Maintaining the Primary Care Relationship in the Long Term Care Setting:

Creating Care Coordination Synergy

Building Leaders – Transforming Hospitals – Improving Care

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Director of Care Coordination and Lean Consulting

Faith Jones began her healthcare career in the US Navy over 30 years ago. She has worked in a variety of roles in clinical practice, education, management, administration, consulting, and healthcare compliance. Her knowledge and experience spans various settings including ambulance, clinics, hospitals, home care, and long term care. In her leadership roles she has been responsible for operational leadership for all clinical functions including multiple nursing specialties, pharmacy, laboratory, imaging, nutrition, therapies, as well as administrative functions related to quality management, case management, medical staff credentialing, staff education, and corporate compliance. She currently implements care coordination programs focusing on the Medicare population and teaches care coordination concepts nationally. She also holds a Green Belt in Healthcare and is a Certified Lean Instructor.

Healthcare Focus | 45 Year Company History | Experienced Consultants | Technology Partnerships

Objectives

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Following this presentation, the participant will understand:

- The essential elements of a care coordination program
- The billing and reimbursement implications of CCM that allow for additional resources
- The impact of utilizing the team based care approach of CCM on the resident's care

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America is Getting Older

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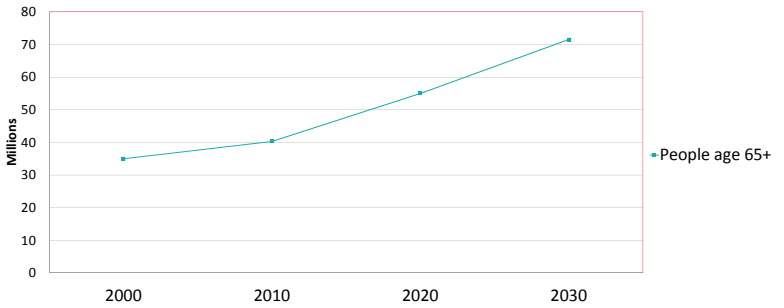

http://www.aarp.org/livable-communities/info-2014/livable-communities-facts-and-figures.html

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By 2050

4

88.5 Million people aged 65+

OR

20% of the population

http://www.aarp.org/livable-communities/info-2014/livable-communities-facts-and-figures.html

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Aging in Place

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87%

of adults age 65+ want to stay in their current home and community as they age.

http://www.aarp.org/livable-communities/info-2014/livable-communities-facts-and-figures.html

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Care Coordination Trifecta

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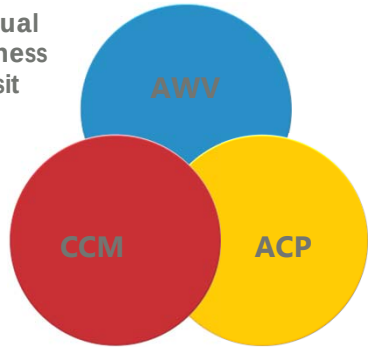
Annual Wellness Visit



Chronic Care Management

Advance Care Planning

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The Provider Question

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What do I have to do?

Embrace the concept of Team Based Care

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Team Based Care

Care Coordination uses a Team Based Care Approach

Shared goals: The team—including the patient and, where appropriate, family members or other support 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 accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage 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.

Source: Mitchell et al., 2012

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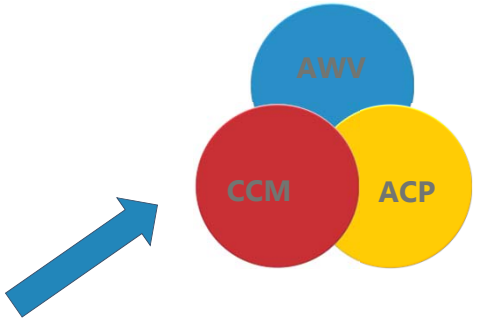
Chronic Care Management



