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How to Set Up a Chronic Care Management (CCM) Program (A Five-Step Guide)

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The Case for Chronic Care Management (CCM)

If you are reading this article, I am assuming you are convinced of the value of Chronic Care Management (CCM) programs. If that's indeed the case, please proceed to Step 1 (below), which acts as the genesis for understanding CCM and formulating an appropriate strategy to realize its value. But first, I think it's important to understand why chronic care rose to prominence in the first place, and why Center for Medicare and Medicaid Services (CMS) saw it necessary to introduce Current Procedural Terminology (CPT) codes reimbursing chronic care from 2015.

Centers for Disease Control and Prevention (CDC) report that 21% of Americans between the ages of 45-64 have two or more chronic conditions. This percentage increases to 45% for those ages 65 and older. If we look at the census, this amounts to (21 % of 84 million) 17 million people and (45 % of 52 million) 23 million people respectively. Rounded to the nearest million in each case. So then, a total of 40 million people in USA suffer from multiple chronic conditions. This may be a conservative number, as in 2017, Health Catalyst had said that 1 in 4 American adults are afflicted with two or more chronic diseases, so roughly 61 million people (25% of 245 million). Going back to 2014, RAND Health reported that 42 % of American Adults had multiple chronic conditions so roughly 103 million people. (42% of 245 million).

So the total number of people suffering from two or more chronic conditions is somewhere between 40 million to 103 million people. By standard definition, chronic conditions cannot be cured by medicines or vaccinations, but care for chronic care patients can be managed to prevent exacerbations and ensure that they live long fulfilling lives. Thus, it is a great responsibility for healthcare workers and institutions to deliver this care to those who need it. If untreated or unmanaged, chronic conditions can lead to regular emergency department visits, hospital readmissions, and higher rates of mortality. All three are double-edged blows to the healthcare system. At one end, they have to pay fees in penalties for 30-day readmissions and incur losses through inefficient utilization of hospital capacity to deal with conditions that are not as revenue attractive as some of the more acute care services. Thus operationally speaking, cost increases, while revenue decreases. On the other end, the quality of healthcare system itself takes a hit, as patients do not find the type of care they hoped for that would deal with their chronic conditions, leading to high readmissions and mortality.

In light of such practical reasoning, CMS decided to tackle the issue of chronic diseases in a major way by deciding to systemize the provision of care for it through its Fee-for-service (FFS) model, where CPT

codes would be used to reimburse chronic care. This article talks about how one can take advantage of the CPT codes, and what must be done before one gets to that point. Essentially, it is a guide to set up and run a CCM program for a hospital or provider.

Step 1: Understanding the Rules of The Program

Definition: What Constitutes Chronic Care Management (CCM)?

Before setting up a CCM program, defining chronic care is paramount, as it defines the target population for whom such care can be provided to, and what it entails. For this, we enlist help from Center for Medicare and Medicaid Services (CMS), as they are the ones who took the initiative to create a separate stream of payments solely for chronic care. CMS defines CCM as the non-face-to-face services provided to Medicare beneficiaries who have more than one chronic condition, that are:

1) expected to last at least a year or until the death of the patient.

2)Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

What CCM is:

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

Most activities in CCM program are typically furnished remotely without the need for the patient's presence, such as online or telecommunication, review of files, and coordination of information. But it's possible to count some face-to-face activities as part of CCM were the physician makes a decision that the patient may be better served in person in some instances, or an opportunity arises where a non-face-to-face activity can be accomplished because of the patient's presence in the premises. In such instances those activities have to be billed under the CCM program as well.

Having understood what CCM involves and who it is for if physicians and healthcare executives can be in a better position to evaluate their practice's or hospital's readiness to best implement such a program. Subsequently, they can proceed to Step 2.

Step 2: Identifying Who you will Serve

One should begin by using their EHR to identify patients who are a good fit for the CCM Program in line with the definition of those who are eligible (see Step 1). These patients can be informed through a

regular office visit or an educational outreach campaign. It's important to have a certified Electronic Health Record (EHR) in place which has the following capabilities:

1) Structured recording of demographics, problems, medications and medication allergies.

2) Creation of a summary of care record that can be maintained and accessed any time.

The patients must grant authorization to electronically store and transmit their medical information to various care providers via a certified EHR. One must ensure that their EHR is set up to process all relevant CPT codes. This will be crucial later when it's time to bill the appropriate CPT codes for chronic care.

Best practices: Commence the program by focusing on specific diagnosis from the list of chronic conditions, such as COPD, CHF, CKD, Diabetes. Set up a phone line dedicated to answering questions about CCM services. Healthcare consultant Martie Ross says that those who have profitable CCM practices decide to introduce the service by having an initial conversation about CCM, rather than handing out forms or talking over the phone. Being a member of an ACO is helpful at this stage, as it reduces the pressure of facing the brunt of any upfront infrastructure costs. It can also be helpful when adopting value-based payment models where information needs to be shared between different care providers. This article focuses on the CPT codes, which is the FFS model. But it is noteworthy that chronic care experts such as William Mills say, that a population health management approach is better suited for running CCM, where the health of a large segment of people can be looked after centrally. In his words, a practice with over 500 patients would be ideal for realizing the value of this new revenue stream. That is not to say that a population health approach cannot be undertaken with the FFS model, that is precisely what we are advocating for. When you have a large program where you are getting the same type of revenue from every patient every month, the FFS model almost acts like a capitation model, where you get a certain amount to manage the health of each patient.

Important Strategic Consideration: Outsourcing.

