GETTING STARTED WITH

Agenda:

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

What is Chronic Care Management?

Chronic Care Management (CCM) is a care coordination service provided by practitioners and their clinical staff for patients with two or more chronic conditions who are at risk of death, acute exacerbation, decompensation or functional decline.

CCM involves non-face-to-face clinical staff time that is performed outside the regular office visit including but not limited to clinical phone calls, medication management, referrals and other care coordination activities.

Starting in 2015, this service provides separate reimbursement when at least 20 minutes of clinical non-face-to-face time has been documented in a calendar month.

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What is Chronic Remote Patient Monitoring?

Chronic Remote Patient 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 including blood pressure, glucose readings, pulse ox, weight, etc.

Starting in 2019, this service provides separate reimbursement when at least 20 minutes of RPM care management time has been documented in a calendar month.

CCM vs RPM with ChronicCareIQ

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Understanding the Differences in Code

CCM

- Consent required
- 2 diagnoses/chronic conditions minimum
- Care plan required
- 20 minutes minimum/month
- 60 minutes maximum/month for basic CCM (No limit for complex CCM)
- Initial in-person visit required

RPM Time

- Consent required
- 1 acute condition/chronic condition minimum
- Care plan strongly recommended (not required)
- 1 interactive audio communication/month (phone/video call or non-office visit in-person interaction
- 1 patient-reported physiological data point/month (by patient or staff answered)
- 20 minutes minimum/month
- 60 minutes maximum/month for basic CCM (No limit for complex CCM)

RPM Device

- Consent required
- Physician dispensed device
- Devices ONLY - not based on time spent on patient care
- One time education code eligibility
- Electronically connected devices only
- 16 days of data per 30 day sliding scale

CARE MANAGEMENT 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 Authorization
- Rx Refills/ ePrescribe
- Messaging
- Care Plan Reconciliation
- Phone Calls
- Patient Health Record Updates
- Patient Forms

CCM vs. RPM

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CCM

- Consent Required
- Two Diagnoses/Chronic Conditions Minimum
- Care Plan Required
- 20 Minutes Minimum per Month
- 60 Minutes Maximum per Month for Basic CCM
  - No Limit for Complex CCM
- Initial In-Person Visit Required

RPM - TIME

- Consent Required
- Must be established patient
- One Acute Condition/Chronic Condition Minimum
- Care Plan strongly recommended (not required)
- One Interactive Audio Communication/Month
  - E.g., Phone Call, Video Call or Non-Office Visit In-Person Interaction
- One Patient-Reported Physiological Data Point per Month (by patient or staff answered)
- 20 Minutes Minimum per Month
- 60 Minutes Maximum per Month

RPM - DEVICE

- Consent Required
- Physician Dispensed Device
- Devices ONLY - not based on time spent on patient care
- One Time Education Code eligibility
- Electronically Connected Devices Only
- 16 **Days** of Data per 30 Days Sliding Scale

Program Components:

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

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Practitioner Eligibility:

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

Only one practitioner may be paid for ***CCM & RPM devices services*** for a given calendar month. RPM is billable with CCM!

The practitioner must only report either complex or non-complex **CCM** for a given patient for the month (not both).

NOTE: *CCM may be billed most frequently by primary care practitioners, although in certain circumstances specialty practitioners may provide and bill for CCM. The CCM service is not within the scope of practice of limited-license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, although practitioners may refer or consult with such physicians and practitioners to coordinate and manage care.*

SUPERVISION

CCM & RPM Services

- *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.*

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Patient Eligibility:

Patients with chronic conditions (as determined by physician) 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 CCM services.

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
- Hypertension

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.

Initiating Visit:

A face-to-face visit with patient that gives consent to participate in CCM/RPM services. Provider must discuss CCM and/or RPM during a face-to-face visit for the visit to count as an official initiating visit.

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. Its recommended to bill this code the same day as the E/M visit as this code can not be billed on its own at a later date.*

RPM Setup & Education

*Practitioners and ancillary staff who furnish **RPM** initial setup and patient education on use of the equipment may also bill CPT code **99453**, which is reportable once per device/application, in conjunction with RPM initiation. This code is a one-time billing opportunity.*

CCIQ TIP: These codes are **not time based** and can be billed at the point of service.
Its 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!

