Transform your RHC's Care Coordination Efforts into a Reimbursable CCM Program

Presented by:

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Objectives

Following this session, participants will be able to:

- Understand the Rationale for Care Coordination in AZ RHCs with key examples from Cobre Valley
- Demonstrate the basics of CMS Care Coordination Programs:
- Clarify what the G0511 code covers for RHCs (CCM, BHI, CPM, and PCM)
  - Understand that care management services in a RHC includes chronic care management, behavioral health integration, and principal care management.

Photo from Getty Images

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Inception of Medicare

Countries	Date	Life expectancy - Women	Life expectancy - Men	Life expectancy
United States [+]	1965	73.80	66.80	70.21
United Kingdom [+]	1965	74.80	68.60	71.62
Germany [+]	1965	73.04	67.41	70.15
France [+]	1965	74.50	67.30	70.81
Japan [+]	1965	72.85	67.68	70.20
Spain [+]	1965	73.57	68.18	70.81
Italy [+]	1965	73.04	67.44	70.17

https://countryeconomy.com/demography/life-expectancy?year=1965

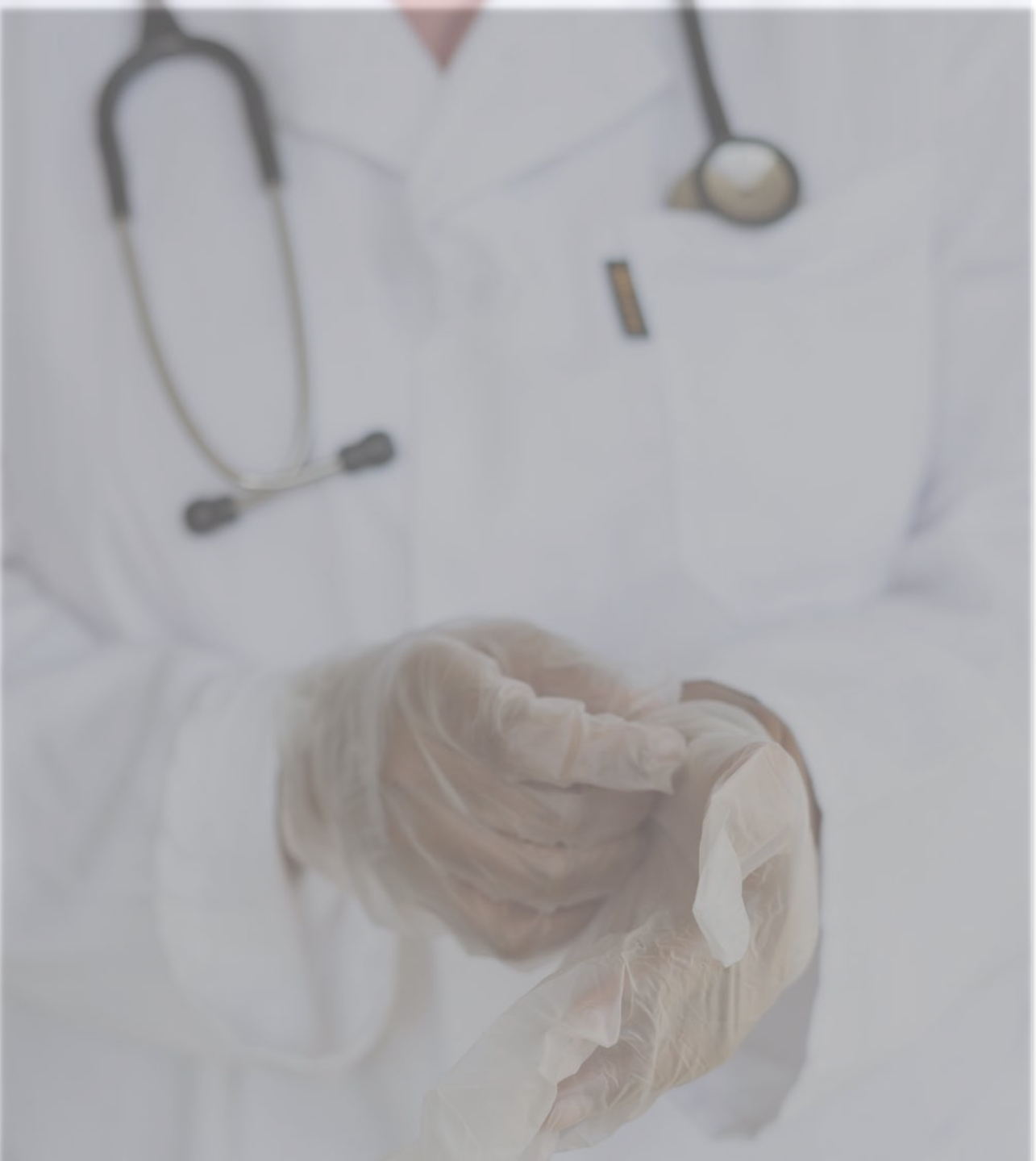
Change from Sick Care to Wellness and Prevention

