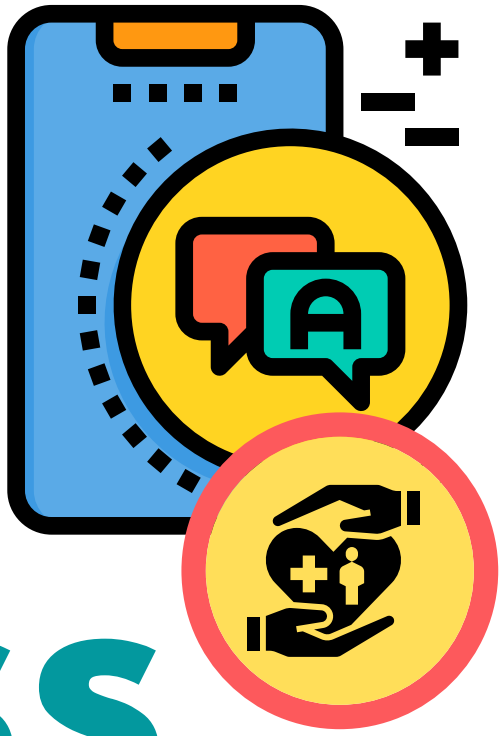
Chronic Care Management Program

# 2022 CPT Codes

# 5 Steps to CCM Success



## The Chronic Care Management Implementation Toolkit

Download Your Free **CCM Codes Summary** & **5-Step Planning Guide**

with tips for Program Planning, Communication, Training & more!

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# Chronic Care Management Billing Codes Summary

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CMS continues to increase the number of Chronic Care Management codes providers can bill for. Starting with just one code in 2015, CPT 99490, the Physician Fee-Schedule now includes 7 codes accounting for various levels of complexity and time.

| Billing Code | Code Description | Summary Requirements | Average Payment |
|---|---|---|---|
| HCPCS G0506 | Comprehensive Assessment & Care Planning | ▪ Patient enrolled in person<br>▪ Systematic assessment & care planning personally performed by the billing provider<br>▪ Add-on code to the standard E&M code (99212-99215), AWV or IPPE initiating visit | $60.50 |
| CPT 99490 | Standard CCM | ▪ 20+ minutes of care management outside of office visits performed by clinical staff<br>▪ Care plan established and regularly reviewed | $61.16 |
| CPT 99439 | Non-complex Add-on | ▪ Additional 20 minutes of "non-complex" CCM<br>▪ Reportable up to 2x per month (after 99490) | $46.28 x 2 |
| CPT 99487 | Complex CCM | ▪ 60+ minutes of care management outside office visits<br>▪ Care plan created and/or significantly revised | $129.93 |
| CPT 99489 | Complex Add-on | ▪ Billed incrementally for each additional 30 minutes spent beyond the first 60 minutes for Complex CCM case | $68.79 |
| CPT 99491 | Physician-provided CCM | ▪ 30+ minutes of care management outside of office visits<br>▪ Provided personally by a physician or other qualified healthcare professional | $82.98 |
| CPT 99437 | Physician-provided CCM | ▪ **Additional 20 minutes of care management outside of office visits**<br>▪ **Provided personally by physician or other qualified healthcare professional** | $58.52 |
| HCPCS G0511 | RHC or FQHC CCM | ▪ 20+ minutes of CCM or behavioral health integration services directed by a provider at a Rural Health Clinic or Federally Qualified Health Center | $76.04 |

What's most interesting about Chronic Care Management is that ALL care provided by clinical staff incident to and under the general supervision of the billing practitioner count towards CCM.

Given the incident to and general supervision mandate, the majority of patient needs and complications can be managed and dealt with by clinical staff, enabling providers to focus on only the most complex patient needs, all while increasing patient access to care and provider reimbursement.

**Phamily is the best way to run your Chronic Care Management program.**

# Chronic Care Management
## Implementation Toolkit

## 5 Steps to CCM Success:



## Step 1. Program Planning

- ☐ **Understand and review the requirements of Chronic Chronic Care Management**
  - Medicare Learning Network:  Chronic Care Management Services

- ☐ **Identify launch team**
  - Executive Sponsor: _____
  - Lead Physician: _____
  - Operational Lead: _____
  - Clinical Lead: _____
  - Care Manager(s): _____

- ☐ **Define program success and targets**
  - Goal 1: _____
  - Goal 2: _____
  - Goal 3: _____
  - Patient Enrollment Target @ 90 days:  250 /  500 / 1,000

- ☐ **Set a target launch date:** _____

☐ **Determine your approach to CCM** (choose one)

| Option 1<br>**Outsourced**<br>(3rd Party Call Center) | Option 2<br>**In-House Do-It-Yourself**<br>(EHR + Phone Calls) | Option 3<br>**In-House with CCM Partner**<br>(EHR + Smart CCM Platform) |
|---|---|---|
| Good option for small practices that want to completely outsource care management to a 3rd party and are okay receiving less than 50% reimbursement. | Good option for a very small CCM program (less than 50 enrolled patients). Mostly manual process with limited scale, but able to retain all of the CCM reimbursement. | Good option for growth & quality oriented practices that want to scale CCM as a core service and enroll 500+ patients. Maximizes patient engagement & net profit. |
| | **50-75 Patients / FTE** | **400-500 Patients / FTE** |

- **PRO-TIP:** Request a free CCM consultation to better understand the options.

☐ **Create a financial analysis to forecast key metrics before starting the program**
- # of Eligible Patients
- Enrollment Rate
- # of Enrolled Patients
- % and # of Patients Qualified for Billing Each Month
- Reimbursement
- # of Clinical Staff Working on CCM
- Labor Cost
- Software Cost
- Net Profit
- **PRO-TIP:** Request a free financial forecast for your organization.

