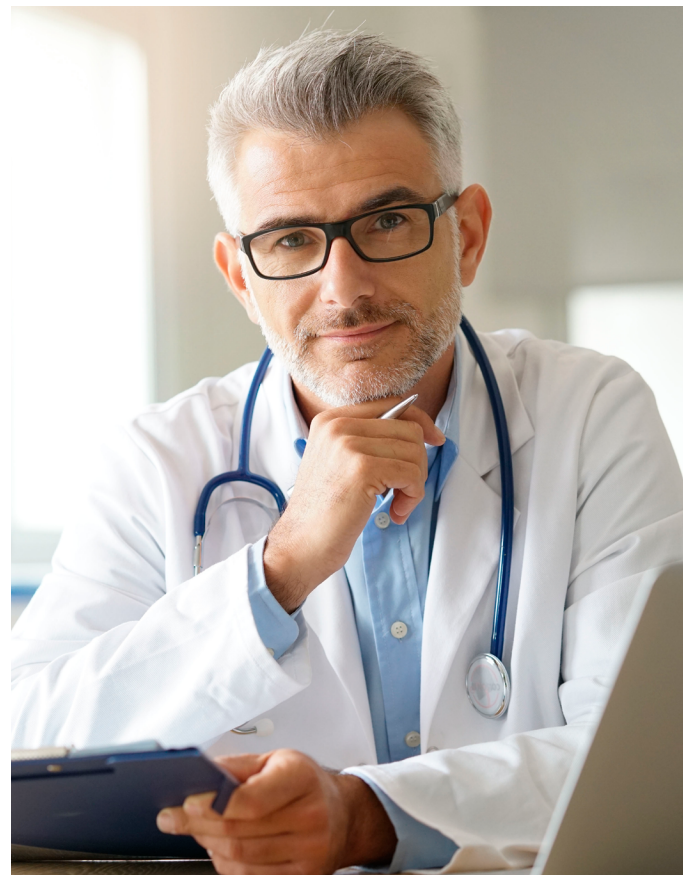# ChronicCareIQ's
3 Ways to Perform CCM

INTRODUCTION:

In recognition of the macroeconomic trends including mobile technologies, the aging boomer population, the proliferation of chronic diseases, and the unsustainable impact they have on the Medicare Trust Fund, CMS offers a new suite of reimbursement codes to help manage patients when they are outside the office and at most risk for disease progression and decompensation with their chronic diseases.

7 in 10 deaths[1], 99% of all the payments made by Medicare[2], and 86% of the U.S. healthcare costs overall are attributed to chronic disease[3]. Approximately 2/3rds of all Medicare beneficiaries have 2 or more and another 10,000 baby boomers each day will be joining the Medicare rolls for the next 8 years[4]. They have the largest impact on Medicare solvency and without dramatic structural changes to how chronic disease is managed, Medicare is broke.

In 2015, CMS introduced a first-of-its-kind reimbursement for physicians treating patients with chronic disease. Chronic Care Management or "CCM," was released with CPT code 99490. Since that time, CMS has introduced additional reimbursements under similar programs including Remote Patient Monitoring (RPM), Behavioral Health Integration (BHI), Collaborative Care Model (CoCM), Oncology Care Model (OCM), and another new category has been introduced to launch in 2020 called Principal Care Management (PCM). Taken with Transitional Care Management (TCM), which was introduced in 2013 to promote rapid patient engagement upon discharge from a hospital, these "Connected Care"

codes are CMS' building blocks for the transition to value which was passed into law in 2015[5] and are the delivery vehicles for preventative care. Traditional ambulatory care is now in the throes of a paradigm shift from re-active and episodic care to pro-active and chronic care.

