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Succeeding at Virtual Patient Engagement: Part 1
Nuts and Bolts of Getting

March 30, 2022

Presented By: Faith Jones, MSN, RN, NEA-BC

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3-Part Series

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Succeeding at Virtual Patient Engagement:

- Part 1 – Nuts and Bolts of Getting Your Clinic and Your Patient Started with Telehealth using Care Coordination
  - Faith Jones
- Part 2 – Mastering the workflow in Your Office for Improved Patient Engagement using Care Coordination
  - Care Coordinator Panel Presentation
- Part 3 – Overcoming the Constant Need for Telehealth Training Due to Employee Turn Over
  - Maribel Frank

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Patient Engagement

Health Promotion and Health

Proactive Care Coordination

Is

Health Promotion

Health is what the individual believes it is

Patient Centered Care

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The National Academy of Medicine (formerly the Institute of Medicine) defines patient-centered care as:

> **"Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."**

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The 4Ms Framework

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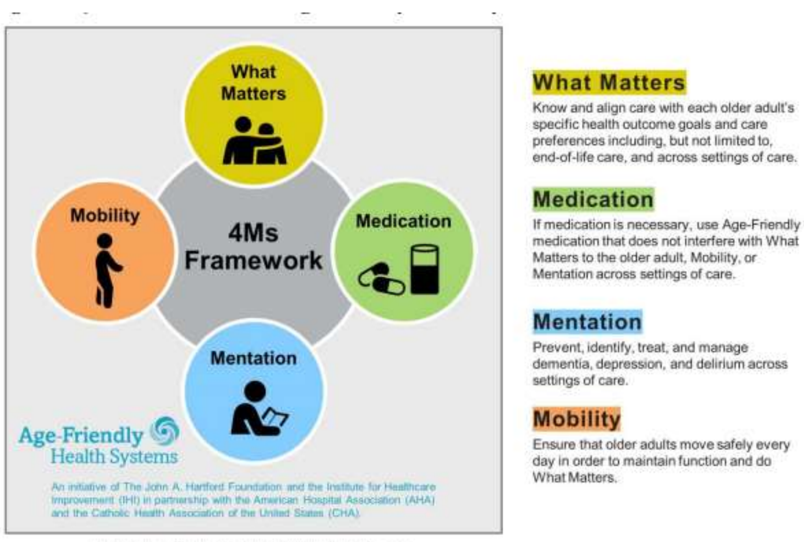

 http://www.ihi.org/Engage/Initiatives/Age-Friendly-Health-Systems/Documents/IHIAgeFriendlyHealthSystems_GuidetoUsing4MsCare.pdf

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Care Coordination Growth and Development

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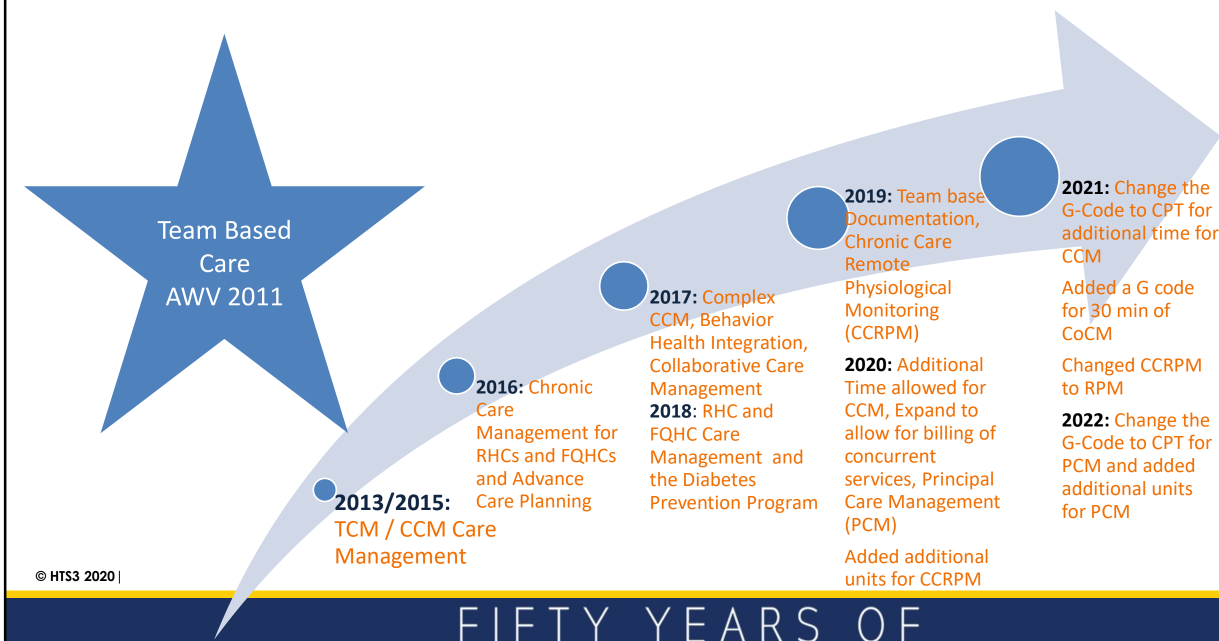

