

Care Coordination between Primary Care Practices and Hospitals:

A Formula for Positive Health and Financial Outcomes for All

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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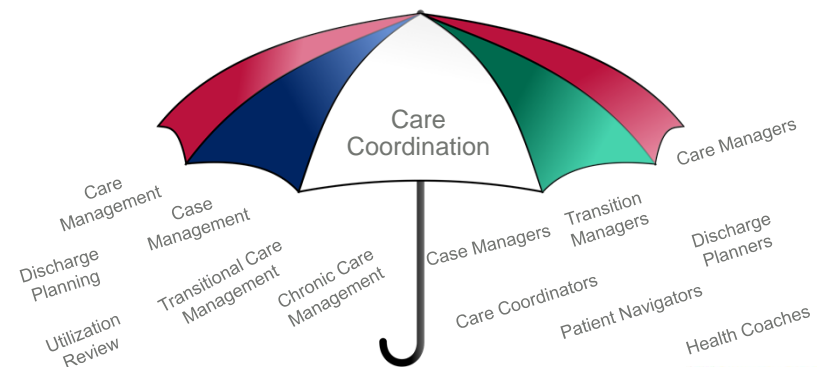
Following this presentation, the participant will understand:

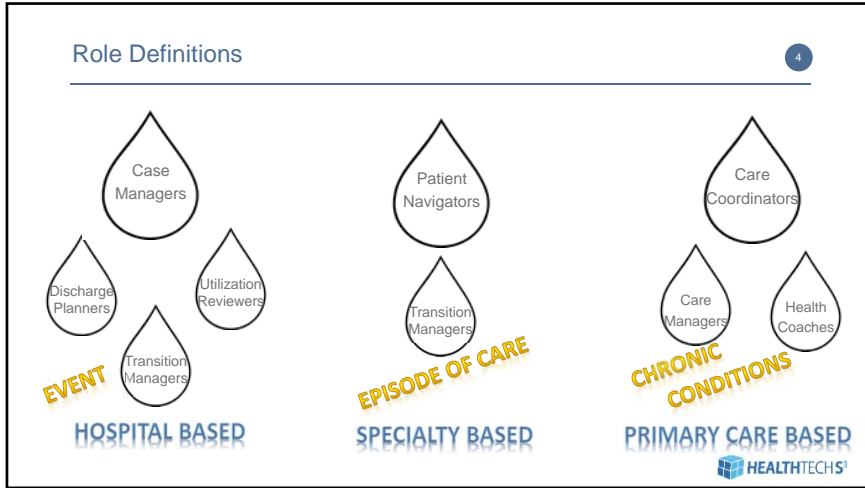
- The essential elements of a care coordination program
- The collaboration needed to provide Transitional Care Management (TCM)
- The requirements to provide Chronic Care Management (CCM) services
- The billing and reimbursement implications of TCM and CCM



Terms and Overlap

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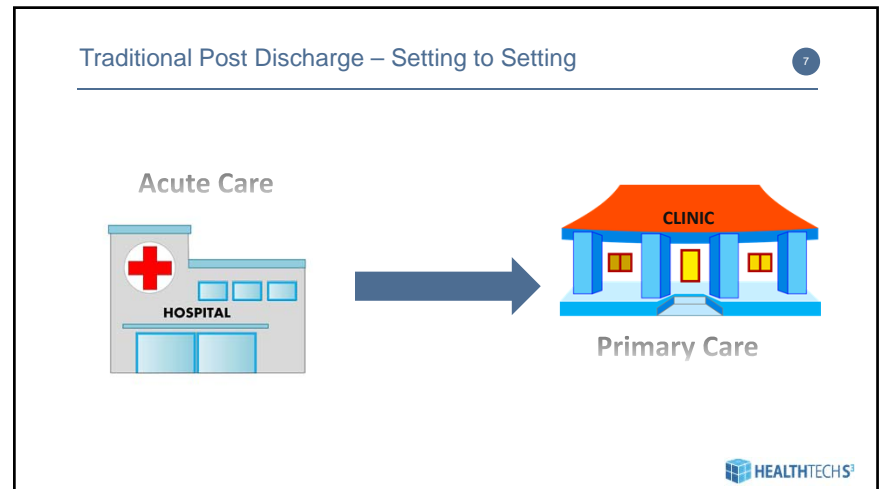
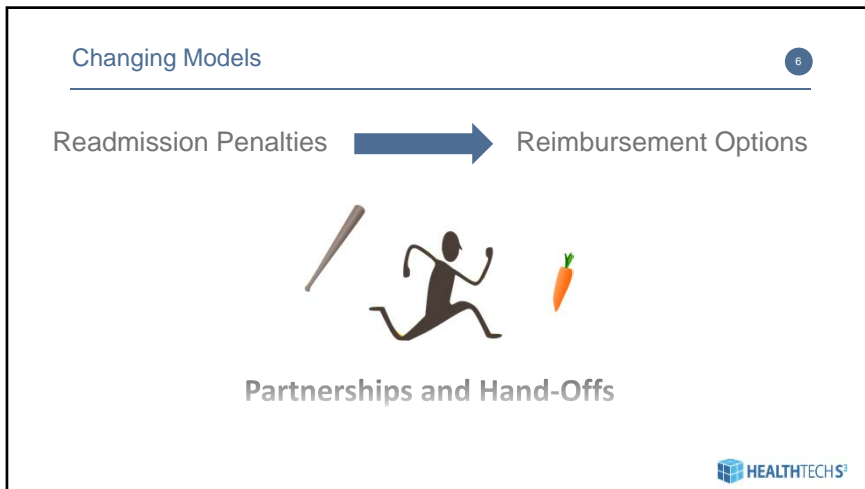


