How to Implement Care Management in Your Office

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Dr. Krebs earned her medical degree from the Ohio State University College of Medicine in Columbus and completed a family medicine residency at Miami Valley Hospital in Dayton, Ohio. She is a solo family physician at a rural federally qualified health center (FQHC) and teaches residents at a new family medicine residency program. She is developing a practice management curriculum and is focused on the patient-centered medical home (PCMH) and quality improvement. Her completed projects include efforts to improve diabetes care, improve preventive health, decrease emergency department and hospital utilization, improve care coordination, address population health, measure physician quality, and deliver medical neighborhood care within the context of the PCMH model. Dr. Krebs has experience writing and evaluating quality measures and served on the American Medical Association (AMA) Prediabetes Quality Measures Technical Expert Panel. She is frequently consulted on matters relating to quality measures, population health, lifestyle modification, value-based payment, and diabetes. In addition, she is a frequent contributor to The Ohio Family Physician and has written on a variety of public health issues. Previously, Dr. Krebs co-ran Family Practice Associates, an independent practice where she led transformation to the PCMH model of care and was involved in the Center for Medicare & Medicaid Innovation’s Comprehensive Primary Care (CPC) initiative. She also implemented clinical staff and electronic health record (EHR) training, numerous quality improvement and population health projects, and other efforts to improve patient and practice team satisfaction. Dr. Krebs currently serves on the AAFP’s Commission on Quality and Practice and is the chair of the AAFP Working Group on Rural Health, as well as serving on the Ohio Academy of Family Physicians Board of Directors. In the past, she has served on the National Conference of Constituency Leaders (formerly the National Conference of Special Constituencies), the Congress of Delegates, and the Reference Committee on Organization and Finance. She served on the quality committee for Premier Health—a physician-led insurance plan—to help make decisions regarding measurement of physician performance, population health, development of quality measures, compensation for quality, and privileging.
Learning Objectives

1. Define a plan to risk stratify your patient population.

2. Utilize a targeted, proactive, relationship based process for providing care management support to high and rising risk patients.

3. Develop a personalized plan of care for patients at high risk for adverse health outcome or harm, integrating patient goals, values and priorities.

Audience Engagement System

Step 1

Step 2

Step 3
Case 1

You work in a small private practice with two other family physicians. You have decided to employ a care coordinator in your office. Where will you find one?

Case 1

Places to find a care coordinator:
– Job sites
– Word of mouth
– Current employees
Case 1

You have been unable to find a care coordinator. You decide to train one of your medical assistants to become a care coordinator. How will you do that?

Case 1

Discuss what you want your care coordinator to do.
Case 1

Things care coordinator can do:
– Follow up on patients with recent ER visits
– Follow up on patients with post hospital visits
– Pre-Visit planning
– Care gap reports
– Work with high risk patients

How to Risk Stratify Patients

• Use objective and subjective data
• Risk level changes
• Meet with care coordinator weekly or monthly to review
Case 1

Your practice gets a bonus if ER utilization stays below a threshold. Your office just missed the bonus.

How can care coordinator improve ER utilization?
Case 1: Patients with Recent ER Visits

Care coordinator reaches out to local ERs and urgent cares
Care coordinator contacts patients with a recent ER visit
  – Give care coordinator guidelines for when you want patient to schedule a visit with your office
  – Have care coordinator educate patients with inappropriate ER visits.
  – Can add new medications to chart.

Case 1: Patients with ER Visits

Possible Inappropriate ER Visits
  – ER visits during hours your office is open
  – Low acuity visits
  – Patients with multiple ER visits

Have care coordinator educate patients to call your office for most issues.
Case 1: ER Visit Outcomes

- Better patient care
- Decreased ER utilization (possible payment)
- Patient satisfaction
- More office revenue

Case 2: Post hospital visits

You dread post-hospital visits. You are frustrated that you never have the reports you need, and the medication list is a nightmare. You are always running behind after these visits.

How would you use care coordinator for patients with post hospital visits?
Case 2: Transitional Care

Have care coordinator reach out to local hospitals and ask them to send all hospital information and discharges to your office.