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Chronic Care Management

"We acknowledged that the care coordination included in services such as office visits does not always describe adequately the non-face-to-face care management work involved in primary care and may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries"

CMS CFR 7-15-2015

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Elements for CCM

Practice Eligibility	Patient Eligibility
• Qualified EMR • Availability of electronic communication with patient and care giver • Collaboration and communication with community resources & referrals • After hours coverage • Care Plan Access • Primary Care Provider supervision of clinical staff	• Medicare Patient • 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

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2017 Regulation Updates

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Practice Eligibility	Patient Eligibility
• Qualified EMR • After hours coverage • Availability of electronic communication with patient and care giver ✓ **Collaboration and communication with community resources & referrals** ✓ **Care Plan Access** ✓ **Primary Care Provider supervision of clinical staff**	• Medicare Patient • 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, decomposition, or functional decline without management ✓ **Patient Consent** ✓ **CCM initiated by the primary care provider**

Care Plan Access

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2015/2016	2017
• The care plan must be available electronically to all members of the care team 24/7 • Access for urgent chronic condition needs	• The care plan must be available in **any format** to the members of the care team in a **timely** manner • Access for urgent needs

Continuity of Care

Collaboration and Communication

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2015/2016	2017
• Required to include community resources and other providers in the care of the CCM patient as appropriate • Ability to communicate electronically with community resources and other providers • Specifically noted that faxing was not considered electronic	• Required to include community resources and other providers in the care of the CCM patient as appropriate • Although electronic communication is preferred, faxing is allowable

Timely Sharing of Info

CCM Initiation by PCP

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2015/2016	2017
• Required PCP to initiate CCM at a face to face comprehensive visit, at the annual wellness visit, or at the Welcome to Medicare Visit. • The PCP must introduce the CCM program, explain the chronic conditions to the patient, and determine and document the level of decline if left unmanaged.	• Requires the PCP to initiate CCM with the patient but only has to be done on a qualifying face to face visit for "new" patients or patients that they have not seen within the last year for a qualifying visit. • The PCP must still explain the chronic conditions to the patient, and determine and document the level of decline if left unmanaged even if not seeing the patient in a face to face visit.

Ensure Relationship

Provider Initiation for CCM

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- Additional payment coding for "when the billing practitioner initiating CCM **personally performs extensive assessment and care planning** outside of the usual effort described by the billed E/M code"
  - "the practitioner could bill **G0506** in addition to the E/M code for the initiating visit (or in addition to the AWV or IPPE), and in addition to the CCM CPT code 99490 (or proposed 99487 and 99489) if all requirements to bill for CCM services are also met"
  - **Does not apply to RHCs or FQHCs**

CMS-1654-F pg. 290 CFR 11-15-2016

Family of Codes

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CCM	Complex CCM
99490	**99487 and 99489**
• All elements of program are met as previously discussed	• All elements of program met as previously discussed PLUS – Moderate or high complexity medical decision making;
• At least 20 min of clinical staff time in the month	• At least 60 min of clinical staff time in the month. – Use code 99489 for each additional 30 min of clinical staff time in a month
• Billed only once per calendar month	• Billed only once per calendar month
• **Applies to PFS clinics, RHCs and FQHCs.**	• **Only applies to PFS clinics** – **RHCs and FQHCs may not bill**

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Criteria to Bill for CCM

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- Patient Consent/Agreement
- Documentation of at least 20 minutes per calendar month spent coordinating care
- Patient Centered Care Plan
  - Include outside healthcare providers (as appropriate)
  - Include community resources (as appropriate)

Payment Codes for 2017

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Chronic Care Management (CCM)

- Billed per calendar month for 20 plus minutes of care coordination
  - CPT Code 99490
  - National Average Reimbursement **~$42.70**
- Billed per calendar month for 60 plus minutes of Complex Chronic Care Management
  - CPT Code 99487
  - National Average Reimbursement **~$93.66**
- Billed with 99487 for additional 30 min per calendar month for Complex Chronic Care Management
  - CPT Code 99489
  - National Average Reimbursement **~$47.00**