- **Medically Necessary**
  - Since its inception Medicare coverage focused on treating beneficiaries' conditions and diseases

- **The Affordable Care Act – made a significant change**
  - As of January 2011, Medicare beneficiaries began receiving the new benefit of a FREE Annual Wellness Visit
- **Care Delivery Models**
  - **Team-Based Care**
  - **Non-face to face Care Management**

Team-Based Care

https://www.boonehospital.com/careers-and-volunteers/nursing-at-boone-county-hospital/met-team



ALL CARE PROVIDED BY CLINICAL STAFF INCIDENT TO AND UNDER THE GENERAL SUPERVISION OF THE BILLING PROVIDER COUNT TOWARDS G0511

Team-Based Care

Shared goals: The team-including the patient and, where appropriate, family members or other sup port persons-works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.

Clear roles: There are clear expectations for each team member's functions, responsibilities, and ac countabilities, which optimize the team's efficiency and often make it possible for the team to take ad vantage of division of labor, thereby accomplishing more than the sum of its parts.

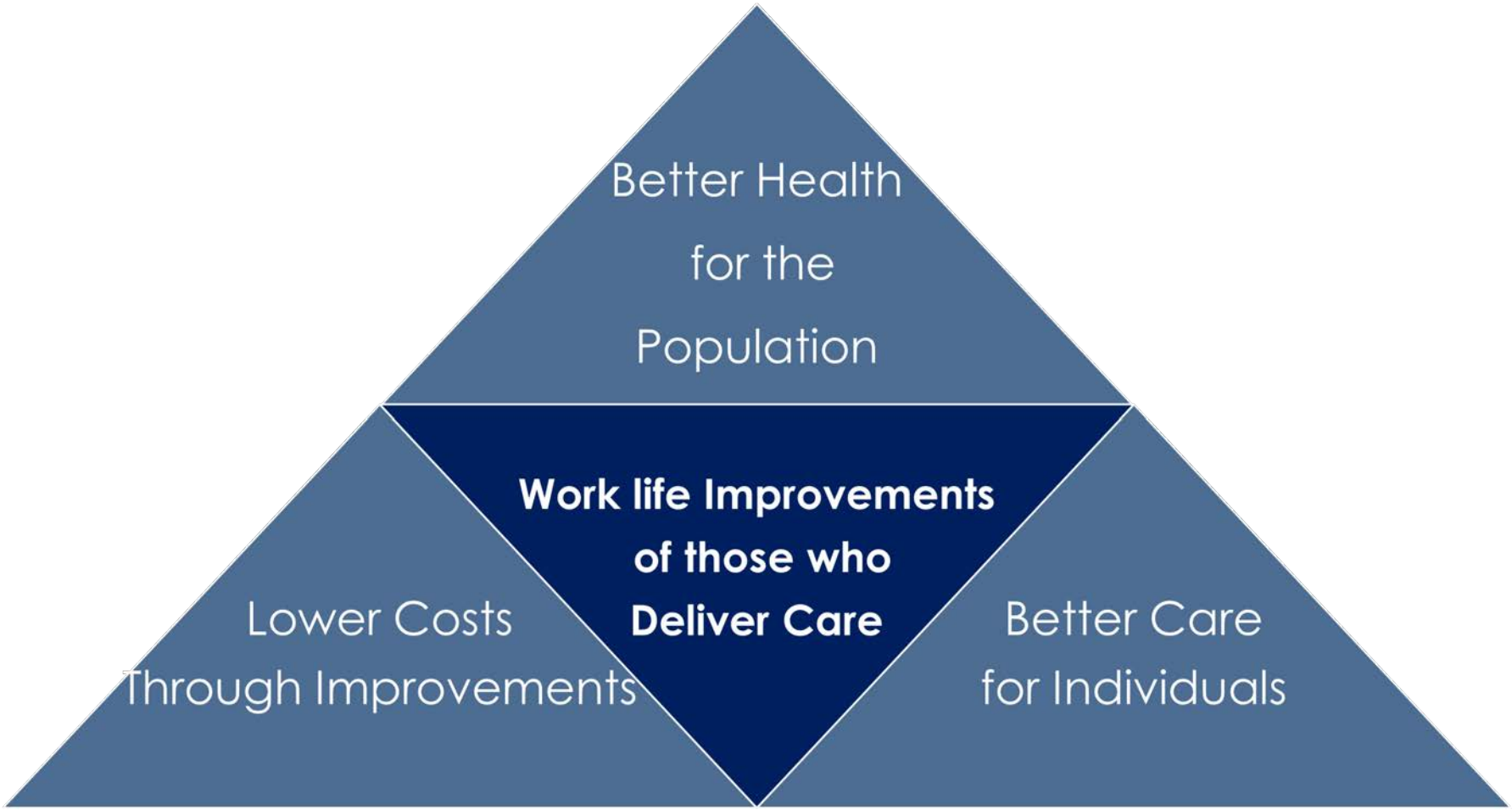
Mutual trust: Team members earn each other's trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

