Chronic Care Management Practice Model

UNT Health Clinical Practice Group Pharmacy

Division

Last Revised 3/5/2018

Not for External Distribution

Chronic Care Management Process Map (Co-Care Visit Model)

Definitions and Purpose

Chronic care management (CCM) is an interprofessional service provided by UNT Health for Medicare beneficiaries with 2 or more chronic disease states. This service is designed to enhance quality and continuity of care for at-risk patients. While CCM may be provided in a variety of ways, the process described in this document is designed to provide an optimal patient experience and represent the best in collaborative care. Two process maps are included in this document: (1) CCM that incorporates a co-care visit model and (2) CCM with separate pharmacist and physician encounters.

Required Elements by Medicare

CCM service must incorporate the following elements: (1) Enhanced communication, e.g. electronic health record and telephone contact, (2) 24/7 access to address urgent needs, (3) Comprehensive Care Management, (4) Continuity of Care, and (5) Advance consent. How each required service element is delivered is described below:

1) **Enhanced communication**
   The pharmacist will provide telephonic consultation upon request of the patient and schedule telephonic encounters when appropriate. Telephonic encounters may be used to assess medication adherence, monitor for side effects, insulin titration, and progress to CCP goals. NextGen electronic health record will be used for CCM documentation, helping to facilitate written communication across the team.

2) **24/7 access to address urgent needs**
   For urgent needs, patients may contact the UNT Health on-call service. Urgent needs will be addressed by the medical resident or physician on call.

3) **Comprehensive care management**
   Care for patients enrolled in CCM will be driven by a Comprehensive Care Plan (CCP). The CCP should be developed from the most recent problem list. No problems should be excluded. In the UNT Health Model, the pharmacist will develop the CCP for all problems allowed by the UNT Health Collaborative Drug Therapy Management protocol. All other problems should be addressed by the physician and included in the CCP.

   Comprehensive Care Plan
   The Comprehensive Care Plan will be housed in the NextGen Chronic Care Management note template. The plan must be reviewed and revised at least once annually. As a best practice, the CCP should be reassessed at each clinic or telephonic visit. The CCP must include the following elements: (1) Complete problem list, (2) Expected outcomes and prognosis, (3) Measurable treatment goals, (4) Symptom management, (5) Planned interventions and person responsible, (6) Medication management, (7) Community/social services ordered, (8) Description of how services outside of the practice will be coordinated, (9) Schedule for periodic review and revision of the care plan, and (10) Documentation that care plan provided to patient/caregiver.

4) **Continuity of care**
   If a patient enrolled in CCM is discharged from the hospital, the pharmacist providing CCM services should be notified as soon as possible. The pharmacist should assure quality of the care transition pertaining to medication management.

5) **Advanced consent**
   Consent is obtained verbally and documented during the Enrollment or Enrollment+Initiation CCM note. The verbal consent should include an explanation of what is included in CCM, that he/she may contact the clinic at any time if they have questions concerning services, how to access services, and how to cancel service. The patient should be informed that health information will be shared among their entire treatment team to enhance their care. In addition, the patient should be informed on how CCM will be billed, specifically how cost-sharing and co- pays apply to the service, that services are billed on a calendar month basis, and that only one provider may be paid for this service during the calendar month. Following an explanation of service, the patient should be asked if he/she consents to receive CCM services provided by the clinic.

Chronic Care Management Process Map (Co-Care Visit Model)

Enrollment and Initiation occur in a SINGLE Co-Care Encounter – Page 1 of 2

IDENTIFICATION:
Patient's qualifying for service are identified:
- 2 or more chronic disease states
- Medicare beneficiary
- Preference to at-risk patients*

SCHEDULING:
Patient is scheduled for 45' CCM Enrollment Co-Care Visit with pharmacist (30') and physician (15')

ENROLLMENT+INITIATION VISIT Part 1 (PharmD):
Estimated at 30 minutes
- PharmD provided comprehensive medication management
- PharmD describes CCM and obtains consent
- PharmD develops initial comprehensive care plan (CCP)
- PharmD briefs DO/MD during warm handoff
- PharmD bills by checking box for G0506