Changing Models 5


“Our goal is to recognize the trend toward **practice transformation** and overall improved quality of care, while preventing **unwanted** and **unnecessary** care”

CMS CFR 11-12-2014

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Partnerships and Hand-Offs – Person to Person 8




Primary Care

Acute Care

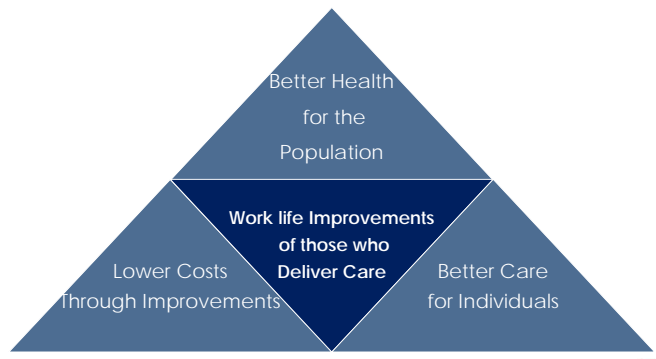



New Payment Models for Primary Care 9

- Transitional Care Management (TCM)
 - Effective January 1, 2013 (2016 for RHCs and FQHCs)
 - CPT codes 99495 and 99496
- Chronic Care Management (CCM)
 - Effective January 1, 2015 (2016 for RHCs and FQHCs)
 - CPT code 99490
 - Effective January 1, 2017 (Excludes RHCs and FQHCs)
 - Complex CPT codes 99487 and 99489



Quadruple Aim 10





Addressing the 4th Aim 11


**From Triple to Quadruple Aim:
Care of the Patient
Requires Care of the Provider**

EXPANDED ROLES


- Expanding the role of nurses and other clinical staff in the practice to work to the highest level of licensure

APPROACHES TO WORKFLOW

- Team based documentation
- Pre-visit planning
- Co-locating for communication



<http://www.annfammed.org/content/12/6/573.full.pdf+html>



Care Delivery Models

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“...new and evolving care delivery models, which feature an increased role for non-physician practitioners (often as care coordination facilitators or in team-based care) have been shown to improve patient outcomes while reducing costs, both of which are important Department goals as we move further toward quality- and value-based purchasing of health care services in the Medicare program and the health care system as a whole.”

Vol. 80 Wednesday, No. 135 July 15, 2015, P 226



Transitional Care Management (TCM)

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- Patient does not need to be enrolled or agree to service
- Elements include:
 - An interactive contact
 - Non face to face review by provider
 - Non face to face reviews by clinical staff
 - Medication Reconciliation
 - Community Resource Identification
 - Referral Management
- 99496 – Patient seen within 7 days of discharge
- 99495 – Patient seen within 14 days of discharge
- Cannot bill TCM and CCM for same time period



Transitional Care Management (TCM) Reimbursement

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- Covers the 30 day period following Discharge
- By using the TCM CPT code – the primary care provider confirms all required elements are met
- Elements include:
 - An interactive contact
 - Non face to face review by provider
 - Non face to face reviews by clinical staff
 - Medication Reconciliation
 - Community Resource Identification
 - Referral Management
- 99496 – Patient seen within 7 days of discharge
- 99495 – Patient seen within 14 days of discharge
- Cannot bill TCM and CCM for same time period

RHCs do not get paid more for TCM CPT Code



Transitional Care Management (TCM) Reimbursement Rates

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2017 National average reimbursements:

- 99496 – Patient seen within 7 days of discharge = **\$234.00**
- 99495 – Patient seen within 14 days of discharge = **\$165.00**

Compared to 2017 National average established office visits reimbursements:

- 99211 = **\$20.00**
- 99212 = **\$44.00**
- 99213 = **\$73.00**
- 99214 = **\$108.00**
- 99215 = **\$146.00**

RHCs do not get paid more for TCM CPT Code



Partnerships and Hand-Offs – Person to Person

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- An interactive contact
- Non face to face review by provider
- Non face to face reviews by clinical staff
- Medication Reconciliation
- Community Resource Identification
- Referral Management



During those 30 days ...

