

Improving Ohio's Health Series

Establishing a Chronic Care Management Program in an Independent Group Practice

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This article is the third in a series devoted to hypertension and diabetes in Ohio and the prevalence of these chronic conditions. It is provided as a tool to support the webinar presented on Tuesday, June 14, 2016, of the same title. A recording of the webinar can be viewed at: <https://www.youtube.com/watch?v=p2Q4nmGxPnM>.

The webinar and article were developed in conjunction with Westshore Primary Care, a group of 60 Ohio providers with locations in Cuyahoga and Lorain counties.

Westshore Primary Care established a Chronic Care Management (CCM) program early in 2016 to address the needs of patients with two or more chronic conditions. They have focused on enrolling patients with diabetes who require routine care and who meet the requirements of their CCM program, or patients who have been discharged from the hospital.

Members of Westshore's CCM team include:

- Michael Adornetto, DO, President
- Jason Ridgel, MD, Director of Medical Informatics
- Irene Nikokirakis, NP, Coordinator of the Chronic Care Program
- Nancy Lempke, Billing Director
- Lynn Folz, CPC, Billing Specialist
- Kaye Gorman, Director of Information Technology

Westshore Primary Care uses Allscripts Pro as their EHR.

Lisa Martin, Community Outreach Manager for the CliniSync HIE, also provided technical support for the webinar and this article.

What is Chronic Care Management (CCM)?

Chronic Care Management is a program to provide additional coordinated health and social services to patients with chronic conditions. It is designed to look at the patient holistically and to address additional needs of the patient, as well as their medical issues.

CCM provides ongoing support for patients with chronic diseases to help coordinate their needs in between visits to their physician or other primary care providers.

What is Transitional Care Management (TCM)?

Transitional Care Management is the coordination and continuity of health care when a patient transitions from one healthcare setting to another, or, from a healthcare setting to home in between health care practitioners and settings, as their condition and care needs change.

TCM can only be billed for patients during the 30 days immediately following a hospitalization.

- To bill for TCM, you would bill either **CPT code 99495 or 99496**. There are separate requirements to bill these codes, including:
 - a call to the patient within two business days of discharge, AND;
 - a patient visit scheduled within 7-14 days of the discharge date.

What are CMS's Requirements for CCM?

- Patient must have at least 2 chronic conditions which the treating provider identifies and documents in the medical record
- Patient must have comprehensive Evaluation/Management visit, annual wellness visit or initial preventive physical exam
- Patient must consent in writing for participation in the program
- Structured patient data must be available in the EHR system to populate care plan, follow-up care
- Practitioner must have access to record and care plan 24/7
- Continuity of care by practitioner or member of the team
- Treating provider conducts an assessment of needs and develops a care plan
- Electronic transitions of care or referrals sent by the practice through DIRECT email, HIE or other electronic means (not fax); coordination with community service providers



WESTSHORE PRIMARY CARE

The CCM team at Westshore Primary Care provided their input on the following questions with the hopes of informing practices that managing chronic care patients, while time-consuming at the beginning to change workflows and develop reporting options, benefits everyone in the end!

1. *Can you share with us a little bit of Westshore's thinking on why you established a CCM program?*

We knew we needed our physicians to support the new program. Our biggest hurdle was educating our physicians about the program and what we thought it could accomplish for the care of our patients. But we also knew our physicians are progressive and open to change.

We were nervous about whether we could cover our costs for establishing the program, but we were sure we had a good team that could bring the program up, both clinically, technically and in the billing department. Therefore, we opted to move ahead. Ultimately, we decided we needed to move forward because it was the right thing to do for our patients.

2. *What does the community think about your program?*

The community definitely is very supportive of the program. Some of our colleagues have told us that it's a great program! We've even been asked "Why isn't everyone doing it?"

3. *How have you structured your CCM program? Who manages the program?*

We moved one of our nurse practitioners into the role of coordinator for the CCM program. We felt Irene Nikokirakis, as a nurse practitioner (NP), could provide the best level of care since she could respond to some of the clinical issues raised *and* react to any new clinical situations with the patient.

Irene uses her clinical judgment to determine if the physician needs to be contacted for follow-up about a new problem or change in medication. If so, she can either message the physician within the EHR or call the physician for more in-depth directions. Her notes and any follow-up by the physician are documented in the patient's medical record.

4. Who gets the patient's consent for CCM?

If a patient with diabetes (or other chronic condition) comes into the office for a visit, the treating physician determines whether the patient qualifies for the program, then documents the chronic conditions in the medical record. The physician takes the responsibility for speaking with the patient about the program, alerting them to the fact there may be a co-pay, and printing off the consent form for the patient to sign to participate in the CCM program.

If the patient is seeing the physician within 14 days as follow-up to a hospital stay, then the physician can enroll the patient into the CCM program during that visit, but Irene cannot start working with them until the next month. This is because transitional care management and chronic care management claims cannot be submitted for payment for the same 30-day period. Irene gets notice of their addition to the CCM program at the end of the month as the bills are generated and the patient moves from transitional care management into chronic care management.

