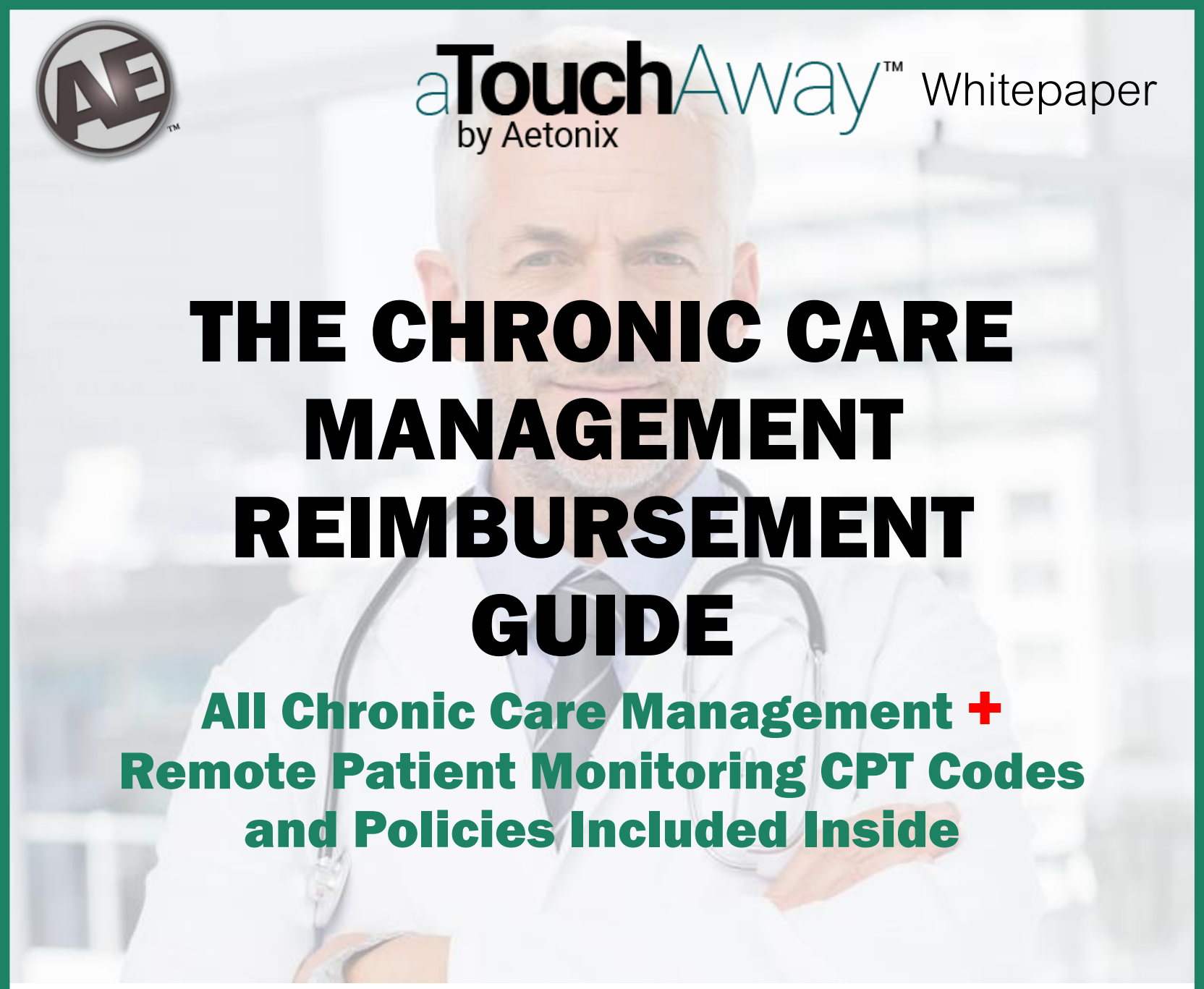
aTouchAway™ by Aetonix Whitepaper



THE CHRONIC CARE MANAGEMENT REIMBURSEMENT GUIDE

All Chronic Care Management + Remote Patient Monitoring CPT Codes and Policies Included Inside

So you want to start a CCM Program for your hospital/practice, but don't know where to start? This actionable whitepaper tells you all you need to know to get started with a top of the line CCM program, equipped for maximum reimbursement. Please be informed, that the original articles used to write this are on Aetonix's website. If you are interested in knowing more, we strongly encourage you to read How to Set up a Chronic Care Management and Strategizing for Chronic Care Management. This whitepaper is more a compact practical guide. Consider it a one stop shop for all CCM essentials. Need something even more compact? Jump to the CCM + RPM Cheat Sheet at the end.