Effective communication: The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.

Measurable processes and outcomes: The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

https://nam.edu/perspectives-2012-core-principles-values-of-effective-team-based-health-care/

Quadruple Aim



FROM PHYSICIANS: "WITH CCM PATIENTS I CAN ACTUALLY HAVE AN APPOINTMENT WITH THEM--- INSTEAD OF OUR EMR."

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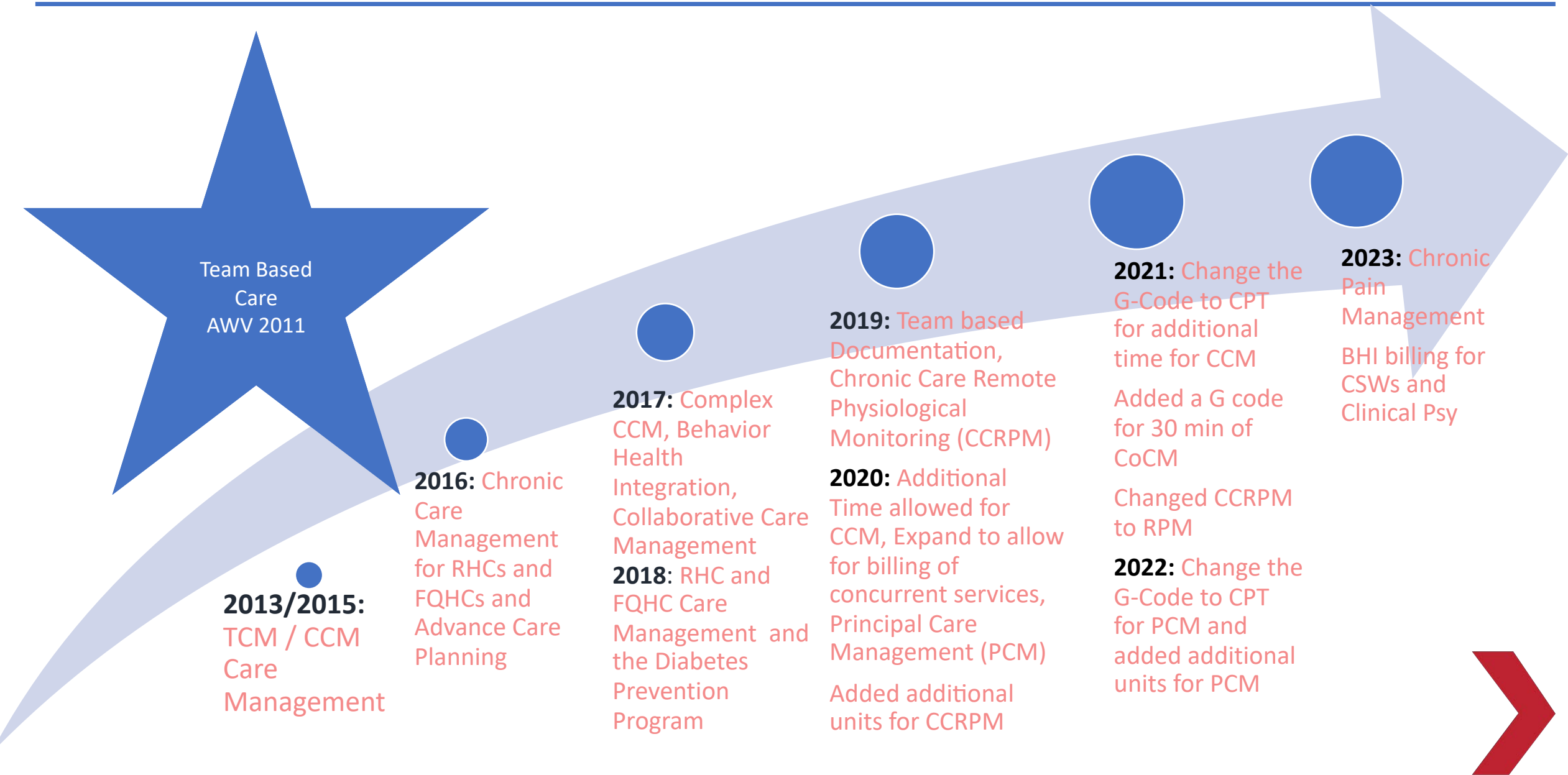
Care Coordination Growth and Development



Transitional Care Management is a Leadership Opportunity for Ambulatory Care Nurses

Background

Transitional Care Management (TCM) is a combination of face to face and non-face to face services that begin when a patient is discharged and continues for a full 30 days.

