Five Steps to Implementing Chronic Care Management

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Chronic care management (CCM) is essential to controlling the cost of chronic diseases in the United States. Recently, Medicare introduced CPT Code 99490, which provides about $42 per patient per month to providers who deliver 20+ minutes of non-face-to-face chronic care coordination to eligible Medicare beneficiaries with two or more chronic conditions. Providing CCM services can be a smart way to decrease healthcare operational costs across the country while also creating recurring revenue. With a competent workflow in place, even the most modest reimbursement can be a positive boost to your clinic's bottom line.

There are five steps to implementing chronic care management: identifying patients, educating and enrolling those patients, engaging with patients, maintaining documentation, and billing for reimbursement. This whitepaper describes the importance of chronic care management and cost-effective methods to implement this service in your practice. This not only diversifies your sources of revenue but also helps patients with chronic conditions lead a healthier lifestyle.

Background on Chronic Care Management

On January 2015, chronic care management was brought front and center in U.S. health care when Medicare began offering a modest reimbursement for approximately 20 minutes of preventative-like care each month. The program intends to improve the quality of care for beneficiaries with two or more chronic conditions while reducing hospital readmission rates. So far, the program has proven popular and beneficial. A recent survey of participating physicians showed that the vast majority (84 percent) believe the program is succeeding in having a positive impact on patient care.

How does it work? The requirements are quite extensive. To summarize them, chronic care management is a means of providing ongoing oversight and support for those who are at greatest risk for health complications such as high blood pressure and diabetes. Chronic care management includes maintaining a comprehensive, patient-centered **Health Summary and Care Plan** that includes all current records from all the patient's providers. Other important services include 24-hour access to clinical staff to address urgent chronic care needs, continuity of care, coordination with home and community-based clinical service providers.

The program can seem complicated at first glance. In fact, program adoption is still quite low with fewer than 20 percent of U.S. physicians choosing to participate. There are two reasons for this: most physicians (70 percent) don't fully understand the program and about half are still relying on corporate

to make a decision[2]. Some complicating factors have been related to staffing strategies to optimize the program. There is some flexibility, for example, on who can take the 20-minute calls with patients. Optimizing the workflow is essential to ensure your clinic is meeting the chronic care management requirements for each patient every month and to make the service cost effective.

What steps should physicians take to implement a chronic care management program at their facility? Below, we identify the top five challenges and the steps they should take to qualify.

Step 1: Identify Patients

Medicare only reimburses chronic care management for patients who have two or more chronic conditions that are expected to persist at least 12 months. These conditions should also put the patient at significant risk for mortality or morbidity. Patients should also be at a position where non-treatment or negligence has the potential to exacerbate their condition to the point where it affects their ability to function.

Physicians should leverage their existing database of electronic medical records to search for patients who would benefit from chronic care management. If they lack such systems or if the systems are too rudimentary to perform search functions, consider extending your current solution. Partnering with an information technology provider such as Nalashaa can also better prepare you with clinical solutions that improve search functionality, documentation and billing.

Other strategies include contacting patients through outreach campaigns or discussing the chronic care management program with them during a regular visit. The goal is to raise awareness about the value of prevention and regular oversight when it comes to controlling chronic conditions. Patients who are contacted through an outreach campaign may have questions, so it may be helpful to maintain a dedicated phone line with staff members on hand who understand the CCM program.

Step 2: Educate and Enroll Patients

In addition to finding qualified patients, physicians must obtain their consent to be part of the program. The best way to receive their consent is to educate them about the benefits of chronic care management. Prospective patients should understand how the program works and its potential impact to their health. They should also know that they can decline, transfer or terminate their participation in the program at any time. If they are interested, physicians should obtain their written consent as well as authorization to transmit electronic communication of medical records with other clinicians as appropriate.

Program-specific requirements such as recurring nurse assessments over the phone should be described in detail since this "visit" is likely to be unfamiliar to most. Despite the differences, patients should still treat the phone call like a regular visit. Proper patient education early on sets the tone for later interactions, such as patient engagement and billing.

Step 3. Encourage Patient Engagement

Once a patient is enrolled they should be immediately assessed. The first step is to provide a systematic assessment of the patient's medical, functional, and psychosocial needs. If a patient's assessment presents risk factors, appropriate recommendations for preventative care services should be issued along with regular follow-ups to ensure timely care.

Improper medication regimen is one of the first red flags. That's because patients with chronic conditions are often prescribed a host of medications to control symptoms. These medications can come with some unpleasant side effects that patients attempt to control through over-the-counter drugs. Unfortunately, patients can inadvertently harm themselves by taking contraindicated

medications—mixing over-the-counter drugs such as NSAIDs with regular prescriptions. Performing a medication review can end such interactions while also maximizing adherence.

All the assessments come together to create a comprehensive care plan that is shared with the patient and with other providers as necessary. If your clinic has access to a patient portal, this medium is likely to be the best and most cost-effective route to deliver a patient's care plan along with alerts, educational resources, patient health records, consent forms, and other relevant details.

Step 4: Incorporate Automated Documentation Tools

To qualify for chronic care management reimbursement, clinics must record and maintain proper documentation of each enrolled patient. Although keeping track of paperwork seems easy, the ratio of billed-to-enrolled CCM patients is only 0.52. In other words, only half of those enrolled are actually being billed each month. This inefficiency is partly due to ineffective workflows relying on traditional, slower record-keeping tools.

The documentation system should effortlessly keep track of the time spent on non-face-to-face services such as phone calls. Records should also note the time spent coordinating care with other clinicians, facilities and caregivers as well as time spent managing prescriptions. While this kind of record keeping can be accomplished manually, staffing and other opportunity costs quickly add up on the modest CCM reimbursement offered by Medicare. To be cost effective, clinics should incorporate custom CCM workflow tools.

This kind of clinical solution is often referred to as **care coordination**. These platforms coordinate everything from admission and assessment to care planning and team coordination.

Step 5: Billing and Reimbursement

Before submitting CCM billing under CPT code 99490 each month, it is important to validate that patient requirements were met. For more answers on billing, take a look at the extensive FAQ available on the Centers for Medicare and Medicaid Services website.

Preparing Your Clinic to Support Chronic Care Management

Excited about the potential value CCM can bring to your practice? Consider upgrading your clinical support systems to support CCM. With the modest reimbursement for services, it becomes practical to incorporate technology wherever possible to maximize the use of your staff's time and to help your bottom line. By collaborating with an experienced information technology vendor such as Nalashaa, you can customize your existing HIPAA-compliant electronic health record systems to support care coordination and documentation requirements to enroll and bill CCM patients.

Nalashaa can also help you create a patient portal. With patient portals, you can share information, documents and vital forms with patients. This real-time access to their information will also help you streamline the way you disseminate information, improving the speed and efficiency of your workflow.

Interested in contacting Nalashaa to discuss how to incorporate chronic care management in your clinic? Reach out to a representative at info@nalashaa.com.

Sources:

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