Considerations: 100 patients per month, is a number often cited by CCM programs who have a well-designed process in place to provide care. While this number can be further scaled up, it is an important baseline number for one to really capture value with a streamlined process in place. We will consider an intake of 100 patients for the program when showing the reimbursement calculations.

UNDERSTAND PRACTICE AND PATIENT ELIGIBILITY

A Chronic Care Management (CCM) Program entails

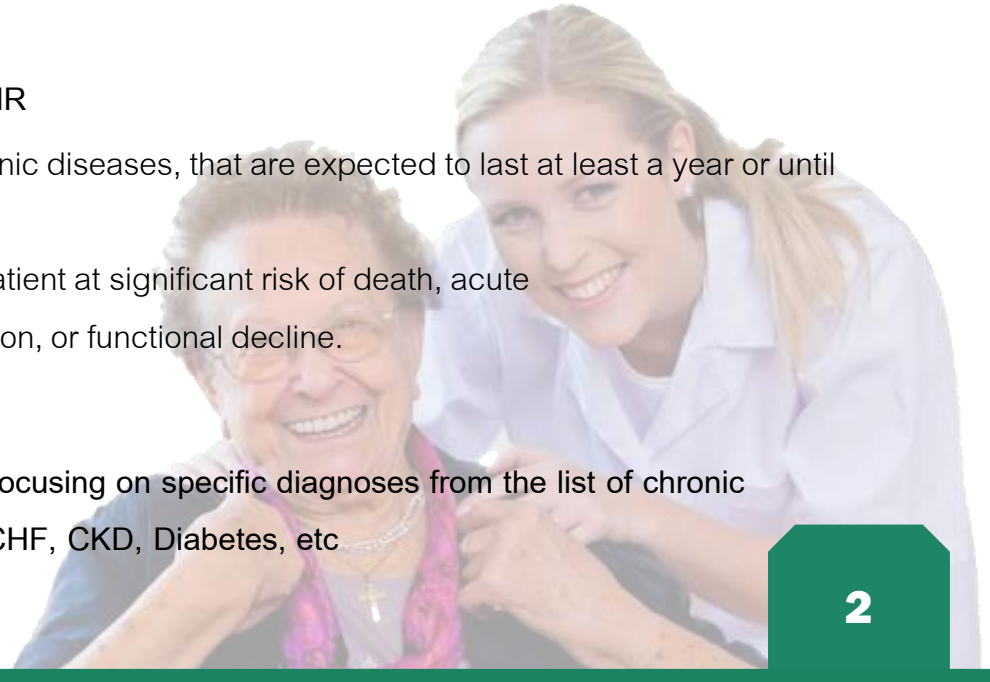
- Communication between the patient and clinicians for care coordination through the phone or electronically.
- Medication Management
- Creation and revision of care plans
- 24-hours a day access

Gauge your preparedness for the program. See if you have trained staff and resources to provide the above remotely.

Note: While CCM service is furnished remotely, face-to-face communication where the physician makes a decision that the patient may be better served in person can be billed under the CCM program, but cannot be counted for any other services.

In order to be reimbursed, you must record all activities and their duration which fall under the CCM program. In general, this includes time spent on:

- Phone calls and email communication with the patient.
- Coordination of care with other clinicians, facilities and caregivers.
- Prescription management and medication reconciliation.



Identify eligible patients from EHR

- Must have two or more chronic diseases, that are expected to last at least a year or until death.
- The disease must put the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Commence the program by focusing on specific diagnoses from the list of chronic conditions, such as COPD, CHF, CKD, Diabetes, etc

ENROLL PATIENTS Initiation Reimbursement

- Provide them a written consent form where they declare their willingness to participate in the program. Explain the ins and outs of the program, including the fact that they can decline or cancel at any time in the future, or transfer to another physician.