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How Well is Care Coordination Working?

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"…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

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Elements of Chronic Care Management

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Practice 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 general supervision of clinical staff

Patient Eligibility

- Medicare Patient (other ins also)
- 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

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Purpose

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Care Coordination is more than time tracking More than just calling your patients

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Research

- What is the purpose of the visit?
  - Review the last note
  - Review any labs, reports, etc
  - Review the consult request
- What does the patient expect from the visit?
  - Care Coordination phone calls
  - Assessing the patient's understanding

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Right Setting for the Right Follow Up

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Follow up appointment?
- **When does it need to be scheduled for?**
- **What is the plan?**
  - **Can it be accomplished by Telehealth?**

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Technology

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- Starts with connection
  - Are you using the patient's WiFi? Cellular Service? Hotspot?
- Lights, Camera, Action
  - Where is the camera? Is it enabled? Is it an add on?
- Sound Check
  - How loud are the speakers? Where is the volume?
  - Is there a microphone? Is it clear?
  - Privacy issues? Need headset?

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Pulling it all Together

Does the patient have everything needed to be successful on a telehealth visit?

- Will they be better served with help at home during the visit?

Yes – but who?

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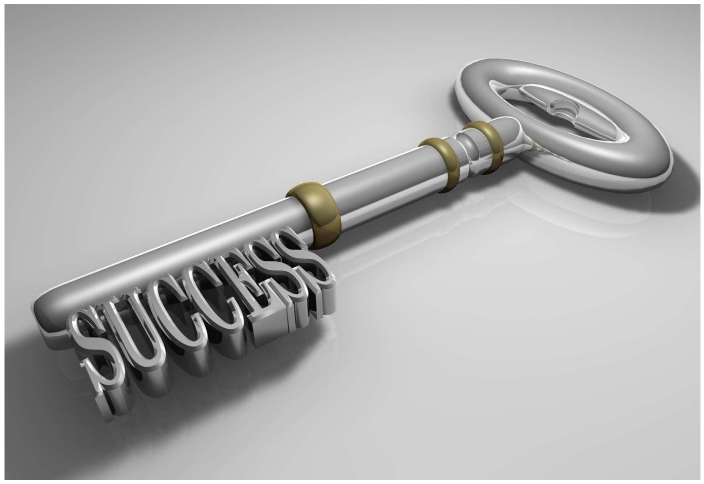
Care Coordination Models

Creativity is the …



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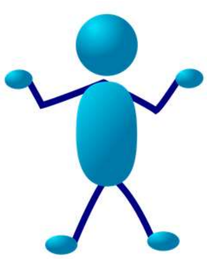
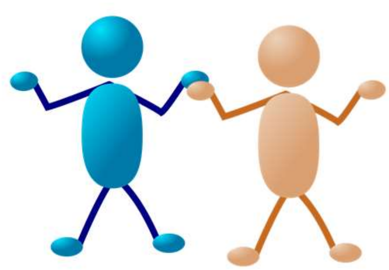
Care Coordination Models

- Care Coordinators can make home visits

  OR

- Care Coordination Teams
  - Community Paramedics
  - Community Health Workers





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Tracking Time

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- **All time spent with the patient:**
  - **Calling and talking to the patient** ✓
- **All time spent on behalf of the patient**
  - **Researching in the chart** ✓
  - **Getting clarification from the provider about a note** ✓
  - **Using the planning tool** ✓
  - **Reviewing the labs and reports** ✓
  - **Assessing and scheduling of appointment** ✓
  - **Driving to the patient's home or community visit** ✓
  - **Setting up telehealth** ✓
  - **Talking to community resources** ✓

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Manage Patient and Family Expectations

Time of arrival
Time to set up
Time of the appointment
Time to discuss follow up

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Telehealth Visit and In-Person Visit Integration

Increases

Patient and Provider expectations and satisfaction

Frustrations and inefficiencies

Decreases

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Planning Future Encounters

WHO has time?