☐ **Create a shared project plan and task tracker**

☐ **MILESTONE: Financial analysis and project plan review**

## Step 2. Workflow Design

☐ **Identify eligible patient population**
- Create a report of all patients in your EHR.
- Filter to patients with Medicare or Medicare Advantage.
  - Include Medicaid patients if your state Medicaid reimburses for CCM.
- Filter to patients with multiple chronic conditions.
- Filter to patients who had a qualifying visit (E/M, AWV, or IPPE) in the last year.
- Analyze the report to arrive at the potential eligible patient population.

- [ ] **MILESTONE: Enrollment opportunity confirmed as _____ eligible patients!**

- [ ] **Determine care team staffing needs**
    - Calculate how many care managers (NPs, LPNs, MAs) will be needed based on your approach to CCM, target patient enrollment, and financial forecast.
    - **PRO-TIP:** Ask our CCM advisors about enrollment and productivity benchmarks.
        - In-house DIY caseload is about 50-75 patients per care manager.
        - In-house with CCM partner caseload is 400-500 per care manager.
    - Determine existing resource capacity, and additional FTEs to hire.

- [ ] **MILESTONE: Target enrollment confirmed as _____ patients to be managed by a care team comprised of _____ existing FTEs and _____ FTEs to be hired.**

- [ ] **Evaluate using EHR + phone calls vs. smart CCM software**
    - **PRO-TIP:** In addition to features, compare results at comparable organizations:
        - Enrolled patient panel size
        - Patient satisfaction & care quality
        - Time to launch & scale
        - Caseload & productivity
        - Monthly reimbursement
        - Net profit
    - **PRO-TIP:** Request a demo at **phamily.com**

- [ ] **Design patient enrollment workflows**
    - Design outreach plan to inform all eligible patients about CCM.
    - Design patient brochures and collateral to educate patients.
    - Design enrollment workflow for in-person office visits.
    - Ensure patient consent will be properly obtained and documented.
    - **PRO-TIP:** Make discussing CCM a natural part of the office visit workflow.

- [ ] **Design care management workflows and protocols**
    - Develop care plan templates for chronic conditions you specialize in.
    - Decide how to engage patients on a consistent, frequent basis.
    - Create scripts and templates to help care managers engage patients.
    - Establish protocols to handle escalations and follow-ups.
    - Align on what care management activities you will focus on for CCM.
    - Create templates for documenting activity and logging time.
    - **PRO-TIP:** Streamline workflows to focus on doing a few simple steps very well.

- [ ] **Decide on billing workflow and schedule**
    - Understand the requirements of the CCM billing codes.

- Align with your billing / revenue cycle team on the information needed & schedule to submit claims on a timely basis.
- **PRO-TIP:** Don't forget to bill add-on codes. for patients needing extra care.

☐ **MILESTONE: Workflows designed!**

## Step 3. Team Training

☐ **Patient Enrollment**

- Train office staff on in-person enrollment workflow to obtain patient consent.
- Train care team to explain the program benefits and answer any questions.

☐ **Care Management**

- Train care team on developing patient-centric care plans using your templates.
- Train care team on tools required to deliver personalized care for each patient.
- **PRO-TIP:** Reduce need for phone calls by using patient messaging capabilities.
- Train care team on escalation protocols and handling follow-ups.
- Train care team to document activity and log time.
- **PRO-TIP:** Create a care team schedule with care management shifts.

☐ **Billing**

- Train Billing / Revenue Cycle team for monthly CCM claim submission.

☐ **MILESTONE: Team is trained and has the right tools!**

## Step 4. Patient Enrollment

☐ **Introduce CCM to patients**

- Put flyers, brochures, and/or posters about CCM in your waiting room.
- Send information to all eligible patients informing them about CCM.
- Utilize the Patient Advocacy program for Enrollment Outreach

☐ **Start enrolling patients**

- Begin in-person enrollment during office visits.
- **PRO-TIP:** Bill G0506 add-on code if doing care planning during office visits.
- **PRO-TIP:** Call eligible high-need patients to ramp up enrollment.

- [ ] **Develop & share care plans for enrolled patients**
    - Begin in-person enrollment during office visits.

## Step 5. Program Management

- [ ] **Establish core routines**
    - Daily care management calls, resulting activities, and follow-ups.
    - Daily huddle to review escalations and highlight patient wins.
    - Weekly meeting with care management team.
    - Monthly meeting with Executive Sponsor & program leads.

- [ ] **Celebrate key result milestones**
    - ★ **First patient enrolled!**
    - ★ **First patient win!**
    - ★ **First billable event**
    - ★ **First G0506 claim submitted**
    - ★ **First 99490 claim submitted**
    - ★ **First month reimbursement confirmed**

- [ ] **Financial Reporting / Analysis**
    - Every month: # of patients enrolled, # of claims submitted vs. target
    - Every 90 days: claims collections vs. target
    - Every 180 days: return on investment (reimbursement, labor costs, software costs, net profit vs. target)

- [ ] **Quality of Care Reporting / Analysis**
    - Every month: # of touchpoints per patient, # of clinical interventions, key patient stories (de-PHIed)
    - Every 90 days: quality analysis - types and volume of clinical interventions, tracking of care gaps and key vitals
    - Every 180 days: patient satisfaction survey & analysis of responses

**Need help? Have questions? Speak with a CCM advisor.**

Request your free CCM consultation at **phamily.com**