- Provide the names of all the people who will be involved in the patient's care network. At the basic minimum, provide the designated physician's name and CCM nurse who will be conducting the monthly schedule nurse visit over the phone.

For patients not seen within 1 year before the commencement of the CCM, there needs to be an initiating face-to-face visit with the billing practitioner.

How can you do this?

Annual Wellness visits (AWV) and Initial Preventive Physical Exam (IPPE) are two popular means of introduction into CCM for patients who are eligible.

G0438 initial visit ($164)- For new first-time patients who have been enrolled with Medicare for more than one year.

Yearly revenue for new patients =($164 x 100)= $16400

G0439 subsequent visit ($109)- For returning patients who have had the AWV before. A patient is only eligible for a subsequent visit a year after the initial visit.

Yearly revenue for returning or 2nd year patients =($109 x 100) = $10900

START TREATMENT Service Reimbursement

As a starting point for new patients, one can use either CPT Code 99490 or 99491. CPT 9940 requires the least amount of minutes, and would be the code used to bill new chronic care patients who are at the beginning stages of their diseases. **Note:** Except complex CPT Codes, **no** other CPT codes in CCM can be billed more than once, or in the same month as each other.

CPT 99490 ($42 for non-facility/ $32 for facility) "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. Assumes 15 minutes of work by the billing practitioner per month."

Yearly revenue = ($42x12x100) = $50400

If the patient needs more time that spans beyond 30 minutes, then CPT 99491 should be used. It is reimbursed at double the rate because 30 minutes of time is allocated to the patient by either the doctor or other qualified healthcare professional, as opposed to the 15 minutes in CPT 99491.

Also notice, there is no mention of clinical staff in CPT 99491. This is because all of the 30 minutes of work is expected to be provided by the physician or qualified health professional. Whereas for CPT 99490, the 20 minutes of time can be performed by clinical staff, but must be directed by the physician or qualified healthcare professional. It does say 15 minutes of work should be performed by the billing practitioner, but this 15 minutes are a part of the 20 minutes of directed work.

CPT 99491($84 for non-facility and facility) "Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month."

Yearly revenue= ($84x12x100) = $100800

While the needs of the patient and the subsequent minutes of care recorded in the EMR system per month should dictate what CPT code is used, there is also scope of strategizing. It comes down to whether you have clinical staff at your disposal and if you want to use them. If you do, then you can train them to do the monthly outreach electronically and use CPT 99490. If physicians or qualified healthcare professionals were to involve themselves, then CPT 99491 would be preferred. Yes, it would take away valuable time, but that is why there is higher compensation.

FOR COMPLEX CASES

CPT 99487 ($93 for non-facility/ $53 for facility) "60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. Needs establishment or substantial revision of a comprehensive care plan, with moderate or high complexity medical decision making."

CPT 99489 ($47 for non-facility/ $27 for facility) "Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)."

CPT 99487 can be billed once per month, but CPT 99489 can be billed as many times as it is required to properly treat the patient. The patient's situation should absolutely dictate the invocation of such codes. One hopes it does not get to this point for the patient. But if it does, and there is the need to spend 60 minutes or more time monthly with the patient, then such codes are available at the physician's disposal.

The time requirement apart, in order for it to be a complex care episode, there needs to be a moderate or high complexity of medical decision making.

We didn't calculate revenues using these complex CCM codes, because revenue will be tied more to volume and not outcome. The expectation is that a base CCM program can be started where everyone's chronic conditions are managed without any exacerbations or complications. This allows you to provide a value-based payment (VBP) system of care while still getting paid for using the FFS model. But it also sets you up nicely, to switch over the VBP in the future. 67% of all healthcare reimbursements are now non-FFS.

ADDING RPM COMPONENT TO CCM

Speaking from a business perspective, remote patient monitoring has its own CPT code, which can be billed in the same month as any CCM code. CMS recognizes that equipping a CCM program comes with costs that do not overlap with costs required to run a CCM program. Hence, they have created CPT codes that specifically allow one to be reimbursed for providing RPM. Thus, both RPM and CCM can be billed in the same month due to their complementary nature, but the time allocated for one cannot be attributed to another, that is, no double counting.

Reimbursement aside, why does it make sense to add a RPM component to your CCM program?

- Each patient can have a tailored care plan based on real time data, intervene before potential emergency situations, and recommend new actions based on other similar cases.

