  - ✔ Offline Time
  - ✔ CallerIQ (phone interface)
- All events tracked on Audit Reports
- Monthly Billing Reports display eligible, billable patients based on monitoring