Charging vs. Tracking

20

Billable Visit	Time Tracking
• No Double Dipping • Continue to bill for eligible services • If service is billable do not track time	• No Double Dipping • Track all time for non-billable services • Do Not track time if billing for the visit

Cannot bill CCM and Skilled for same time period

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Population Health: It Takes a Village

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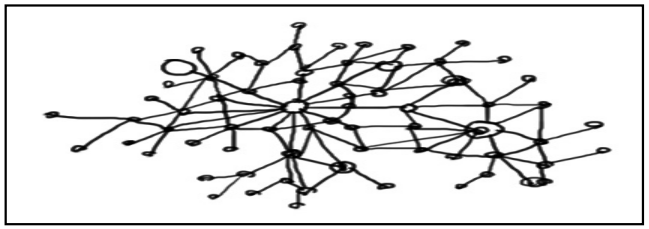
Caring. Community. Connections.



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Bridging the Gap

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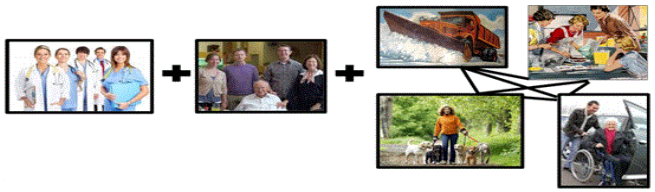
- Connect and integrate existing informal/non-traditional community networks with the healthcare team
- Invest in tools & processes to maximize the benefits of connectivity



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Right Tool for the Job

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- Communication and Coordination System
- User friendly product
- Easy to learn and implement
- Responsive to customer needs and changing environments
- Avoid duplication of work

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Annual Wellness Visits

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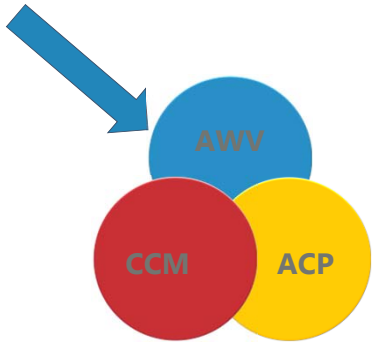

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Why Wellness Visits?

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"The AWV will include the establishment of, or update to, the individual's medical and family history, measurement of his or her height, weight, body-mass index (BMI) or waist circumference, and blood pressure (BP), with the ***goal of health promotion*** and disease detection and ***fostering the coordination of the screening and preventive services*** that may already be covered and paid for under Medicare Part B."

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf

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Roles in Wellness Visits

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Who is Eligible to Provide the AWV?

- A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act); **or**,
- A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); **or**,
- A ***medical professional*** (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii)) ….

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7079.pdf

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Annual Wellness Visit ABC's

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Required Elements:

- Administer a Health Risk Assessment (HRA)
- Establish a list of current providers and suppliers
- Establish the beneficiary's medical/family history
- Review the beneficiary's potential risk factors for depression
- Review the beneficiary's functional ability and level of safety
- Assess height, weight, BMI, BP, other routine measures appropriate to medical history

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

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Annual Wellness Visit ABC's

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Individualized Prevention Plan of Care:

1. Establish a written screening schedule for the beneficiary
2. Establish a list of risk factors and conditions with interventions
3. Provide personalized health advice and referrals to programs as appropriate
   - Community-based lifestyle interventions to reduce health risks, promote self-management, and wellness
   - Fall Prevention
   - Nutrition
   - Physical Activity
   - Tobacco-Use Cessation
   - Weight Loss

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_Chart_ICN905706.pdf

Outcome

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The purpose of the Annual Wellness Visit is…

To provide:

- **Personalized Prevention Plan Services**
  - **The 3 part Plan**

1-Screening Schedule

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What is Covered…

https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#PNEUMO

2- List of Risk Factors, Conditions and Interventions

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Review all Risk Assessments

- Provide the results of each with level of risk
  - Identify appropriate interventions

Review all Conditions

- Provide the list of conditions **(Problem List/Care Plan)**
  - Care Plan - **This is Done** - review the care plan in place and make any updates
  - Communicate and Share!!