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The Best Practice of TCM
will assist in dodging the readmission bullet



And after those 30 days?

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Evaluate if the TCM meets eligibility to be enrolled
in the Chronic Condition Management Program



Changing Models

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“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




Elements for CCM 20

Practice Eligibility	Patient Eligibility
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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



Family of Codes 21


CCM	Complex CCM
<p>99490</p> <ul style="list-style-type: none"> • All elements of program are met as previously discussed • At least 20 min of clinical staff time in the month • Billed only once per calendar month • Applies to PFS clinics, RHCs and FQHCs. 	<p>99487 and 99489</p> <ul style="list-style-type: none"> • All elements of program met as previously discussed PLUS <ul style="list-style-type: none"> – Moderate or high complexity medical decision making; • At least 60 min of clinical staff time in the month. <ul style="list-style-type: none"> – Use code 99489 for each additional 30 min of clinical staff time in a month • Billed only once per calendar month • Only applies to PFS clinics <ul style="list-style-type: none"> – RHCs and FQHCs may not bill




Communication and Tracking for CCM 22

The Right Tool for the Job

- Referral and coordination System
- User friendly product
- Easy to learn and implement
- Responsive to customer needs and changing environments
- HIPAA compliant access
- Avoid duplication of work
- Don't wait for the perfect system
- Don't be afraid to layer technology






Chronic Care Management (CCM) Reimbursement Rates for 2017 23



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 24

Billable Visit	Time Tracking
<ul style="list-style-type: none"> No Double Dipping Continue to bill for eligible services If service is billable do not track time 	<ul style="list-style-type: none"> No Double Dipping Track all time for non-billable services Do Not track time if billing for the visit






Cannot bill TCM and CCM for same time period



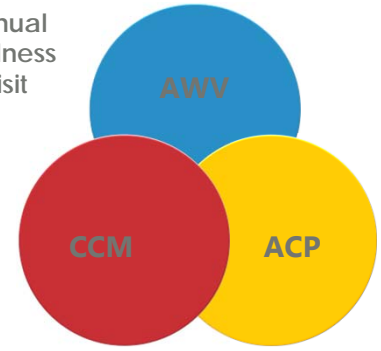

Potential Revenue 25

Potential Care Coordination Annual Revenue	
Insert practice panel size in Green box and % of Medicare in Yellow box	
Annual Number of Unique Patients in Provider Practice Panel**	2500
% Patients Covered by Medicare**	25.00%
Number of Unique Medicare Patients	625
Percentage Unique Medicare patients with 2+ Chronic Conditions***	68.60%
Annual Number of Potential Unique CCM patients	429
CCM Monthly Payment****	\$ 42.70
Estimated Annual Gross Revenue for Primary Care Provider	\$ 219,691.50

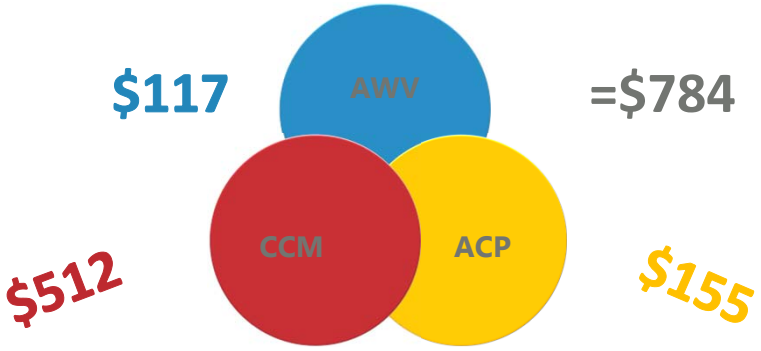






Care Coordination in Primary Care 26


Team Based Care Revenue per Patient per Year 27

RN Care Coordinator Revenue per Year 28


 **\$784 per Patient**

×

 **200 Patients**



=

\$156,800



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HEALTHTECH S³
strategy solutions support

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