This document is intended to provide an understanding of Chronic Care Management or CCM and the three most common strategies for its deployment in your practice along with the pros and cons of each. For full CMS guidelines, we recommend the Medicare's MLN Booklet on CCM available here: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

1   Centers for Disease Control and Prevention. The Power to Prevent, The Call to Control. (2009) Accessed at https://www.cdc.gov/chronicdisease/pdf/2009-Power-of-Prevention.pdf

2 & 4   Understanding and Promoting the Value of Chronic Care Management Services https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2017-02-21-CCM-Presentation.pdf

3   Health and Economic Costs of Chronic Diseases https://www.cdc.gov/chronicdisease/about/costs/index.htm

5   What is MACRA? https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

OPTION 1: PERFORMING CCM WITH YOUR EHR AND NOTHING ELSE.

Although resource intensive, it is possible to perform CCM internally within your EHR and nothing else. Create a template in your EHR and name it "CCM." Include standard items such as name, DOB, Pt ID number, problem list, med list, and care team members – essentially a CCD template will work. Create an open field labeled "Non-face-to-face Activities" where you or staff can free text and document information.

At the beginning of the month or when you enroll a new patient in CCM during the month, open the CCM template which will populate with the CCD info for the patient(s). As activities are required for each patient during the month, train staff to update the free text field with the date, time committed, and activity performed. Leave the note OPEN until the end of the month so that activities may be added throughout the billable calendar month. At the end of the month, add the time, close the note, forward those that meet minimum billing requirements to the doctor's in-box for signature, and create the appropriate claims. There is a plethora of non-face-to-face activities that can and should be included in your documentation. Things like pre-certs, pre-auths, lab reviews, chart reviews, med reconciliation, patient education, etc.

Staff can close the CCM note once minimum time is met and submit the charge. At the end of the month, run an open note report which will show you those CCM patients that didn't reach billing minimums and close those notes. If you believe your practice will exceed the minimum 20 minute per calendar month for patients,

you can accommodate this by closing all notes on the last day of the month and submitting applicable claims then. It's a bit more month-end activity, but an effective way to accommodate the higher reimbursements for complex CCM which reimburse considerably more.

It is possible to perform Chronic Care Management in your EHR with nothing else.

Here's a real-world example of a documented CCM note:

CCM Note: Non Face to Face Activities – [Month/Year]:
Last Name, First Name   DOB:
Patient ID:
Diagnosis Codes:

June 3, 2019 **5 minutes** Refilled 2 medications (staff initials)

June 11, 2019 **17.5 minutes** Coordinated care with Jenna @ Dr. Rayburn's office. Pt spouse reports he is dizzy and confused. Dr. Smith changed HT Meds and I called those in (staff initials)

June 11, 2019 **12 minutes** Called pt and discussed syncope w/ pt & wife. Confirmed will stop taking metropolol & get new Rx at pharmacy, reviewed diet, asked to call me if anything changes. (staff initials)

June 14, 2019 **4.5 minutes** Pt called. Good week. No add'l problems. Check back in 2 weeks

June 27, 2019 **6 minutes.** Called pt to check in. Daughter answered. No add'l problems. Will check back in in 1 month

Total Time: 45 Minutes

NOTE

The EHR has already documented med refills and changes, and likewise for important phone conversations, but you need to account for the time since CCM is a time-driven reimbursement. The purpose of the CCM Note is for compliance documentation (time & activity tracking), not clinical documentation. Your EHR should remain your home for clinical documentation.

DOES YOUR STAFF HAVE TIME?

Consider this: As a business, this example shows your practice already has 45 minutes of time spent with this patient. Unless reimbursed, that is SUNK COST for work that has already been performed. Let's repeat that for emphasis: Your staff is performing this work every day anyway. 45 minutes at $20/hr is a hard cost to your practice of $15.00. If it took an additional 10 minutes (or $3.33 at $20/hr), that 10 minutes of extra documentation would swing your business from a $15 cost to a $42 reimbursement.   Subsequently, the $3.33 investment in filling out that CCM note generated a $57 swing from loss to revenue on that patient. Can you think of scenarios like this happening every day at your practice? With 100 or so patients like this every month, that's over $50,000/year in additional revenue for work already being performed. Note: Your cost would be much more of an RN or more highly paid individual is performing this work.