TCM is a primary care service,and the payment model agrees. For Primary Care Providers, TCM became a reimbursable service in 2013. Continued opportunities grew with the regulatory changes of 2020 and 2022 which allowed for TCM and Chronic Care Management (CCM) to be billed concurrently. As ambulatory care nurses lead CCM, this provides an opportunity for RN Care Coordinators in the Primary Care Practice to reach out and partner with case managers and to incorporate TCM patients into the existing CCM program workflow.

Supporting Literature

Continuity of Care Coordination

For seniors, decreased hospitalizations and fewer emergency room visits have been attributed to a continuity of care in the primary care or specialty care setting (Bayliss et al., 2015; Miller, J., 2022). Successful patient engagement may be attributed to continuity of care and active involvement of the health care team, leading to improved health outcomes (Burton et al., 2022; Miller, 2022; Schurrer et al., 2017).

Healthcare settings may improve patient outcomes by applying different care coordination models for different situations, resulting in a more individualized approach of care continuity (Walton, et al., 2022).

TCM Medlearn available at:
https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf

Structure

TCM requires planning and tracking of time sensitive indicators. The use of a care coordination platform is essential to close gaps in care. Adding TCM to an existing CCM program allows for efficiencies and standardization of work.

The clinic had an existing CCM program, and the RN was using the CrossTx care coordination platform to manage CCM. In September, there was a care coordination staffing change and the newly hired care coordinator in collaboration with the care coordination consultant began assessing the structure and tools in the CCM program. This completed assessment resulted in proposing the expansion of the program to include TCM to grow the total CCM patient enrollment, decrease readmissions, and increase clinic revenue.

Process

To be effective, TCM ,like discharge planning, must begin at admission. Enlisting the assistance of the hospital case manager and embedding the TCM process into the workflow is key.
- The case manager was given access and education for the CrossTx
- Education was provided to the primary care providers
- The target population was identified as:
  - Medicare patients discharging from Acute, Swing , or Observation to home
  - Established patient of one of the PCPs in the clinic
  - Currently enrolled in CCM or agreed to be enrolled

The case manager reviews every patient admission to ascertain if the patient meets criteria and once identified, discusses the opportunity with the patient and engages the provider in the conversation during rounds.

If patient agrees to the service, the case manager enrolls the patient in CrossTx and schedules the required elements for the care coordinator to complete which is communicated via CrossTx

Regulatory Requirements

In order to bill for TCM under one of the two CPT codes of 99495 or 99496, the following elements must be met:
-Patient must be discharged from a qualifying facility and returning to a community setting
-The TCM visit should be completed within 7 or 14 days
-Prior to the visit, the care coordinator will:
  - Complete an interactive contact within 2 business days of discharge
  - Complete a Medication Reconciliation
  - Conduct an assessment of the hospital record for completeness
  - Present findings to provider for review (SBAR recommended)

-Following the TCM visit, the care coordinator will continue to coordinate care for the patient for a full 30 days.

Outcomes

Under the leadership of the clinic's care coordinator and through collaboration with the hospital case manager, a structured TCM service that is embedded into the CCM program is beneficial to the patient, the provider, the practice, and the hospital.

The Patient - receives close monitoring post discharge and establishes a relationship with the care coordinator for long term support to manage their conditions

The Provider - has effective and efficient hospital follow up visits as a result of the care coordinator's assessment of the discharge records and recommendations prior to the visit

The Practice - both CCM and TCM provide reimbursement to the practice to support the RN in the ambulatory care setting where RN leadership and assessment skills are needed

The Hospital - decreases readmission rates to avoid any payment penalties and to improve star rating.