- Opportunity to not only improve individual health, but population health as well. If the CCM program is fitted with a RPM program, then multiple vital signals(variety) can be monitored in real time(velocity) from each patient, which amounts to a lot of data at a population level (volume).

- Without RPM, a CCM can only receive communicational benefits, such as being alert to the patient's condition, sharing and revising care plans, sending medication reminders, etc. A RPM program **already** consists all of these best in class features, but it also collects and monitors patient data. It thereby does not need to rely on just communication (which can be hindered by lack of articulation or bias), but on the actual patient data which can be used to change care plans, prescribe new medicines, intervene and triage as necessary. It makes the CCM program more complete.

Like CCM, a provider must acquire patient consent and document it in the patient's medical record. Also, just like CCM, new patients or patients not seen by the practitioner within the last 12 months, must first be inducted into the program by a face to face initiating visit. One more similarity of RPM with CCM is that it is not considered a telehealth service, and for that reason the patient beneficiary does not need to be in a designated originating site. Such shared characteristics make for an ideal partnership between RPM and CCM, where the core service provided is so closely tied with remote delivery, that its remote aspect does not automatically categorize it into the telehealth bin.

REIMBURSEMENT FROM RPM

CPT code 99091($58 eligible in both non facility and facility): "Collection and interpretation of physiologic data (e.g. ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days."

Yearly revenue = ($58 x 12 x 100) = $69600

CPT Code 99091 was a 16 year old code. It did not reflect the way RPM operations were carried out. So beginning in 2019, CMS unbundled it into three different codes. The first two of those are regarding RPM equipment set up and running the program.

CPT code 99453 ($19): "Remote monitoring of physiologic parameter(s) (e.g, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment."

Yearly revenue for new patients = ($19 x 100) = $1900

CPT code 99454 ($64): "Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days."

Yearly revenue = ($64 x12 100) = $76800

CPT code 99457($52 for non-facility/ $32 for facility): "Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month."

Yearly revenue = ($52 x12 100) = $62400

The lower price tag on CPT 99457 is because it requires at least 20 minutes of care per calendar month, as opposed to at least 30 minutes of care per 30 day period in CPT 99091. The calendar month cycle is said to be better for record keeping than the 30-day period. Submitting claims is easier on a monthly basis.
CPT 99457 can be furnished by clinical staff, in addition to physicians and qualified health professionals. CPT 99091 had only mentioned the latter two groups on eligibility. Thus CPT 99457 is more flexible on who can management the treatment.

Difference Between CCM AND RPM

Billing & Supervision

	CCM	RPM
		Physicians, qualified healthcare professionals, and clinical staff.
Who can Bill	Physicians and other qualified healthcare professional (certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners and Physician Assistants).	A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service
Level of Supervision	CCM allows incident to billing under general supervision, where the physician and auxiliary personnel do not have to be in the same building at the same time. Thus qualified medical professionals in charge of billing can also be reimbursed at the same rate as physicians.	RPM requires direct supervision. There is no Incident to Billing without direct supervision. However, general supervision for RPM has been proposed in Physician Fee Schedule for 2020.

CCM + RPM REIMBURSEMENT CHEAT SHEET

1st Year

CCM

G0438. Initial visit **($164)**

CPT 99490. At least 20 minutes of clinical staff time generally supervised by a physician or other qualified health care professional per month **($42 x 12)**

RPM

CPT 99453. Set-up and patient education on use of equipment **($19)**

CPT 99454. Device(s) supply with daily recording(s) or programmed alert(s) transmission **($64 x 12)**

CPT 99457. Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time per month **($52 X12)**

Minimum Annual Revenue Per Patient= $2079

For 40 minutes of work monthly. 20 mins of general supervision, and 20 minutes of direct supervision.

***Subject to increase,** if the physician has the time to spend 30 minutes of personal time on each case, and if the patient requires more care.**

2nd Year

CCM

G0438. Subsequent visit **($109)**

CPT 99490. At least 20 minutes of clinical staff time generally supervised by a physician or other qualified health care professional per month **($42 x 12)**

RPM

CPT 99454. Device(s) supply with daily recording(s) or programmed alert(s) transmission **($64 x 12)**

CPT 99457. Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time per month **($52 X12)**

Minimum Annual Revenue Per Patient= $2005