We do not cold call our diabetic patients to recruit them for the program. We only follow up with patients that come to us from hospital discharges (we get a list every day) or from patients that already have an appointment for care.

5. What types of issues do you handle for patients in the program? What social service agencies do you coordinate with?

Irene talks to and coordinates with quite a few different social service agencies, such as:

- Behavioral health programs
- Exercise programs
- Visiting nurse programs
- Home health agencies
- Transportation services
- Medical equipment suppliers
- Area agencies on aging
- Social workers
- Adult protective services
- Local pharmacies

Irene identifies these community providers based upon the needs of the patients and her knowledge of the community. Some groups and agencies are identified by the patient. If these groups can't assist Irene, they will refer her to someone who can. If there needs to be some follow-up with the physician, Irene creates a reminder or a pop-up in the patient's record to let the physician know to discuss it when the patient is seen next.

6. *Is it difficult to meet the 20-minute/month requirement for time spent on the patient's case outside of an office visit?*

Not at all! For any given patient, a call may take from a few minutes up to an hour. The time spent reviewing the chart or hospital records prior to the call can count toward the 20-minute requirement. The patients' needs are so varied, that with all the follow-up, it is very easy to meet the 20-minute requirement.

7. *How do you make information available to treating providers on a 24/7 basis?*

Irene makes sure to document each day's calls on the same day so the record is current and available to the treating physician or provider if it needs to be pulled up and consulted or acted upon.

All the physicians have access to the Allscripts Pro system which allows them to review any notes about the patient's care that Irene has entered.

8. *How do you use your EHR to support Westshore's CCM program?*

We have customized our Allscripts Pro system to create the documentation for the program.

- First the primary care physician (PCP) adds the ICD-10 code R69 (Chronic Disease) to the active problem list. This identifies the patient and allows us to run a report monthly that contains all patients that have R-69 on the active problem list.
- A custom consent form is printed from the EHR, signed, and scanned back into the record.
- This patient's chart will now appear on the report the following month.
- The physician documents the chronic problems as usual in the visit note and puts the care plan in the assessment.
- During the call Irene fills out a custom template that documents the time spent and the topics discussed which is then saved as a phone encounter.
- Irene can customize a reminder in the EHR for the physician to alert him or her to talk to the patient about any issues that are unresolved.

9. *How can patients contact the practice?*

Patients can contact the practice by either emailing through the patient portal or calling us. In fact, since establishing the CCM program, many calls now go directly to Irene and she can manage them without a delay.

10. *How does Westshore contact other practices? What about social service agencies?*

There are two ways that we can send information when referring a patient to another practice:

- DIRECT HIPAA-secure email;
- The Community Health Record (CHR). The CHR is the cloud-based record of all the patient summaries or tests that are posted to the HIE.

Currently, Westshore is sending its referral documents through DIRECT email.

For social service agencies, Irene usually calls them but documents the call in the patient's medical record.

11. *Can the HIE help with establishing technical connections with other practices?*

CliniSync HIE's Community Outreach Managers will work with a practice such as Westshore to help them develop its list of referrals. Then, if the receiving practice is not on DIRECT email or using the CHR, the Community Outreach Manager such as Lisa Martin, will contact the practice and help them develop their electronic capabilities for referrals.

12. *What were the biggest issues you faced in billing for CCM?*

The billing function for CCM and TCM is still so new that we need to monitor each claim to make sure the requirements are met before we send the bill, then make sure the payments are received.

Probably the biggest problem is that the payers do not have a consistent internal approach to handling the claims. If you call three times on the same claim to the same payer, you might get three different responses on how to handle. *But* it is improving as the payers get more comfortable with the claims for these services.

13. *What do you do to verify the CCM billing requirements?*

Irene submits her coding for all CCM and TCM patients the last Friday of each month. Lynn, our coder who oversees the financial side of the program, then

reviews the documentation for each patient to make sure all requirements are met before the claim is sent.

14. *Is there a special billing code for CCM billing to CMS?*

Yes, you *must* bill using **CPT 99490** in which CMS requires the following:

- Must have 20 minutes of documented non-face-to-face contact within a month
- Must not have billed for transitional care management for care immediately following discharge (either **CPT 99495** or **99496**) within same 30-day period.
- Must document within the record contacts with the patient, treating providers, community based providers or service organizations.
- Only one provider can bill for CCM for the same patient during the same 30-day period.

15. *Will other payers besides Medicare pay for CCM services?*

Currently CCM billing will cover patients in Medicare Part B and Medicaid fee-for-service as well as Medicaid managed care. Other payers are starting to adopt including Medicare Advantage programs. We monitor each CCM or TCM claim that is sent out to make sure payment is received correctly.

16. *Has the program given you better insight into your patients' needs?*

We knew we wanted to work with patients who were recently discharged from the hospital to prevent their re-hospitalization. Working with them on an ongoing basis through the CCM has created the bridge between visits that helps *us* help *them*. It allows us to go a lot deeper into our patients' social needs—why does a patient miss an appointment and how can we help? That way we're addressing more than just their medical issues.

The improvement in the continuity of our patients' care has been enormous!



*Thank you to everyone at Westshore
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It was truly appreciated!!*

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