3- Personalized Health Advice and Program Referrals

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Life Style Changes

- Review the Patient holistically
- Know what your organization and community offers – Communicate and Share
- Consider:
  - ✓ Activities – Leisure Pursuits
  - ✓ Fall Prevention
  - ✓ Nutrition – Weight Loss
  - ✓ Physical Activity - Restorative
  - ✓ Socialization
  - ✓ Advance Care Planning

Next Steps

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You now have a plan = End of Visit

- CCM Patient
  - **Determine appropriate follow up appointment with provider for Chronic Conditions – May be addressed in required 60 day visits**
  - **Assist patient/care center staff in making all appointment**
    - **all of the time spent on making the referrals and appointments counts towards CCM**
- Non-CCM Patient
  - **Determine if there is a medical necessity for a follow up appointment with provider - May be addressed in required 60 day visits**
  - **Assist patient/care center staff in making all appointment as needed**

AWV Payment Codes for 2017

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Billed only once if first wellness is after 12 months of Part B Coverage – Initial wellness visit

- CPT Code G0438 National Average Reimbursement **~$173.70**

Billed one per year – Subsequent wellness visit

- CPT Code G0439 National Average Reimbursement **~$117.72**

Use Appropriate Place Of Service Codes

Other Reimbursement Options

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- Annual Wellness Visits via Telehealth
  - Effective January 1, 2014

SNF = Originating Site

Advance Care Planning

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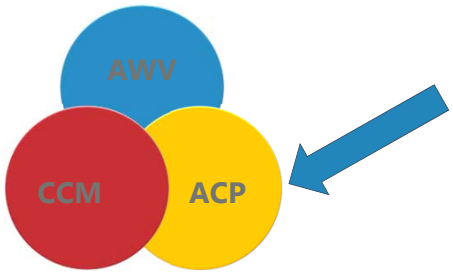

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Medicare's Definition of ACP

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Voluntary Advance Care Planning

- "Voluntary ACP means the face-to-face service between a physician (***or other qualified health care professional***) and the patient discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. "

MLN Matters® Number: MM9271 Related Change Request Number: 9271

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Approach to the Conversation

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Why ??

Voluntary Advance Care Planning

- "ACP enables Medicare beneficiaries to make important decisions that give them control over the type of care they receive and when they receive it."

MLN Matters® Number: MM9271 Related Change Request Number: 9271

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Who Can Perform ACP?

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"the services described by CPT codes 99497 and 99498 are appropriately provided by physicians or using a team-based approach"

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

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Reimbursement for the Conversation

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- Advance Care Planning (ACP)
  - Effective January 1, 2016
    - CPT code 99497 and 99498
      - Added to the Telehealth list in 2017

SNF = Originating Site

CPT Description

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CPT Code 99497- Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

CPT Code 99498- each additional 30 minutes (List separately in addition to code for primary procedure)

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-Advance-Care-Planning.pdf

Reimbursement Rate for 2017

42

CPT Code 99497 - ***$82.90***

(National Average)

CPT Code 99498 - ***$72.50***

(National Average)

https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=3&H1=99497&M=5

Advance Care Planning & Advance Directives

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Advance Care Planning = Procedure

Advance Directive = Product

Start with Conversation – Not the Form

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"Talking with your loved ones openly and honestly, before a medical crisis happens, gives everyone a shared understanding about what matters most to you at the end of life."

Before you Re-do

http://theconversationproject.org/starter-kits/

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Thank You

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strategy solutions support

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