ENROLLMENT+INITIATION VISIT Part 2 (DO/MD):
Estimated at 15 minutes
- DO/MD modifies/approves CCP
- DO/MD conducts E/M and provides additional care as needed
- PharmD and DO/MD determine follow-up plan
- PharmD provides patient with copy of CCP
- DO/MD bills E/M for full encounter as appropriate
- DO/MD approves Master IM Final for full encounter

CCM FOLLOW-THROUGH (PharmD):
Estimated at 20 minutes
- PharmD coordinates follow-up care to include referrals, PAP, social work
- PharmD records time in NextGen as CCM Time on Task

Continue to Next Page

Chronic Care Management Process Map (Co-Care Visit Model)

Enrollment and Initiation occur in a SINGLE Co-Care Encounter – Page 2 of 2

OPTIONAL: CCM Telephonic Encounter (PharmD):
Estimated at 10 minutes
1-2 weeks post enrollment
- PharmD obtains info from patient to assess progress on CCP goals
- PharmD adjusts medication as needed

CCM PHARMD CLINIC VISIT (PharmD):
Estimated at 30 minutes
4-8 weeks post-enrollment
- PharmD provides comprehensive medication management
- PharmD assesses progress on CCP and adjusts accordingly
- PharmD records time in NextGen as CCM Time on Task

CO-CARE VISIT (PharmD and DO/MD):
Estimated at 45 minutes 8-12 weeks post-enrollment
- PharmD provides comprehensive medication management
- PharmD assesses progress on CCP and adjusts accordingly
- PharmD and DO/MD exchange warm hand-off
- DO/MD modifies/approves CCP
- DO/MD conducts E/M and provides additional care as needed
- PharmD provides patient with copy of updated CCP
- DO/MD bills E/M for full encounter as appropriate
- DO/MD approves Master IM Final for full encounter
- **NOTE: Pharmacist does NOT bill this encounter**

CCM FOLLOW-THROUGH (PharmD):
Estimated at 20 minutes
- PharmD coordinates follow-up care to include referrals, PAP, social work
- PharmD records time in NextGen as CCM Time on Task

Chronic Care Management Process Map (Co-Care Visit Model)

Enrollment and Initiation occur in TWO separate encounters – Page 1 of 2

IDENTIFICATION:
Patient's qualifying for service are identified:
- 2 or more chronic disease states
- Medicare beneficiary
- Preference to at-risk patients*

ENROLLMENT VISIT (DO/MD):
Estimated at 15 minutes
- DO/MD conducts E/M or AWV
- DO/MD describes CCM and obtains consent
- DO/MD bills E/M for full encounter as appropriate

SCHEDULING:
Patient is scheduled for 30 mins. CCM Initiation Visit with pharmacist