COST		REIMBURSEMENT
-$15	$\Longrightarrow$	**$42**
SUNK 45 MINUTES		EXTRA 10 MINUTES

3 PRO'S:

- *Turns losses into revenue* – Since your staff are already has a SUNK COST on many patient care activities that are performed anyway, any revenue would be good.

- *Transition to value* – This scenario enables you to start connected care without hard costs. It's important that you be in the game. The transition to value-based care was set in motion by federal law in 2015. CCM is a heavily weighted activity under MACRA/MIPS. As evidence it is happening, consider that in 2014, there was 1 CPT code for managing chronic patients. Today in 2019, there are too many CPT codes to list here in the categories of: Chronic Care Management (CCM), Remote Patient Monitoring (RPM), Oncology Care Model (OCM), Behavioral Health Integration (BHI), Collaborative Care Model (CoCM), and already announced for January of 2020 – Principal Care Management (PCM).

- *Improve patient satisfaction* – That 7 in 10 deaths in America are caused by chronic disease shows that patients need help managing these conditions. Whether newly diagnosed, experiencing disease progression, or being recently discharged, it's an unsettling time when patients are especially vulnerable. CCM is the reimbursement that enables your practice to provide these patients additional resources that have a positive and long-lasting impact.

3 CON'S:

- *It doesn't scale* – Like the example provided above, your team is already performing some CCM work but the outreach is manual and limited to what your team can perform individually. That makes it expensive. In addition, you'll need robust audit logs if you're going to charge Medicare. The team is already performing the work, but building in the additional documentation must become a habit which requires discipline, process, and management.

- *It leaves out the other Connected Care Codes* – There are more than 10 additional reimbursements in 5 categories that relate to monitoring and managing patients with chronic conditions. Don't underestimate the power of the additional Connected Care codes. For example: Remote patient monitoring in conjunction with CCM can yield as much as $265 per patient per month, a whopping 650% more than base CCM. A single TCM code pays twice as much as a level 4 office visit and is being increased even more in January of 2020.

- *It's hard to convince patients to sign up* – Patients are like any other rational consumer. Your practice is already providing these services to patients at no charge. What additional services or value can you add to convince your patients to sign up?

WHO THIS WORKS FOR:

Quality-focused small practices seeking only to engage a limited population of eligible patients. Practices that aren't participating or seeking to maximize MIPS scores. Practices with loyal patient populations.

OPTION 2: OUTSOURCE CCM TO A THIRD PARTY

CCM can be performed 'incident to' the doctor's "general" supervision, which means it can be performed by a third party under the doctor's overall control although his or her physical presence is not required. There are many third-party call centers in the market that will offer to take over CCM responsibilities in exchange for a share of the revenue. The pitch is simple: You get the patients to sign up and they'll handle the details and patient engagement. Services vary but typically include: Obtaining enrollment paperwork, calling the patient for at least 20 minutes a month, and intermediate for your practice. Call centers typically charge between $25 and $30 per patient per month and you're responsible for collecting the co-pay. A common objection is that the practice payment (after the co-pay) is about $4.00 - $6.00 per patient per month. Depending upon the call center, some offer the additional benefits of providing patient education and serving as an after-hours contact for enrolled patients. Third-party CCM services often bundle with services that provide on-site services for Annual Wellness Exams.

PRO:

- It's convenient because the patient engagement is left to a third party.

3 CON'S:

- **MASSIVE RISK** – Medicare pays you directly for CCM and you are held solely accountable for the actions or inactions of any third party provider. While you retain as little as four or five dollars per patient, you own 100% of the risk.

  » **Quality of Care –** What kind of care are you anticipating your chronic and fragile patients will receive from someone else for only $25 to $30 per month? Do you want these patients relying on someone else? Would you submit a loved one to that level of care? How will you ensure it is up to your standards? How will you avoid a negative impact to your reputation?

  » **HIPAA & Security –** Are the third party's hardware, software, staff, processes, and standards up to modern HIPAA requirements? How do you know? At a minimum, does the vendor have appropriate security documentation and a HIPAA officer? Remember, it is you that will be held responsible, not the third party.