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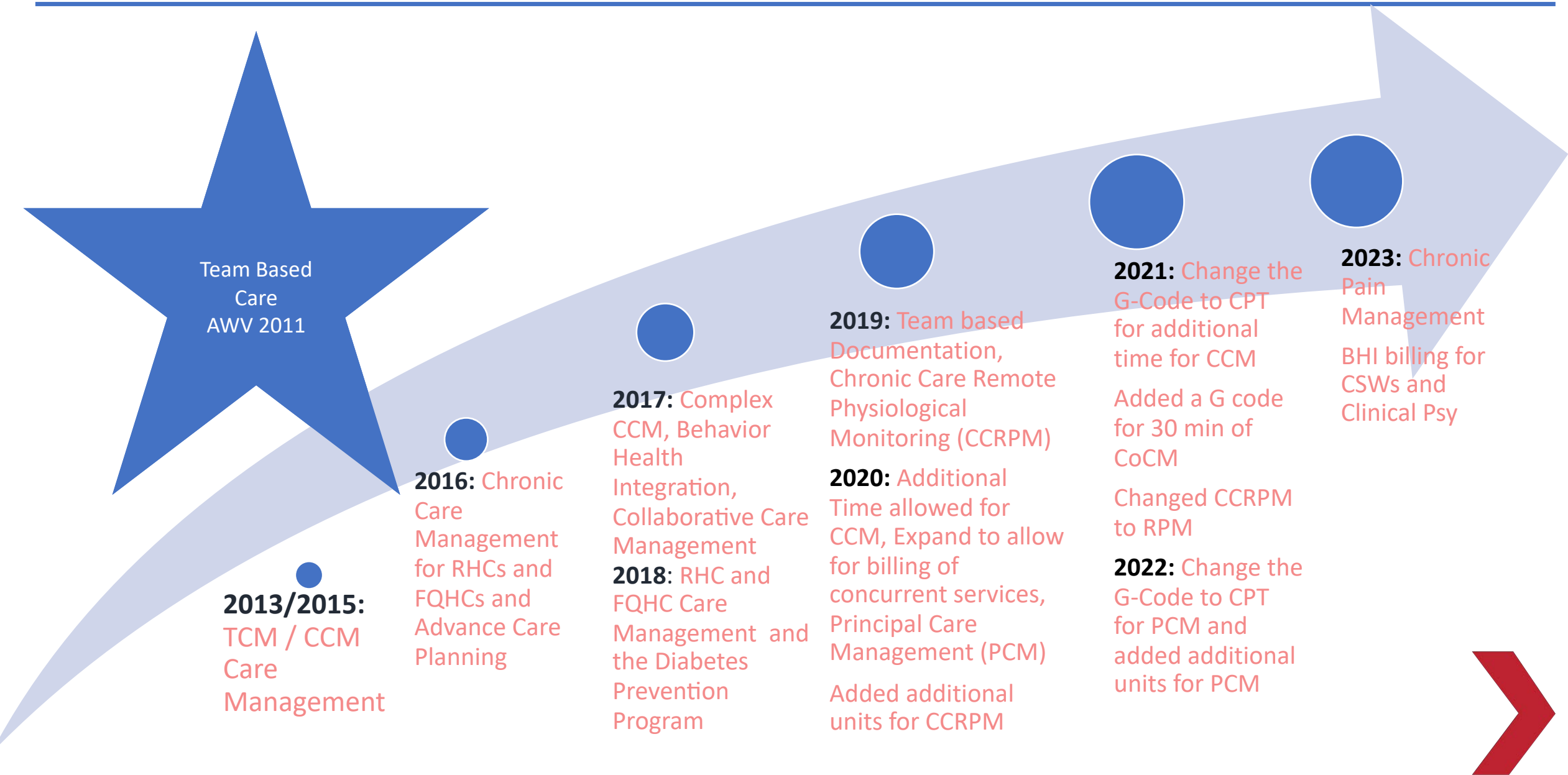
Care Coordination Growth and Development



Elements of Pain Management and Treatment Services

CMS Goal:

We finalized new HCPCS codes, G3002 and G3003, and valuation for chronic pain management and treatment services (CPM) for CY 2023. We believe the CPM HCPCS codes will improve payment accuracy for these services, prompt more practitioners to welcome Medicare beneficiaries with chronic pain into their practices and ***encourage practitioners*** *already treating Medicare beneficiaries who have chronic pain to spend the time to help them manage their condition within a trusting, supportive, and ongoing care partnership.*

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

How Well is Team-based Care Coordination Working?