The RN Care Coordinator is responsible for growth and maintenance of the care coordination program which includes recruitment and maintenance of patients enrolled in care management services; assurance of the completion of the annual wellness visit and follow up on all elements of the preventative plan of care.

This position will work to improve the quality of life of patients enrolled through supporting quality outcomes, smooth care transitions, coordination of care across the health continuum, encourage healthy lifestyle choices to reduce long term effects of chronic illness.

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2022 Fee Schedule

- **Chronic Care Management (CCM)**

➢ Billed per calendar month for 20 min of care coordination

- CPT Code 99490 National Average Reimbursement from $38.89 to **$64.02**

➢ Billed with 99490 for each additional 20 min of care coordination – Max of 2

- CPT Code 99439 National Average Reimbursement from $35.65 to **$48.45**

➢ Billed per calendar month for 60 plus minutes of Complex Chronic Care Management

- CPT Code 99487 National Average Reimbursement from $88.48 to **$134.27**

➢ Billed with 99487 for additional 30 min per calendar month for Complex Chronic Care Management

- CPT Code 99489 National Average Reimbursement from $41.48 to **$70.60**

2022 Fee Schedule

- **Behavior Health Integration**

➢ Billed per calendar month for 20 plus minutes of care coordination

- CPT Code 99484 National Average Reimbursement from $44.40 to **$44.64**

- **Collaborative Care Management**

➢ Billed per calendar month for 1st month of at least 70 plus minutes of Psych collaborative care

- CPT Code 99492 National Average Reimbursement from $146.16 to **$153.65**

➢ Billed per calendar month for subsequent month of at least 60 plus minutes of Psych collaborative care

- CPT Code 99493 National Average Reimbursement from $145.84 to **$148.81**

➢ Billed with 99492 or 99493 for additional 30 min per calendar month for Psych collaborative care

- CPT Code 99494 National Average Reimbursement from $56.71 to **$63.68**

➢ Billed per calendar month for subsequent month of at least 30 minutes of Psych collaborative care

- CPT Code G2214 National Average Reimbursement from $61.58 to **$61.95**

2022 Fee Schedule

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- **Principle Care Management (Specialty Practice target)**

➢ Billed per calendar month for 30 min of care coordination by clinical staff

- CPT Code 99426 National Average Reimbursement from $36.30 to **$63.33**

➢ Billed per calendar month for additional 30 min of care coordination by clinical staff

- CPT Code 99427 National Average Reimbursement from $0 to **$48.45**

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2022 Fee Schedule

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- **Remote Physiologic Monitoring**

➢ Billed per calendar month for at least 20 minutes of patient and or care giver interaction related to remote physiologic monitoring treatment management services

- CPT Code 99457 National Average Reimbursement from $48.29 to **$50.18**

➢ Billed with 99457 for additional 20 min of physiologic monitoring management services with the patient and or care giver in the month

- CPT Code 99458 National Average Reimbursement ~$38.89 to **$40.84**

➢ Billed on initiation for initial set-up and patient education of the monitor and service

- CPT Code 99453 National Average Reimbursement ~$18.80 to **$19.03**

➢ Billed each 30 days of supplying the device with daily recording ability

- CPT Code 99454 National Average Reimbursement ~$61.90 to **$55.72**

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2022 Fee Schedule

- **Welcome to Medicare (IPPE) Annual Wellness Visit (AWV)**

➢ IPPE Billed only once within the first 12 months of Part B Coverage

- CPT Code G0402 National Average Reimbursement from $160.42 to **$169.57**

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

- CPT Code G0438 National Average Reimbursement from $160.75 to **$169.57**

➢ Billed one per year – Subsequent wellness visit

- CPT Code G0439 National Average Reimbursement from $126.39 to **$132.54**

- **Advance Care Planning (ACP)**

➢ Billed per 30 minutes of dedicated time for conversation and completion of documentation as appropriate - Initial 30 minutes