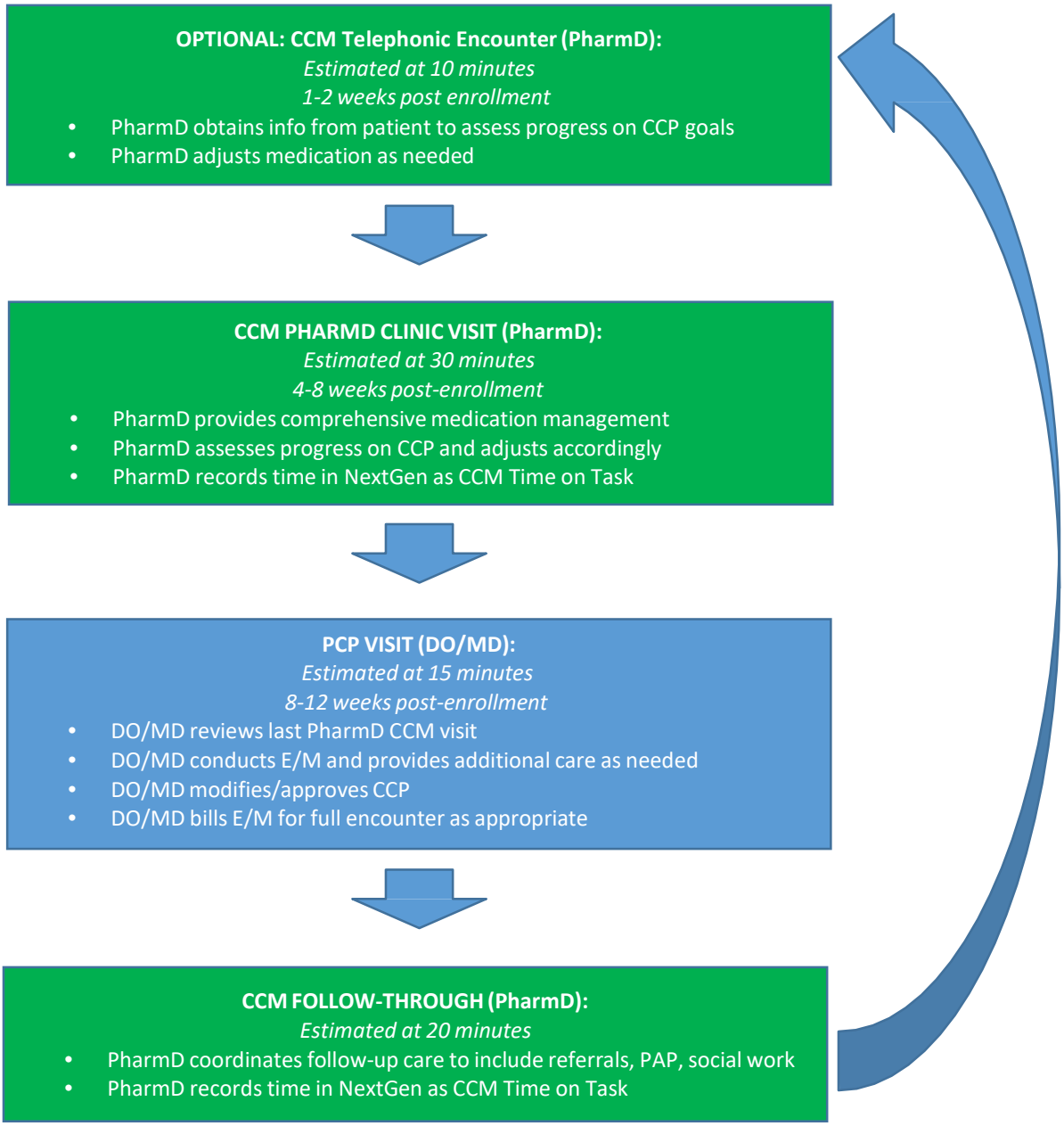
INITIATION VISIT (PharmD):
Estimated at 30 minutes
- PharmD provided comprehensive medication management
- PharmD develops initial comprehensive care plan (CCP)
- PharmD briefs DO/MD during warm handoff
- PharmD records time in NextGen as CCM Time on Task

CCM FOLLOW-THROUGH (PharmD):
Estimated at 20 minutes
- PharmD coordinates follow-up care to include referrals, PAP, social work
- PharmD records time in NextGen as CCM Time on Task

Continue to Next Page

Chronic Care Management Process Map (Co-Care Visit Model)

Enrollment and Initiation occur in TWO separate encounters – Page 2 of 2



Chronic Care Management Process Map (Co-Care Visit Model)

UNT Health CCM Billing Procedures

The Enrollment+Initiating CCM Encounter is billed differently than ongoing CCM service. Additionally, it is important to note that CCM is designed to augment care and is not a substitute for E/M, AWV, or similar services. Since physician oversight, direction, and management are required of CCM, all codes are submitted by the physician.