"…CMS estimated that approximately 3 million unique beneficiaries (9% of the Medicare FFS pop) received [care coordination] services annually, with a higher use of CCM, TCM and advance care planning services"

Noted outcomes:

"reduced readmission rates, lower mortality, and decrease health care costs"

Vol. 84, No. 221/Friday, November 15, 2019/Rules and Regulations p.62685

Team-Based Care Services/ Care Coordination Programs

Annual Wellness Visit (AWV)

Advance Care Planning (ACP)

Transitional Care Management (TCM)

Chronic Care Management (CCM)

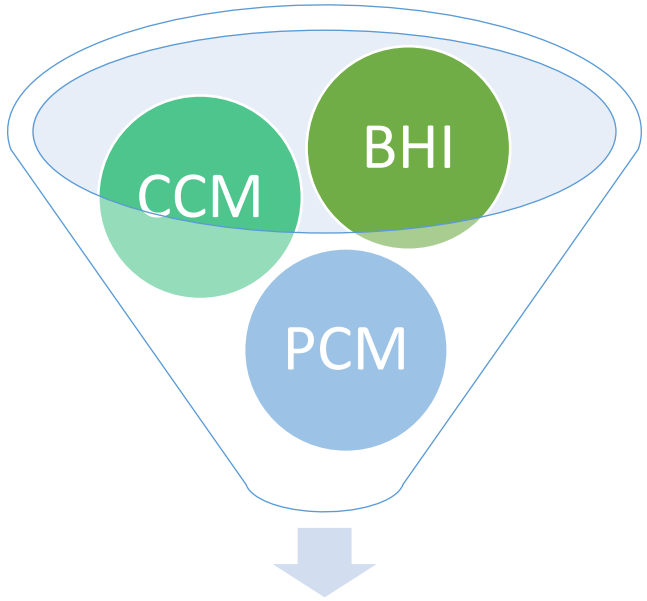
Behavioral Health Integration (BHI)

Principal Care Management (PCM)

Chronic Pain Management and Treatment Services (CPM)

Remote Physiological Monitoring (RPM)

Rural Health Centers



Care Management

CCM Practice Eligibility

Qualified EMR	Availability of electronic communication with patient and care giver	Collaboration and electronically communication with community resources & referrals
After hours coverage	Care Plan Access	Primary Care Provider general supervision of clinical staff

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

CCM Patient Eligibility

Medicare Patient (other insurances also reimburse)

Two or more chronic conditions expected to last at least 12 months or until the death of the patient

At significant risk of death, acute exacerbation, decompensation, or functional decline without management

Patient Consent

CCM initiated by the primary care provider

Time tracking of at least 20 min per calendar month

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Behavioral Health Integration vs Integrated Behavioral Health

Terminology Matters

BHI – Behavioral Health Integration

- Care Coordination Model

IBH – Integrated Behavioral Health

- Care Delivery Model

BHI Practice Eligibility

BHI initiated by the primary care provider

Initial assessment (Initiating visit, if required, then separately billed) Administration of applicable validated rating scale(s)

Systematic assessment and monitoring, using applicable validated clinical rating scales

Care planning by the primary care team jointly with the beneficiary, with care plan revision for patients whose condition is not improving

Facilitation and coordination of behavioral health treatment

Continuous relationship with a designated member of the care team

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

BHI Patient Eligibility

Medicare Patient “Any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time”.

Patient Consent

Documentation of at least 20 minutes per calendar month

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Patient Eligibility Comparing CCM and BHI

CCM

- Medicare Patient
- 2 Chronic Conditions – determined by PCP
- Patient Consent (verbal or written)
- CCM initiated by the primary care provider
  - At a visit
  - Visit not required for “established patient” Established = seen in 12 months
- Plan of Care
- Documentation of at least 20 minutes per calendar month

General BHI

- Medicare Patient
- 1 Behavioral Health Diagnosis – determined by PCP
- Patient Consent (verbal or written)
- BHI initiated by the primary care provider
  - At a visit
  - Visit not required for “established patient” Established = seen in 12 months
- Plan of Care including rating scale
- Documentation of at least 20 minutes per calendar month

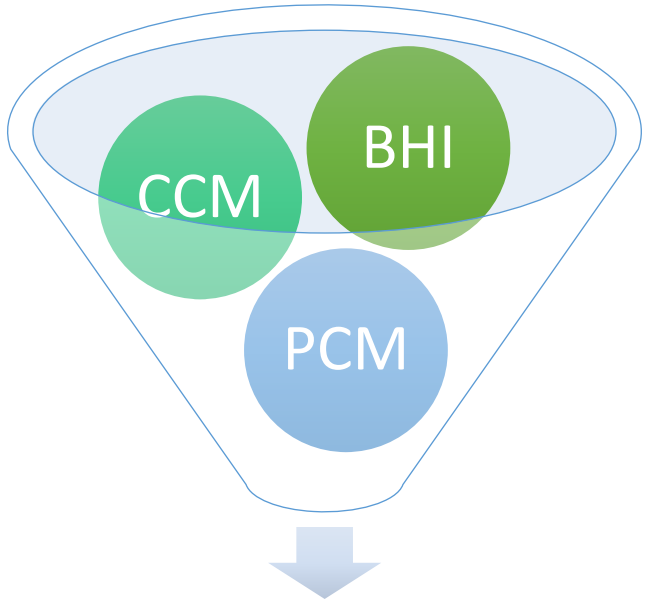
- Under the Right Circumstances

- One serious chronic conditions

OR

- high-risk disease expected to last between 3 months and a year or until the death of the patient
- Condition may have led to a recent hospitalization or places patient at significant risk of hospitalization, death, acute exacerbation, decompensation, or functional decline without management