  » **Documentation for CMS and Payers –** You must have a process for routinely evaluating third-party documentation and ensuring it is adequately robust. CMS is reimbursing you and will fine you, not your third party, if documentation suffers. It's a conflict of interest to give up billing control to a third party that is paid only upon compliance with activities they themselves are performing. This is a major red flag and you are the one that CMS will hold responsible.

  » **Certification Standards –** If you're outsourcing CCM to a third party that operates out of state, do they guarantee that the employees they've hired out of state have appropriate certifications in your state? Remember, it is you that will be held responsible, not the third party.

» **Obsolescence –** CMS' stated initiative in providing CCM and other connected care codes is to improve patient access to care. Outsourcing your most fragile patients to a third party does the exact opposite.

• **INCOMPLETE SOLUTION –** What about the work already being done by your staff: the time on the phone, the med refills, the pre-certs, the care coordination…you're paying your staff for that work, why should a third party get 60% of that reimbursement? Do you really need a third party? And what about the other 4 categories and 9 reimbursements of patient management codes that the third party can't perform or bill for? Will you purchase additional solutions for those? Some can be billed together and some can't. How will you keep that straight? If your core competency is ambulatory care of adults and seniors, you'll have up to speed on all of these codes because they are foundational to how you'll be paid in the future.

• **POOR ROI = SUSTAINABILITY QUESTIONS–** Simple truth – there's very little revenue here to share that can sustain two businesses. Consider the call center's overhead, their employee turn-over, and their margins. How can they manage your most fragile and chronic of patients for only $30 per patient per month?

WHO THIS WORKS FOR:

No one. The business calculus of accepting high risk for low reward is unfavorable. Outsourcing your core competency and core clientele to a third party is poor business strategy and may feel like a betrayal to your patients. For more about third parties, see CMS' Final Report on CCM. First paragraph, top of page 19:

Three of the four practices that used vendors for CCM were unhappy with them and had discontinued their work with the vendor by the time of our interviews. Providers reported firing vendors because they felt the vendors

contributed to fragmented care, created unnecessary paperwork that practice staff then had to review, only communicated electronically with the provider, and were not providing clinically meaningful care to patients.

NOTE

This is CMS' own document. https://innovation.cms.gov/Files/reports/chronic-care-mngmt-finalevalrpt.pdf

OPTION 3: UTILIZING TECHNOLOGY SPECIFICALLY DESIGNED FOR CONNECTED CARE.

ChronicCareIQ is award-winning technology that uses your existing EHR to proactively engage at-risk patients with patient-specific, dynamic questions about their health status. Questions are pushed through whatever technology the patient or care-giver is most familiar, including smart phones, web, email, text and land lines. Responses are collated on a color-coded dashboard alerting staff to those patients trending poorly or who have exceeded clinical thresholds. Whereas traditional care is characterized by large gaps between patient visits and blind spots that result in decompensation and hospitalization, this newer technology delivers up-to-date situational awareness of entire at-risk population(s). A single click from the dashboard delivers actionable intelligence on the patient's trends, thresholds, and outliers. Whether titrating meds for newly diagnosed or managing complex patients with multiple comorbidities, care-team members and a long list of medications, better decisions made can be made faster with fewer gaps.

The PROVEN results are tangibly reduced hospitalization, improved outcomes, and happier patients, with less burden to providers and staff.

Monitoring patients in this fashion is not only good for their care, it also counts towards CCM time effectively contributing towards the minimum 20 minutes of time required for reimbursement. You'll want technology like ChronicCareIQ that plugs into your phone system and your EHR to capture the work your office is already performing. Without automation such as this, too much slips through the cracks. By plugging in and centralizing, you're not only effectively and efficiently billing for the work you performed, you're also robustly documenting and producing excellent audit logs.

Another important reason to centralize is that there are now more than 15 CPT codes in 5 categories where many of these activities and time spent can be applied for reimbursement. Some conflict and some are complimentary. A centralized platform optimizes your activities, your time capture, your documentation, your reimbursement, and correct coding while minimizing work, improving patient outcomes, and reducing risk.