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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
- TCM is billable with separate codes based on complexity, timeliness of contact and appointments. TCM generally needs access to a hospital discharge feed.

CCM Coding & Billing:

Billing Code	National Rate	Clinical Staff Time	Description
99490	$61	20 minutes (staff)	**Non-Complex CCM (base)** First 20 minutes of clinical staff time for chronic care management services, per calendar month
99439	$47	40, 60 minutes (staff)	**Non-Complex CCM (add-on)** Each additional 20 minutes of clinical staff time for chronic care management services, per calendar month. Max of 2 per month.
99491	$83	30 minutes (provider)	**Non-Complex CCM – Physician or QHCP (base)** First 30 minutes of care management provided personally by a physician or other QHCP, per calendar month
99437	$58	60, 90 minutes (provider)	**Non-Complex CCM - Physician or QHCP (add-on)** Each additional 30 minutes of physician or other QHP time, per calendar month. Max of 2 per month.
99487	$131	60 minutes	**Complex CCM** • Moderate to high medical decision making • Substantial review and/or revision of care plan
99489	$71	Each additional 30 minutes	**Complex CCM (add-on)** Add-on code for each additional 30 minutes for complex CCM care
G0506	$61	n/a	**Care Planning** Practitioner performs care planning outside the normal effort described by the CCM initiating visit (must be billed as add on to the E/M visit)

RPM Coding & Billing:

Billing Code	National Rate	Clinical Staff Time	Description
99457	$48	20 minutes (staff time)	**RPM Time service (base)** First 20 minutes, RPM treatment management services, requiring interactive communication with the patient/caregiver during the month
99458	$38	40, 60 minutes (staff time)	**RPM Time services (add-on)** Each additional 20 minutes, RPM treatment management services including interactive communication. Max 2 per month.
99453	$19	n/a	**RPM Device - setup and education of equipment** Initial, setup and patient education on use of equipment (after at least 16 days). One time allowance.
99454	$46	n/a	**RPM Device Usage** Connected device(s) supplying recording(s) or alert(s) transmission, each 30 days (must report at least 16 days in the calendar month)
99091	$52	30 minutes (provider time)	**RPM provider service** Collection and interpretation of physiologic data by physician or qualified healthcare provider for 30 minutes

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.

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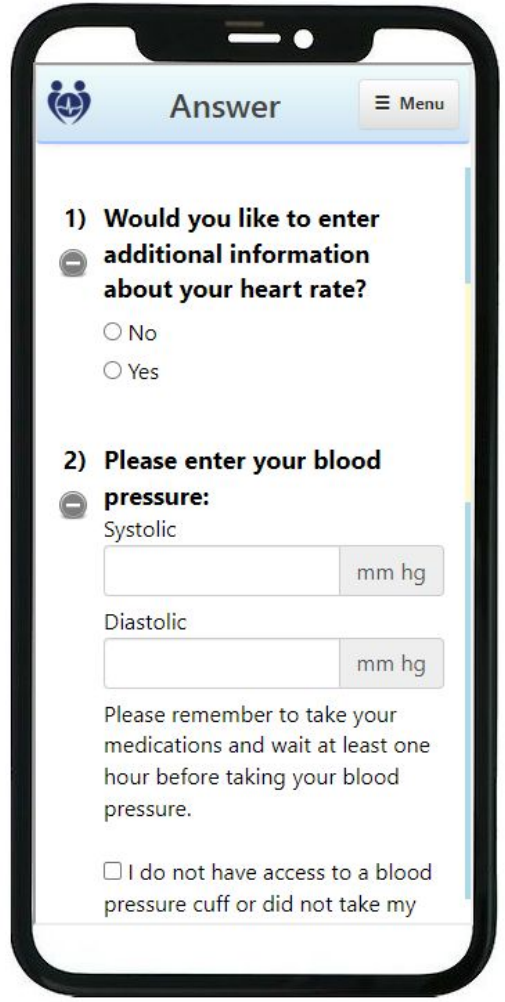
How It Works

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.