If it is too taxing on current resources, hospitals may take help from third-party vendors in implementing their CCM programs. But it is important to develop robust workflows that address any and all gaps in care that may result from two organizations collaborating to implement ongoing care. One of the better ways to coordinate is to risk stratify the patients, whereby the additional resources begotten from working with a vendor are devoted to those who need it most, as it would be a very expensive proposition otherwise. In such instances, quality over quantity is preferred, as it is better to work with vendors who don't simply promise new streams of revenue, but rather act as an extension of the hospital to provide the same level of care that is expected from main organization. Running your program in this fashion will result in a sustainable operation, as patients are more satisfied and thus stay enrolled in the program.

Step 3: Begin Enrolling Patients

After determining the scale of your program, you will be at the stage where you begin to enroll patients. 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. Annual Wellness Visits (AWV) and Initial Preventive Physical Exam (IPPE) are two popular means of introduction into CCM for patients who are eligible. Chronic care, by its very nature lasts a long time, if not for the entire life of the patient, thus it is imperative that it be diagnosed as early as possible, so necessary interventions can be taken to prevent deterioration later on in life. Given the magnitude of its importance, Annual Wellness Visits is billed separately by Medicare, as it's not considered a part of CCM.

After informing the patients about their eligibility and the importance of managing chronic health conditions, it is time to enroll them in the program. 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. Explain how the payments will work, and if the patient has to pay any sum via coinsurance or deductibles. Medigap covers the coinsurance if someone is part of Medicare Part B.

Step 4: Provide CCM

After the patient has been officially enrolled in the CCM program, it's time to provide them with the typical services that a CCM program would entail. This would include providing regular assessments and reassessments of the patient's medical, functional and psychological needs. Create care plans for patients that recommends preventive actions, and monitor the patient's adherence to such plans. An inventory of resources and supports must also be created for the patient, so they can be more aware of their condition, and call on help when there is a risk of exacerbation. A comprehensive care plan should be shared with other clinicians which attempt to attain or maintain the patient's highest achievable physical, mental and psychosocial well-being. It will usually include information on the list of symptoms faced by the patient, the prognosis and clearly outlined treatment goals that are to be measured.

Share the comprehensive care plan with the patient as well so they aware of the expectations and outcomes, and are also more engaged because of it, which leads to greater quality of chronic care. **Best practice:** Use a patient portal to share the care plan with everyone. It improves collaboration and coordination. Develop a process for ongoing implementation which creates a monthly touchpoint of care for each patient enrolled in the CCM program, usually involving an outreach through email, text, phone or any particular remote patient monitoring (RPM) platform. This type of outreach is done by the physician or clinical staff such as nurse practitioner or physician's assistant.

Step 5: Get Reimbursed for Your 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.

Who Can Bill for CCM?

Physicians, Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants.

All monthly requirements must be validated before billing for the appropriate CPT code. One clinician is allowed to bill for CCM services for a particular patient for a calendar month. If a single patient has multiple physicians or subspecialists who are also responsible for treating the chronic disease in question, it is important to understand that only one clinician can bill for the CCM service for a certain month. This person is usually the one who is providing the bulk of the coordination services, usually the primary care physician. Other specialists may also bill for CCM services in other months, provided that they provided the majority of the care. But those months cannot coincide with the months when the primary physician bills.

The fact that only one CCM code can be billed per month makes the selection of the CPT codes very strategic. In reality, the condition of the patient will dictate the treatment, there are codes for more complex cases of CCM, as there are codes for beginner patients. This article uses CPT 9940 as the basis of revenue strategy. It 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.

CMS defines CPT 99490 (Avg. Payment: $42) as below:

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. Assumes 15 minutes of work by the billing practitioner per month.

In order to bill for CPT 9940, document 20 minutes of non-face-to-face clinical staff time. A practice can outsource the delivery of CCM services or do it in house, but it will need to establish a consistent system of documentation whereby all CCM care activities are recorded to see if 20 minutes of CCM care is provided. Services provided by licensed clinical staff other than the physician can count towards the 20 minutes, given that they are under the general supervision of the designated physician. They are part of the Incident-to Billing. Which means they will be reimbursed at the same rate as physicians, and not 85% of what physicians get. General supervision also ensures that the physician and the staff do not necessarily have to be in the same location during the provision of care, as opposed to direct supervision which mandates it.

The other beginner code for chronic care is CPT 99491, which requires 30 minutes of CCM services provided personally by the physician or other qualified health professionals. Thus, the issue about general or direct supervision does not arise, as the care is expected to be provided personally by the physician and not directed by them. For this reason, it is reimbursed at a higher rate, $84 as opposed to $42. So it comes down to the amount of work per patient that the physician anticipates per month because both CPT 99490 and CPT99491 can be billed just once a month. If 15 minutes of work is enough, then CPT 99490 is appropriate. If 30 minutes are needed, then the CPT 99491 code is in place to account for the doubling of work. If the patient's condition worsens, other complex CCM codes are available. If the situation changes where the patient needs to be transferred, or becomes a part of home health supervision, or is in hospice, or is going through end-stage renal diseases, there are more appropriate codes. See below.

From the list below, only the Complex CCM codes are allowed to be billed in the same month as each other. This is because we cannot put a cap on the duration of time of which would be appropriate for a CCM patient whose condition keeps worsening. It could need multiple treatments in a month.

CPT 99490 **(Avg. Payment: $42)**

CPT 99491 **(Avg. Payment: $84)**

Complex CCM- 99487 **(Avg. Payment: $93)** and CPT 99489 **(Avg. Payment: $47)**

Transition Care Management (TCM) – CPT 99495 and 99496

Home Healthcare Supervision – HCPCS G0181

Hospice Care Supervision – HCPCS G9182

Certain ESRD services – CPT 90951-90970

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