CMS has already and continues to introduce multiple new reimbursements as the foundational building blocks of connected care to address and close the gaps that exist in episodic care today. ChronicCareIQ is a simple addition to the EHR that empowers traditional episodic practices to more pro-actively treat and manage chronic and fragile patients. With 10,000 boomers a day entering the medical roles and nearly 70% of them with two or more chronic diseases, the delivery mechanisms of traditional episodic care must be enhanced to change the direction of Medicare's unsustainable path. Investing in technology that automates monitoring of your most at-risk population not only improves outcomes and generates significant revenue, but also scores highly with a direct impact in three areas of MACRA / MIPS and reduce burden on physicians and staff.

PRO:

- **Better Care and Better Quality of Life for your Patients –** In addition to statistically better outcomes, patients report that sending in their updates helps them feel connected to their doctors, eases anxiety, and reduces worry enabling them to have a better quality of life. ChronicCareIQ enjoys 91% patient satisfaction, 87% patient retention at 1 year, and 29% reduction in hospitalization(s).

- **Reduced Burden on You and Staff –** Managing complex patients is difficult, multi-faceted and time-consuming. It becomes much easier with regular patient updates and proactive engagement before small problems turn into large ones. Proactively monitoring patients with automated, patient specific outreach is eligible for CCM and RPM accredited time which makes it easier to reach billing thresholds, which empowers the practice to manage more at-risk patients and prevent more hospitalizations. It's a win for you, for your patients and staff, and for your payers.

- **Net New Reimbursement, Security and Longevity –** There are 15 current reimbursements paying between $42 and $265 per patient per month in 5 categories of patient management that Medicare reimburses. With only a few exceptions, these are in addition to all other E&M codes and procedures. Medicare is not simply recognizing a few areas of care with novel reimbursement. These CPT codes are foundational blocks for the transition to value-based care and the constructs for a more pro-active and preventative healthcare system. It is not unusual for practices to experience net monthly increases in revenue between $6,000 and $12,000 per provider per month.

CON'S:

- **Monthly Fee –** Using the ChronicCareIQ platform requires a fixed monthly fee per provider, per month. The offset to this it that it enables you to manage more patients, more easily and maximize revenue across all Medicare platforms. .

- **Requires Focus –** TThe ChronicCareIQ platform makes it easy to manage multiple populations and multiple individuals at risk. Patients that participate or whose care givers participate via email, text, or smart phone present the largest margins enabling you to scale broadly to the largest number of patients. While the platform has the ability to organize your staff around patients with land lines, they do require more resources and present a larger cost for your team to manage. There will be a portion of your Medicare population that does not participate with internet or email. Stay focused around your patient's 'technology' mix to run the most successful and sustainable program. Or, have their care givers answer their questions with them on their own devices.
- **Patients are Sticky –** 87% of patients that start using ChronicCareIQ are still reporting after one year. That level of retention signifies strong patient satisfaction (which is at 91%) but it may run the risk of representing a loss to them if you discontinue a program where they find that much value.

WHO IT'S RECOMMENDED FOR:

Practices that treat chronic disease(s) and have 30 or more chronic patients per provider. High Medicare volumes are indicative of a strong fit: Cardiology, Pulmonology, Internal Medicine and Hepatology are just a few. Any medical organization with a vested interest in lowering cost and, reducing admission or re-admission is also a good fit.

ChronicCareIQ has designed a CCM solution that can ensure your success with the new Medicare billing program. Getting started with the ChronicCareIQ system is simple and easy to implement. We don't ask you to purchase any new technology or disrupt your current practice workflow. ChronicCareIQ can provide you with a true care coordination and patient management system that will meet all of your practice's needs and CMS' program requirements. Get started quickly and efficiently with a system that finally allows you to manage your chronic care patients and begin capturing that additional revenue for your practice.

Schedule Your FREE Demo of ChronicCareIQ Today! Just Click the Button Below

SCHEDULE A FREE DEMO TODAY