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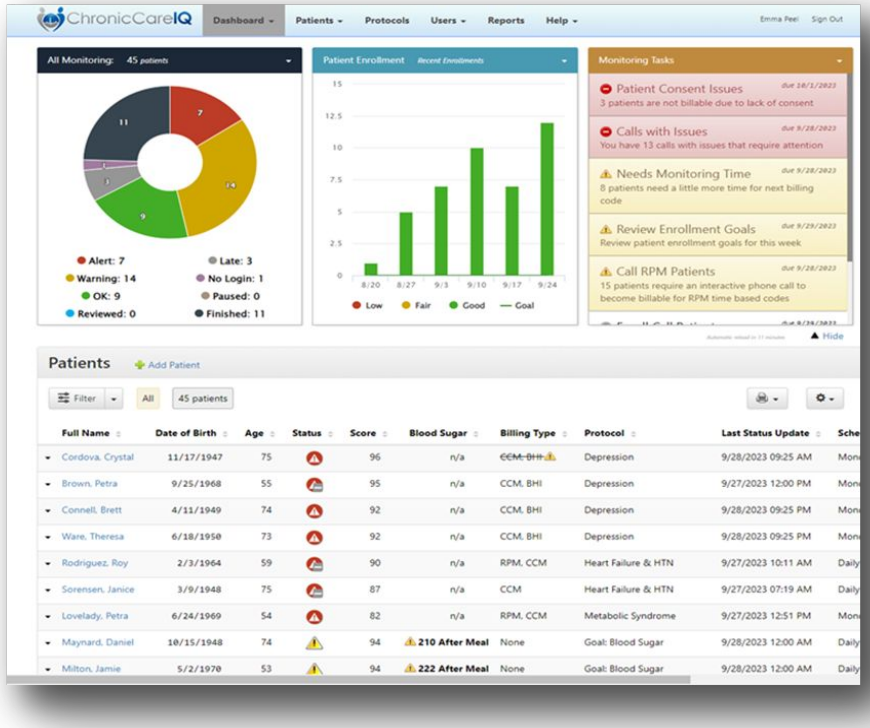
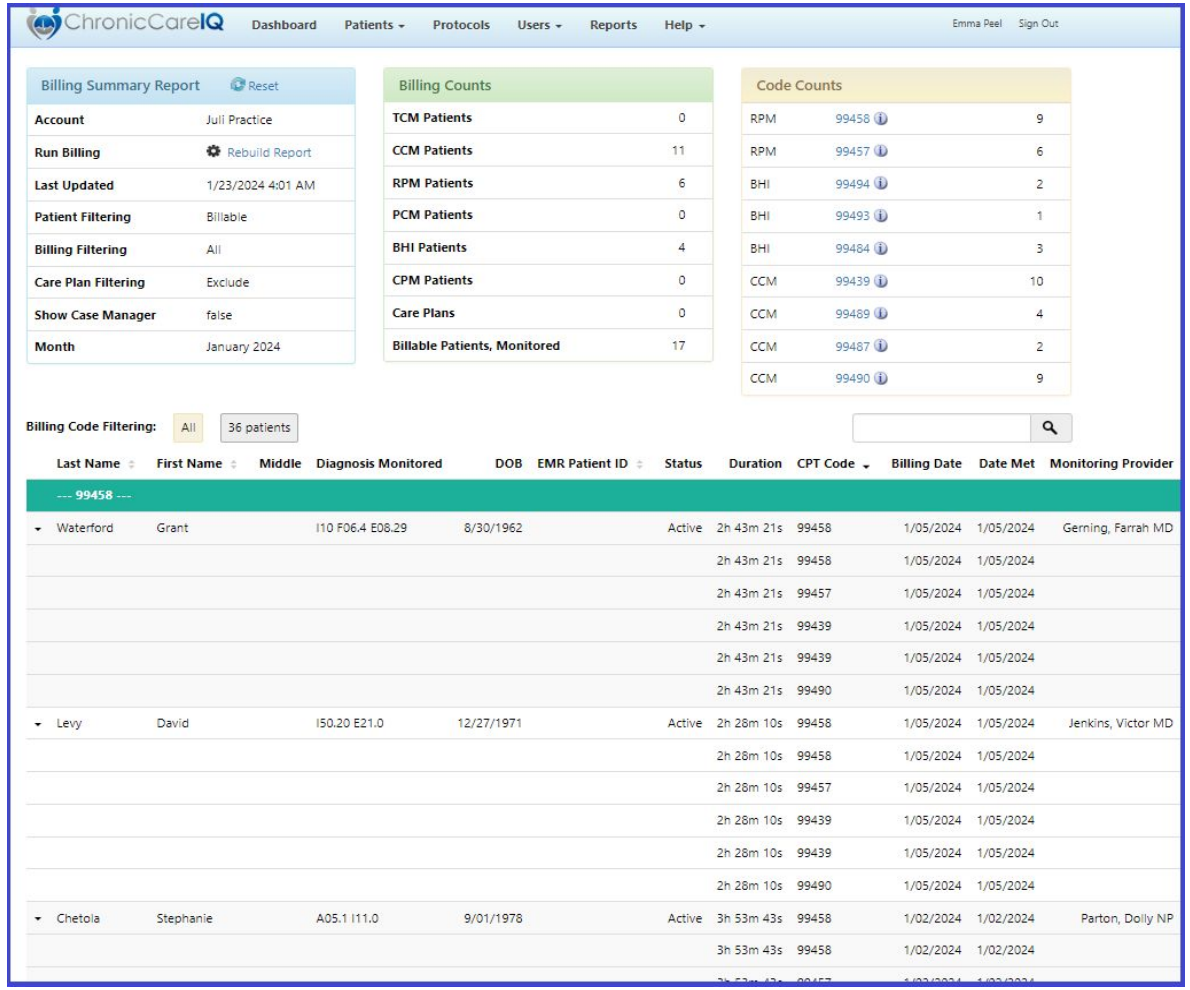
How It Works