- CPT Code 99497 National Average Reimbursement from $80.70 to **$85.48**

➢ Bill in addition to 99497 for each additional 30 minutes

- CPT Code 99498 National Average Reimbursement from $69.35 to **$74.06**

2022 Fee Schedule

- **Transitional Care Management (TCM)**

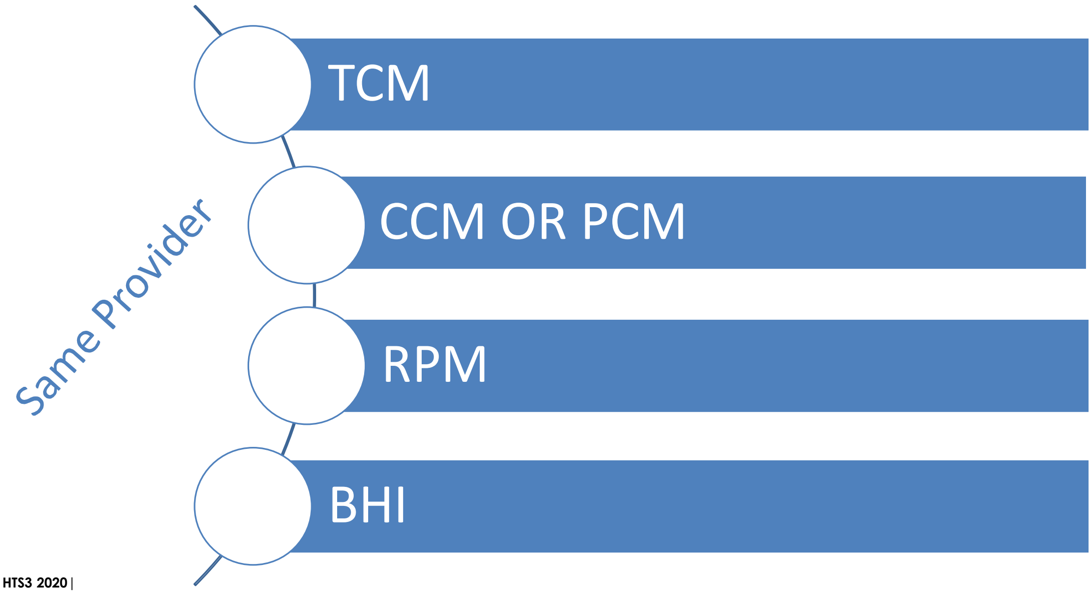
➢ Post Hospital Office visit within 7 days

- CPT Code 99496 National Average Reimbursement from $267.05 to **$281.69**

➢ Post Hospital Office visit within 14 days

- CPT Code 99495 National Average Reimbursement from $197.69 to **$209.02**

Combinations of Care Management for FFS



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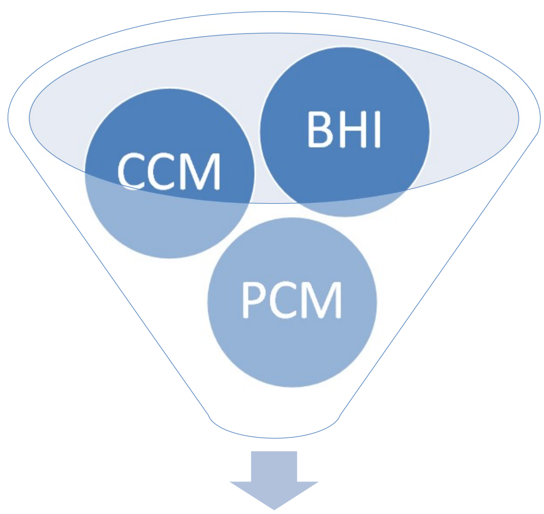
General Care Management for RHCs and FQHCs



Care Management

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2022 Fee Schedule – RHCs/ FQHCs

- **Care Management (CCM – BHI - PCM)**

➢ Billed per calendar month for 20 plus minutes of care coordination

- CPT Code G0511 National Average Reimbursement from $61.90 to **$79.25**

- **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 National Average Reimbursement from $146.16 to **$151.23**

2022 Fee Schedule – RHCs

- **All Inclusive Rate**

➢ For RHCs enrolled in Medicare on or After January 1, 2021 the AIR payment has been set at