Transitional Care Codes

99495
Contact with patient or caregiver within two business days of discharge
Moderate medical decision making
Face-to-face visit within fourteen calendar days of discharge

99496
Contact with patient or caregiver within two business days of discharge
High complexity medical decision making
Face-to-face visit within seven calendar days of discharge
Transition of Care Codes

- 99495 pays approximately $165
- 99496 pays approximately $234

What if Care Coordinator Cannot Reach the Patient?

- If two or more attempts are documented and are unsuccessful, and all other criteria are met, the code can be billed.
- CMS expects that attempts will continue until successful.
Poll Question 1

A patient is seeing you in the office after she was discharged 5 days ago after a CHF exacerbation. Your care coordinator called her three days ago to see how she was doing. She has improved, and you perform an extended-problem focused history, no exam, and the visit has moderate complexity. How would you code this visit?

A. 99213  
B. 99214  
C. 99495  
D. 99496

Pre-Visit Planning

You often run behind in clinic and spend too much time after hours doing charts. During pajama time, you realize you forgot to update the patient’s health maintenance.

What would you like your care coordinator to do prior to the visit to help avoid these challenges?
How Care Coordinators Can Help with Transitional Care

• Contact patient or caregiver (phone, electronic, or in person) within two business days and document.
• Obtain hospital records
• Update medication list (must be documented for TCM)
• Document status of follow up with other physicians
• Schedule office visit in appropriate time frame
  – Since care coordinator is unlikely to know the medical decision making and difficult to predict ahead of time, consider doing all within seven days of discharge

Pre-Visit Planning

• Can review last note and obtain any tests or referral notes
• Vaccines that are due
• Prevention tasks that are due (pap, mammogram, colon cancer screening)
• Diabetes tasks (a1c, foot exam, urine microalbumin, eye exam)
Pre-Visit Planning

• Discuss with your team in a huddle
• MA can ask about vaccines and preventive health tasks
• MA can have patient ready for exam (shoes off for diabetics)

Benefits of Pre-Visit Planning

• Makes the visit more efficient
• Less waiting on test results for both physician and patient
• Improved care
• Improved quality measures (possible payment)
• Support staff can be more helpful
Care Gap Reports

• Teach care coordinator to run care gap reports and work them
• Look at what quality measures you are paid for

Well child checks
• Colon cancer screening
• Mammograms
• Paps
• Vaccines
• Uncontrolled diabetics
• Diabetic eye exams
• Anything that is measured/incentivized

• Use standing orders when possible to improve quality measures
Working with High Risk Patients

Will discuss in other cases

Case 3

Mrs. Jones is a 67-year-old female with diabetes. Her a1c is 11.7. She frequently misses appointments, does not check sugars, and intermittently takes her medication.

How can the care coordinator help you care for Mrs. Jones?
Case 3

You ask the care coordinator to talk to Mrs. Jones to find out what the barriers are to her care. The care coordinator finds out that she does not have reliable transportation, her medications are expensive so she stretches them to save money, and she has trouble paying for food, so her diet is high in carbs. She has not had diabetic education in years.

How can you and the care coordinator work together to help the patient?

Transportation

Care coordinator compiles list of transportation resources

Insurance companies may provide transportation

EveryOne Project Neighborhood Navigator
Neighborhood Navigator

- Food
- Housing
- Transportation
- Employment aid
- Legal aid
- Financial
Food

Care coordinator can compile a list of resources including meals on wheels and local food pantries.

Use the AAFP EveryOne Neighborhood Navigator

Case 3

Care coordinator connects the patient with free transportation and a food pantry, both found on the EveryOne Neighborhood Navigator.

Mrs. Jones felt uncomfortable telling you that the medications were expensive, but told the care coordinator. You adjust her regimen which saves her money.

You refer Mrs. Jones to diabetic education.

Three months later, her a1c is 8.7. Six months later, her a1c is 6.9.
How Do We Get Paid For This?