Rural Health Centers



Care Management

Care Management (CCM – BHI – PCM - CPM)

Care Management Services

Care Management Services includes any of the following:

- Chronic Care Management
- Behavioral Health Integration
- Principal Care Management
- Chronic Pain Management
- Care Management for Behavioral Health by LCSW or CP

Billed per calendar month for 20 plus minutes of care coordination and can only be billed once per month no matter what program you are doing care coordination under

- CPT Code G0511 RVU 1.23 National Average Allowable ~$76.04

Collaborative Care Management

- Billed per calendar month for 1st month of at least 70 plus minutes of Psych collaborative care and subsequent month of at least 60 minutes
  - CPT Code G0512 RVU 1.97 National Average Reimbursement ~$143.15

Care Coordination is more than just phone calls and tracking 20 minutes

Be an investigator, what were the patients last visits?

- Were there any tests ordered? Did they have assessments?
- Are there follow up appointments?
- Do we have the notes from specialists?
- What type of education do they need?

What do they have coming up in the future?

- Document your research
- Create Planned Encounters (PROGRAM SUSTAINABILITY)
- Does their care plan still make sense?
- What additional education would impact their quality of life?

Implementation Guide

Assessment

- Program Planning
- Teams of Resources
- Foundational Education
- Success Criteria and Proforma

Launch and Implementation

- Workflow, Tailored Process and Procedure
- Eligible Patients (Medicare/MA, Medicaid (State Specific), 2+ CC, qualifying visit
- Consent Process
- Evaluate Tools
- Set up Charge Master/ Billing workflow and schedule
- Connect with Community Resources

Establish Routines

- Analyze reporting
- Connect with more community resources and care givers/family members
- Use Assessments and Surveys to show outcomes
- Expand/Scale into additional service lines

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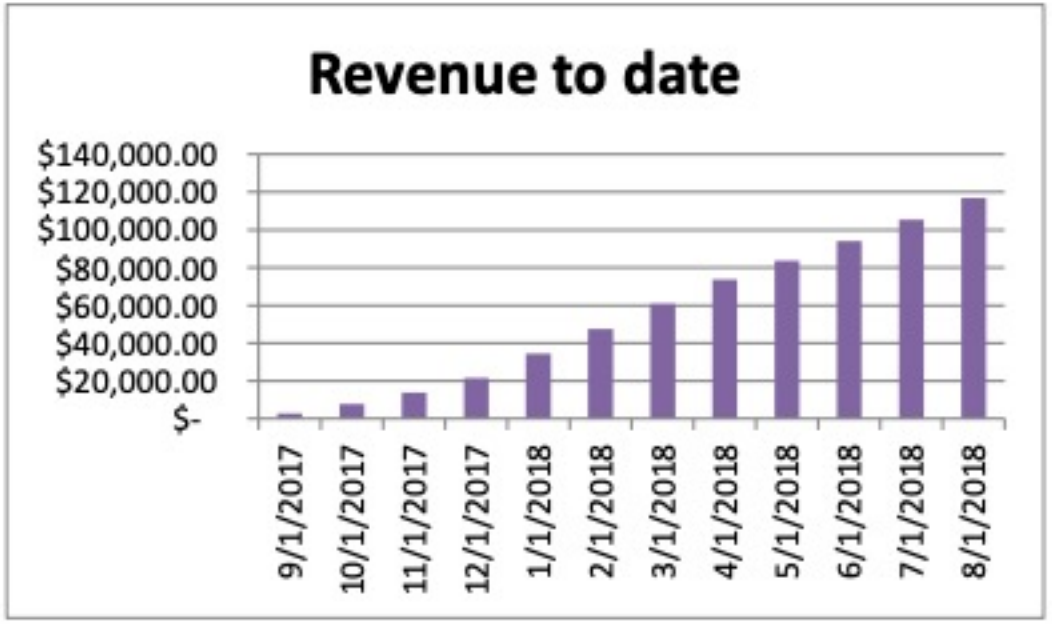
Care Management Example

First Year Case Study



"We often hear from patients how much they appreciate that we care and how we help them value their health. Our success with the program comes from the time we spend with our patients and the relationships we build with them. This is the most rewarding position I have ever experienced as a nursing professional"