1) Enrollment+Initiating CCM Encounter (Co-Care Visit)

This single comprehensive co-visit encounter is billed at E/M as deemed appropriate by the physician for the combined effort of the physician and pharmacist during the visit. Additionally, the physician may bill for G0506 provided that they document their participation in developing, implement, and managing the Comprehensive Care Plan (CCP). G0506 may only be billed once per patient for the duration of CCM services. Both the E/M code and G0506 should be billed on the same Master IM Final document.

2) Separate Enrollment and Initiating CCM Encounters

The enrollment visit is billed as E/M or AWV as deemed appropriate by the physician. The physician may NOT bill for G0506 because the Comprehensive Care Plan (CCP) has not yet been developed. The initiation visit with the pharmacist may be included in the CCM time for that month.

3) Ongoing CCM

CCM activities provided by the pharmacist and other clinical staff should be documented in the CCM template. This time is cumulative for the entire month and should be billed once monthly. Selection of the appropriate CCM billing code is dependent on (1) the time on task and (2) presence of moderate to complex medical decision making. Activities may include coordination and management conducted by the pharmacist.

CCM Billing modalities

- Chronic Care Management (99490) – Must accumulate 20 minutes' time on task during the service period (1 month). Physician oversight, direction, and management required. Moderate to complex medical decision making is NOT required

- Complex Chronic Care Management (99487) – Must accumulate 60 minutes' time on task during the service period (1 month) **and** requires moderate to complex medical decision making. Since these patients already present with 2 or more chronic disease states, adjustments to medication management by the pharmacist as delegated by the physician qualify as moderate to complex medical decision making. 99487 and 99490 may NOT be billed in the same service period.

- Add-on Complex Chronic Care Management (99489) – This code will only be used for extremely complex patients requiring significant effort. This Add-on code may only be billed in addition to 99487. In order to bill 99489, at least 90 minutes of CCM Time on Task must be accumulated and presence of moderate to complex medical decision making. 99489 may NOT be billed in addition to 99490.

CCM Patient Copayment

Patient's without secondary insurance or dual coverage will be asked to provide copayment for CCM services. For the 2018 year, the copayments are as follows: 99490 - $8/month; 99487 - $20/month; 99489 – 20%. Patients who owe a copayment for CCM will receive a bill at the conclusion of each month.

4) Co-Care Visits Following CCM Enrollment

Although the Comprehensive Care Plan should be addressed in all Physician-Pharmacist Co-care visits, CCM codes may NOT be billed for these encounters after the Enrollment/Initiating Visit. The physician should bill for the appropriate level of E/M based on the total effort of both the pharmacist and physician. However, any coordination or follow-up that occurs after completion of the visit may be included in the CCM Time on Task for the month.

Chronic Care Management Process Map (Co-Care Visit Model)

Other Compliance Standards

Chronic Care Management may only be provided by clinical staff (as defined by CPT) under indirect or direct supervision of a primary physician (in the UNT Health model, the pharmacist is providing CCM services under physician supervision and direction). The activities billed may not include clerical activities, but must enhance the care and coordination-of-care for the patient. Only one physician may bill for CCM during a billing cycle. CCM may not be billed for the same service date as E/M, AWV, or similar services.

Attribution of Effort and Revenue

It is the practice's expectation that our model of delivering Chronic Care Management will convey numerous benefits that may be difficult to quantify. The primary goal of the UNT Health CCM model is to improve the quality of care for patients at risk for worsened morbidity and mortality. In addition, this service will reduce the cognitive and care coordination burden for our physicians, increase physician capacity, help advance pharmacy practice, and generate additional revenue for the practice. For purposes of accounting and revenue attribution, (1) physician practices will retain all revenue generated from E/M of the initiating and subsequent co-care encounters and (2) pharmacy practice will retain all revenue generated from G0506, 99490, 99487, and 99489.

Contact information

Randy Martin, Pharm.D., BCCCP Associate Chief of Pharmacy
UNT Health Clinical Practice Group
randy.martin@unthsc.edu

Jeff Beeson, D.O., R.N.
Chief Medical Officer
UNT Health Clinical Practice Group
jeff.beeson@unthsc.edu