- Appropriate CPT code CY 2022 Reimbursement from $100.00 to **$113.00**

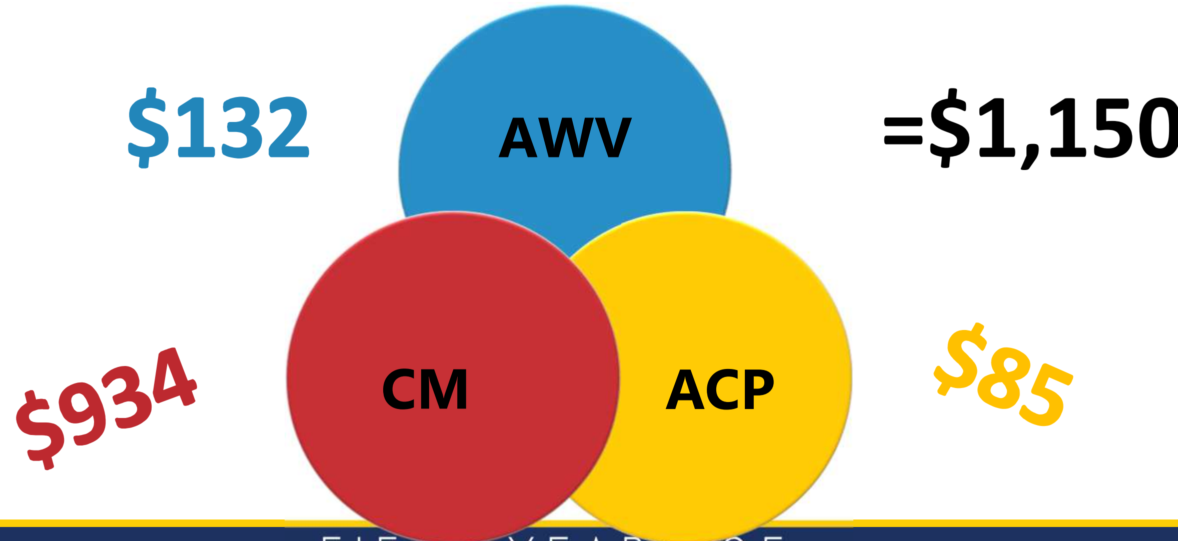
- **Transitional Care Management**

➢ Beginning January 1, 2022, RHCs can bill TCM and general care management services furnished for the same patient during the same service period, if the RHC meets the requirements for billing each code

➢ Note – the RHC will receive their AIR payment for the TCM visit

MLN006398 January 2022

Care Coordination Model: FFS Potential Annual Revenue per Patient



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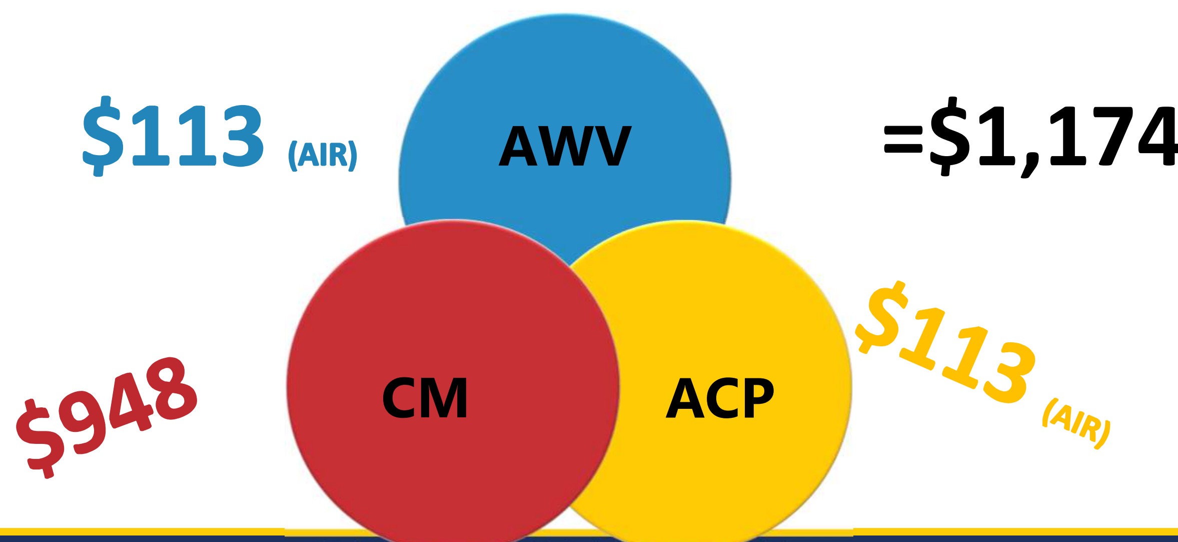
Care Coordination Model: RHC - Potential Annual Revenue Per Patient



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Potential Annual Revenue per Care Coordinator

$1,150 per Patient

×

200 Patients

=

$230,000

33

Preventing Burnout

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

Team Based Care

https://www.annfammed.org/content/12/6/573

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Thank You

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Faith M Jones, MSN, RN, NEA-BC
Director of Care Coordination and Lean Consulting

Faith Jones began her healthcare career in the US Navy over 35 years ago. She has worked in a variety of roles in clinical practice, education, management, administration, consulting, and healthcare compliance.

Her knowledge and experience span various settings from ambulatory to inpatient to post-acute. 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.

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