DOCUMENTATION AND BILLING FOR CHRONIC CARE MANAGEMENT

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GOALS OF PRESENTATION

- Provide an overview of the new Chronic Care Management (CCM) service
- Review Scope of Services required to bill Medicare for CCM services.
- Review billing Medicare
- Provide information on how one clinic system is meeting the requirements and successfully billing for CCM services.
- Provide references and resources to interested parties.
NEW CMS CHRONIC MANAGEMENT PROGRAM

- January 2015 able to bill Medicare $42.60 per 30- day period for 20 minutes of chronic care activity (non-encounter based follow up care).
  - Beneficiaries will face a 20% coinsurance for CCM under Medicare part B. Those without supplemental insurance will have to pay this charge - about $100.00 per year out of pocket.

- Scope of services required to bill:
  - 24/7 access to CCM
  - Insure the patient has continuity of care
  - Provide care management of chronic conditions:
    - Systematic assessment, system- based approaches, medication reconciliation, oversight of patient self- management, patient- centered care plan, manage care transitions, coordination of care, offer enhanced opportunities to communicate with the team.
  - Eligible beneficiary’s written consent
  - 20+ minutes of non face to face care management services per calendar month
CPT code 99490 for this CCM service “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 death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.”

Be certain that the CCM services (20 minutes of care) were provided and that a patient agreement is on file.

Do not bill this service for a routine in-person encounter.

Bill the CPT code no more than one time per 30-day period.

Remember: You can only bill in months when there’s at least 20 minutes of activity in that 30-day period.
WHEN CAN YOU NOT BILL?

- If the below services are being provided and billed during the same calendar month you can not bill for the CCM service.
  - Transitional care management (CPT 99495 and 99496)
  - Home healthcare supervision (HCPCS G0181)
  - Hospice care supervision (HCPCS G0182)
  - Certain End-stage renal disease (ESRD) services (CPT 90951-90970)
Determining, documenting, tracking, and billing for the 2 or more chronic conditions

- Use the MDH Tiering Tool to determine Tier Level of patient and number of chronic conditions.
- In your EMR define a field that documents not only the Tier level but the number of chronic conditions:

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Care Coordinator Reason for Visit - ACMC

Reason For Visit
- Care Coordinator Visit Eval
- Care Coordinator Visit Recheck
- Care Coordinator Phone Call

Medical Home - ACMC

Medical Home
Care Coordinator: [Dropdown]
Care Coordinator Contact Number: [Textbox]

Tier
- Tier 0
- Tier 1
- Tier 2
- Tier 3
- Tier 4

YN Two or more chronic conditions.
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- Build in a way that can data extractable for billing and reporting
EXAMPLE OF A SIGNED CONSENT IN BENEFICIARY'S MEDICAL RECORD

Dear [Name],

Welcome to Medical Home Care Coordination, a new way of managing your health care. Your medical home is not a building, a home visit, or a hospital; it is a model of care designed to improve the coordination of your health care with an emphasis on your all-around well-being.

Based on information you have shared with us, we have identified the following as members of your health care team. These team members will work together to keep you healthy:

- Primary Care Provider: Dr. Test
- Primary Care Provider Phone Number: (320) 441-5499
- Primary Care Health Care Contact: Person Test
- Primary Care Giver Phone Number: 111-111-1111
- Any outside agencies and their roles: None
- Pharmacy: Test Pharmacy
  - Phone Number: 111-111-1111
  - Fax Number: 111-111-1111

We have your insurance provider listed as Medicare. Your Care Coordinator is Mrs. Test. You can reach her by calling (320) 231-5000.

With your signing below, you are agreeing to receive Care Coordination services and will be responsible for any associated co-payments or deductibles. Your care coordinator will assist with coordinating services as well as:
- Provide education
- Support for prevention services
- Chronic disease services
- Collaborate with others involved in your care
- Access to an RN 24 hours 7 days a week

Needed information will be shared with other providers for care coordination services. Only one provider at a time can provide Care Coordination and at any time you can stop care coordination services.

For more information on Medical Home, visit our website at www.acmc.com/medicalhome.

We look forward to walking with you on the path to a healthier you!
5 SPECIFIED CAPABILITIES CMS REQUIRED TO BILL

1. Use a certified EHR for specified purpose
2. Maintain an electronic care plan
3. Ensure beneficiary access to care
4. Facilitate transitions of care
5. Coordinate care

- Care plan includes clinical staff providing service with credentials and summary
TRANSMITING SUMMARY OF CARE

- Must be able to transmit the summary care record electronically for purposes of care coordination—fax transmission is not acceptable.
  - We currently do this via secure email
EMR DOCUMENTATION EXAMPLES
EXAMPLE OF DOCUMENTATION FIELDS IN EMR

- Documentation of reason for referral
- Type of visit and interpreter
- Patient centered goals, likely to attain goals, goal will be met in, if achieved and if not what percent of the time are they meeting the goal
- Frequency of contact
- Home monitoring services
- Minutes spent.
REQUIREMENTS AND HOW WE ARE MEETING

- Follow up ER and Hospitalization
  - Electronic alerts go to the care coordinators daily to notify any change including ER, hospitalizations, new medications or changes, and transitions in care.

- Referrals
  - Coordinated through a central referral center- tracks new, pending, and follow-up to ensure records received and patient attended appt.

- Care plans are accessible to all including the 24/7 triage nurses.

- Medication reconciliation is performed at every visit
REPORTING

- All fields in the care plan and the note are data extractable
  - The fields pull into a report for coding, billing, physicians and care coordinators
    - The reports are auto generated weekly
  - Reports are used to track:
    - Billing
    - Frequency of contact
    - Payer and minutes spent
    - Tier level and/or two or more chronic conditions
    - Care Plan goals, Care Coordinator, Physician
    - ER/Hospitalizations
    - Quality outcomes
QUESTIONS
RESOURCES

- Centers for Medicare and Medicaid Services. Medicare program; revisions to payment policies under the physician fee schedule, clinical laboratory fee schedule, access to identifiable data for the Center for Medicare and Medicaid innovation models & other revisions to Part B for CY 2015 (https://www.federalregister.gov/a/2014-26183).