Chronic care management billing

Chronic Care Management (CCM)

Medicare will pay for CCM is for patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.
8 Elements define the current scope of CCM:
1. Access to care management services 24 hours a day, 7 days a week.
2. Continuity of care.
3. Care management for chronic conditions. This includes the following:
   • Systematic assessment of a patient's medical, functional, and psychosocial needs,
   • System-based approaches to ensure timely receipt of all recommended preventive care services,
   • Medication reconciliation with review of adherence and potential interactions,
   • Oversight of patient self-management of medications.

4. Creation of a patient-centered care plan document to ensure that care is provided in a way that is congruent with patient choices and values. (Template available in FPM Toolkit.)

5. Management of care transitions between and among health care providers and settings. This includes the following:
   • Referrals to other clinicians,
   • Follow-up after a patient visit to an emergency department,
   • Follow-up after a patient discharge from a hospital, skilled nursing facility, or other health care facility.

Has to be electronic (no faxes).
Chronic Care Management

6. **Coordination with home- and community-based clinical service providers.** This is to ensure appropriate support of a patient's psychosocial needs and functional deficits.

7. **Enhanced opportunities for a patient and any relevant caregiver to communicate with the provider regarding the beneficiary's care.** This includes communicating through not only telephone access but also the use of secure messaging, Internet, or other asynchronous, non-face-to-face consultation methods.

8. **Electronic capture and sharing of care plan information.** This information must be available on a 24/7 basis to everyone in the practice who is furnishing CCM services and whose time counts toward the time requirement for billing the CCM code. CMS requires practices to provide the patient a written or electronic copy of the care plan and to document in the EHR that this was done.

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**Chronic Care Management**

CMS requires Patient Agreement. Physicians need to:

- Inform the patient of the availability of CCM services and obtain his or her permission (written best but okay to document verbal agreement) to have the services provided, including authorization for the electronic communication of his or her medical information with other treating physicians as part of care coordination (may or may not be required depending on state),
- Document in the patient’s medical record that all of the CCM services were explained and offered to the patient, and note the patient’s decision to accept or decline these services.
Physicians also need to:
• Inform the patient of the right to stop CCM services at any time (effective at the end of the calendar month) and what effect a revocation of the agreement would have on CCM services, and
• Inform the patient that only one practice/physician can furnish and be paid for these services during a calendar month.
• AAFP has sample letter you can use.

CPT code 99490
Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
• Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
• Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
• Comprehensive care plan established, implemented, revised, or monitored
Chronic Care Management

The Medicare payment allowance (unadjusted geographically) for Medicare participating physicians is approximately $42 per month.

If you participate in either CMS’s Multi-Payer Advanced Primary Care Practice Demonstration or the Comprehensive Primary Care Initiative, you may not bill Medicare for CCM services furnished to any patient attributed to your practice for purposes of participating in one of these initiatives. You may bill Medicare for CCM services furnished to eligible patients who are not attributed to your practice for these purposes.

Chronic Care Management

You cannot bill CCM services for a patient during the same calendar month in which you are otherwise billing Medicare for:

- Transitional care management services (99495 and 99496)
- Home health care supervision (G0181)
- Hospice care supervision (G0182)
- Certain end-stage renal disease services (90951-90970)
- And other excluded services found in CPT.
Chronic Care Management

The 20 minutes per calendar month is a minimum threshold (i.e., you may not round up your time spent in order to meet it), and you can count the time of only one clinical staff member for a particular segment of time (e.g., if two staff people meet about a patient for 10 minutes, that only counts as 10 minutes, not 20 minutes). Documenting this time in the patient’s record to reduce your audit risk.

Chronic Care Management

CCM services will be subject to the usual cost sharing (i.e., deductible and coinsurance) for Medicare patients.
$8 to $9 coinsurance that patients must pay for a month’s worth of CCM vs possible ER visits or hospital admissions.
Poll Question 2

Which patient qualifies for medicare chronic care management fees?

A. Your staff spends 30 minutes doing a patient’s prior authorization
B. 68-year-old with severe persistent asthma who you spend 20 minutes counseling on tobacco cessation
C. A hospice patient who you bill for hospice supervision
D. Your care-coordinator spends 20 minutes arranging transportation for a patient with diabetes and hypertension

Case 3

At the first visit with Mrs. Jones, the care coordinator explains care coordination, giving the letter from the AAFP toolkit. Mrs. Jones signs the agreement, also in the toolkit.