Margo Badilla, BSN, RN

Care Coordinator

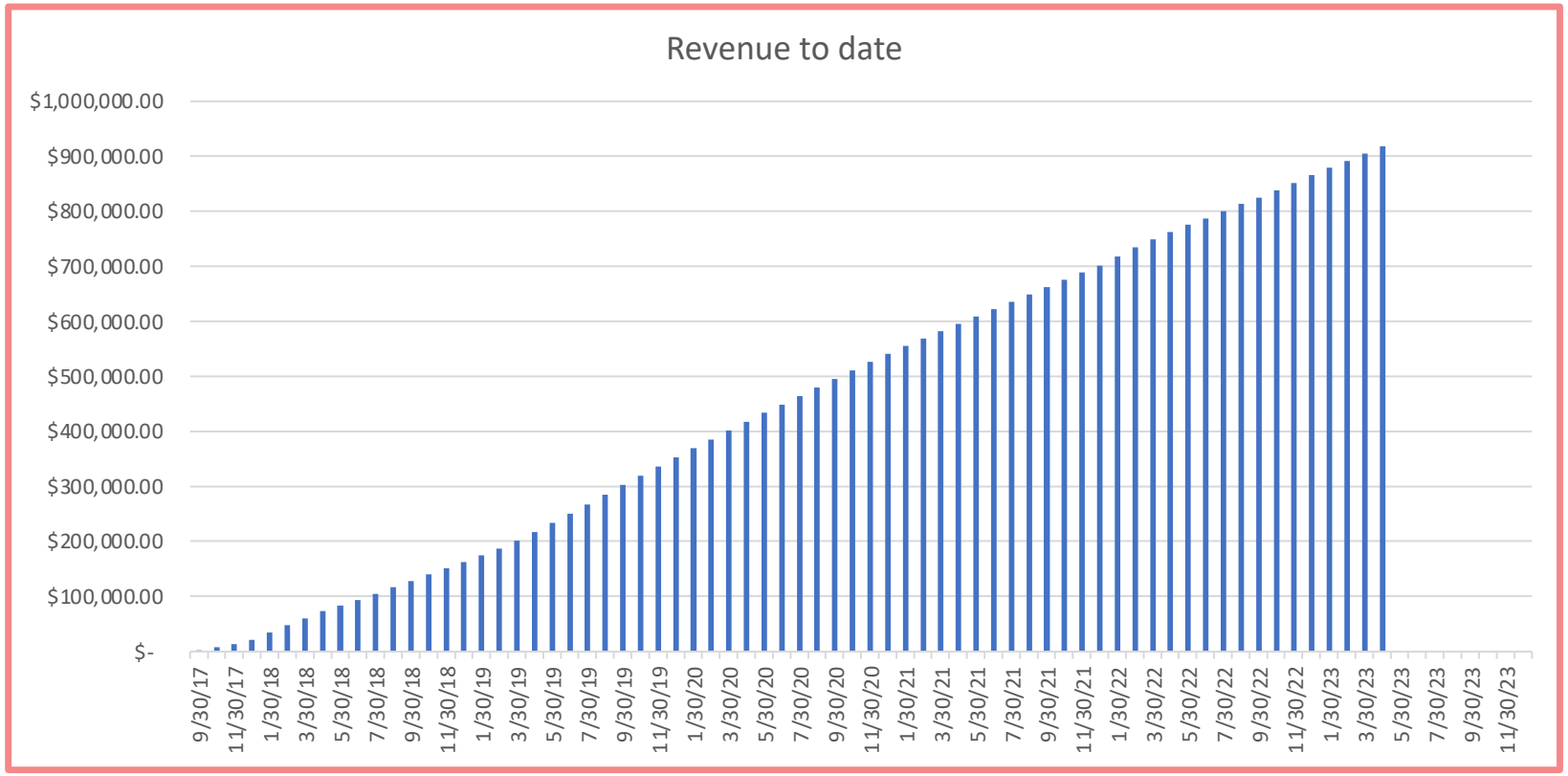
After one year of implementation, the care coordinator had recruited about 100 patients into the program with revenue billed of nearly $120,000.00

Care Management Example

'Working with the CrossTx platform allows us as care coordinators to communicate across various entities resulting in seamless, coordinated and holistic patient care.'

"The CrossTx platform tracks all of our patient encounters and the associated time spent with each patient so billing at the end of the month is a breeze."

"The CrossTx platform helps us provide extraordinary care for our Medicare patients while maximizing our reimbursement from our care coordination program."
--Cobre Valley Hospital



$900K
1 RN

ANY QUESTIONS?

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