The answers are scored using ChronicCareIQ's intuitive built-in algorithm and are triaged on the color-coded dashboard to highlight patients who are at risk.

ChronicCareIQ
How It Works

- Patients are monitored and managed throughout the calendar month by care team
- ChronicCareIQ's system assists in identifying risks early and alerts staff to help prevent hospitalizations
- Tracks clinical staff time to capture billing codes for CCM/RPM programs while allowing for offline time entry



PCM Coding & Billing:

Billing Code	National Rate	Clinical Staff Time	Description
99424	$81	30 minutes (provider)	**Principal care management services** for a single high-risk disease, at least 30 minutes of physician or other qualified healthcare professional time per calendar month
99425	$58	60, 90 minutes (provider)	**Principal care management services**, each additional 30 minutes of physician or other qualified health care professional time per calendar month. Max 2 per month.
99426	$60	30 minutes (staff time)	**Principal care management services** for a single high-risk disease, at least 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month
99427	$46		**Principal care management services**, each additional 30 minutes of physician or other qualified health care professional time per calendar month. Max 2 per month.

Concurrent Billing

CCM & PCM can NOT be billed in the same calendar month by the same provider for one patient.

Other Supported Coding & Billing:

Billing Code		Description
99495 or 99496	TCM	**Transitional care management services** with moderate OR complex medical decision complexity requiring: ● Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge ● At least moderate level of medical decision making during the service period ● Face-to-face visit, within 7 OR 14 calendar days of discharge
99484, 99492, 99493, 99494	BHI and CoCM	**Behavioral Health Integration** is a care management service provided by healthcare providers and their staff to manage and coordinate care for patients with mental or behavioral health conditions. **CoCM** is psychioatirc collaborative aare management.
G3002 & G3003	CPM	**Chronic Pain Management** is a care management service provided *under direct supervision* by healthcare providers to manage and coordinate care for patients with chronic pain conditions lasting over three months.

Concurrent Billing

CCM, RPM, BHI, CoCM, CPM can be billed in the same calendar month provided the times are separate and distinct.