Care coordinator documents the time she spends helping Mrs. Jones according to CMS requirements.

The office is paid $42 for chronic care management.
Case 3: Benefits

- Improved quality of care
- Chronic care management billed
- Quality measure improved (possible payment)
- More office revenue since Mrs. Jones comes in more regularly
- Happier patient
- Happier physician

Case 4

Mr. Jones is a 76-year-old male with COPD. He has been hospitalized 13 times for COPD in the past year.

How can your care coordinator help you take care of Mr. Jones?
Case 4

Care coordinator contacts the patient and assess barriers:
- Medication adherence, side effects, difficulties using inhalers, and cost
- Transportation
- Tobacco use
- Education about COPD

Case 4

• Care coordinator finds out that the patient sometimes skips his medication because he forgets.
• Patient occasionally misses medication due to cost.
• Care coordinator observes patient using his inhaler and notices he is not using it correctly.
• Patient has reliable transportation.
• Patient smokes and is not willing to cut down or quit.
• Patient has poor understanding of his COPD.

• How can you and care coordinator help this patient?
Case 4

- Care coordinator helps patient set up reminder to take medication in his phone.
- Care coordinator helps patient apply for patient assistance for his medications.
- Care coordinator shows patient proper use of inhaler.
- You educate patient on COPD.
- You develop a plan with the patient that as soon as he feels SOB, he calls the office.
- Care coordinator calls him periodically to check on him.

Case 4

- Patient contacts care coordinator whenever his SOB gets worse and schedules a same-day appointment.
- You intervene quickly.
- Depending on severity, you see him back quickly or care coordinator contacts him to check on him.
- Patient only has 2 hospital admissions in the next year.
Case 4

What are the benefits of a care coordinator in this case?

Case 4 Benefits of Care Coordinator

- Improved patient care
- Bill Chronic care management
- Decreased hospital utilization (potential payment)
- Bill for chronic care management
- Increased office revenue from more visits
- Happier patient
- Happier physician
Poll Question 3

Your patient has a history of HTN and CVA, with residual right-sided weakness. He wants to continue to live at home. He has Medicare and has given written permission to start care coordination. You get a phone call stating that he is confused about his medications and physical therapy is no longer coming to his house. Your care coordinator spends thirty minutes educating the patient on his medications and helping get a physical therapist to come to his house. How would you bill for this?

A. 99213  
B. 99214  
C. 99490  
D. Nothing- you did not see him in the office

Case 5

Your office reviews your quality measures, and only 17% of the patients age 50-75 have had a recent mammogram. As a result, your office does not get a bonus for quality metrics.

How can you work with your care coordinator to improve this?
Case 5

Care coordinator asks for permission to order mammograms. You give a standing order and set up parameters.

Care coordinator highlights the pre-visit planning sheets where patient needs a mammogram. She also orders the mammogram and the MA hands it to the patient at the time of the visit.

OR care coordinator faxes to local hospital and arranges for hospital to call to schedule.

Care coordinator also runs gap report for patients seen in the last year. She contacts them and orders the mammogram.

What are the Benefits of this Standing Order and Care Coordination?

- Improved patient care
- Improved quality measure (possible payment)
- Less physician time
Practice Recommendations

If employed and you do not have care coordinator, use the benefits slides to build a case to obtain a care coordinator.

Find and train a care coordinator.

Develop a plan to risk stratify patients.

Use Transition of care codes, using care coordinator to help.

Bill for Chronic Care Management. Use FPM Toolkit to help.

Create standing orders for your care coordinator to improve quality measures.

Use EveryOne Neighborhood Navigator to find resources for patients.

Contact Information

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Questions

Resources

Community-Based Care Coordination- A Comprehensive Development Toolkit
http://www.stratishealth.org/expertise/healthit/carecoord/index.html#select


EveryOne Project Neighborhood Navigator

Frequently Asked Questions about Transitional Care Management

FPM Toolbox- Care Management https://www.aafp.org/fpm/toolBox/viewToolType.htm?toolTypeId=2