HealthTech

Lessons Learned
The Synergy between Care Coordination and Telehealth

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Care Delivery Models

Evolving Models

"...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

Care Coordination

Growth and Development

Team Based Care AWV 2011

2013/2015: TCM / CCM Care Management

2016: Chronic Care Management for RHCs and FQHCs and Advance Care Planning

2017: Complex CCM, Behavior Health Integration, Collaborative Care Management

2018: RHC and FQHC Care Management and the Diabetes Prevention Program

2019: Team based Documentation, Chronic Care Remote Physiological Monitoring (CCRPM)

2020: Additional Time allowed for CCM, Expand to allow for billing of concurrent services, Principal Care Management (PCM)

Added additional units for CCRPM

2021: Change the G-Code to CPT for additional time for CCM

Added a G code for 30 min of CoCM

Changed CCRPM to RPM

2022: Change the G-Code to CPT for PCM and added additional units for PCM

2023: Chronic Pain Management

BHI billing for CSWs and Clinical Psy

How Well is Care Coordination Working?

"…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

Purpose

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

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What is Right for the Patient?

Patient Centered Care

The IOM (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."

Research

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- 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

Technology

- 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?

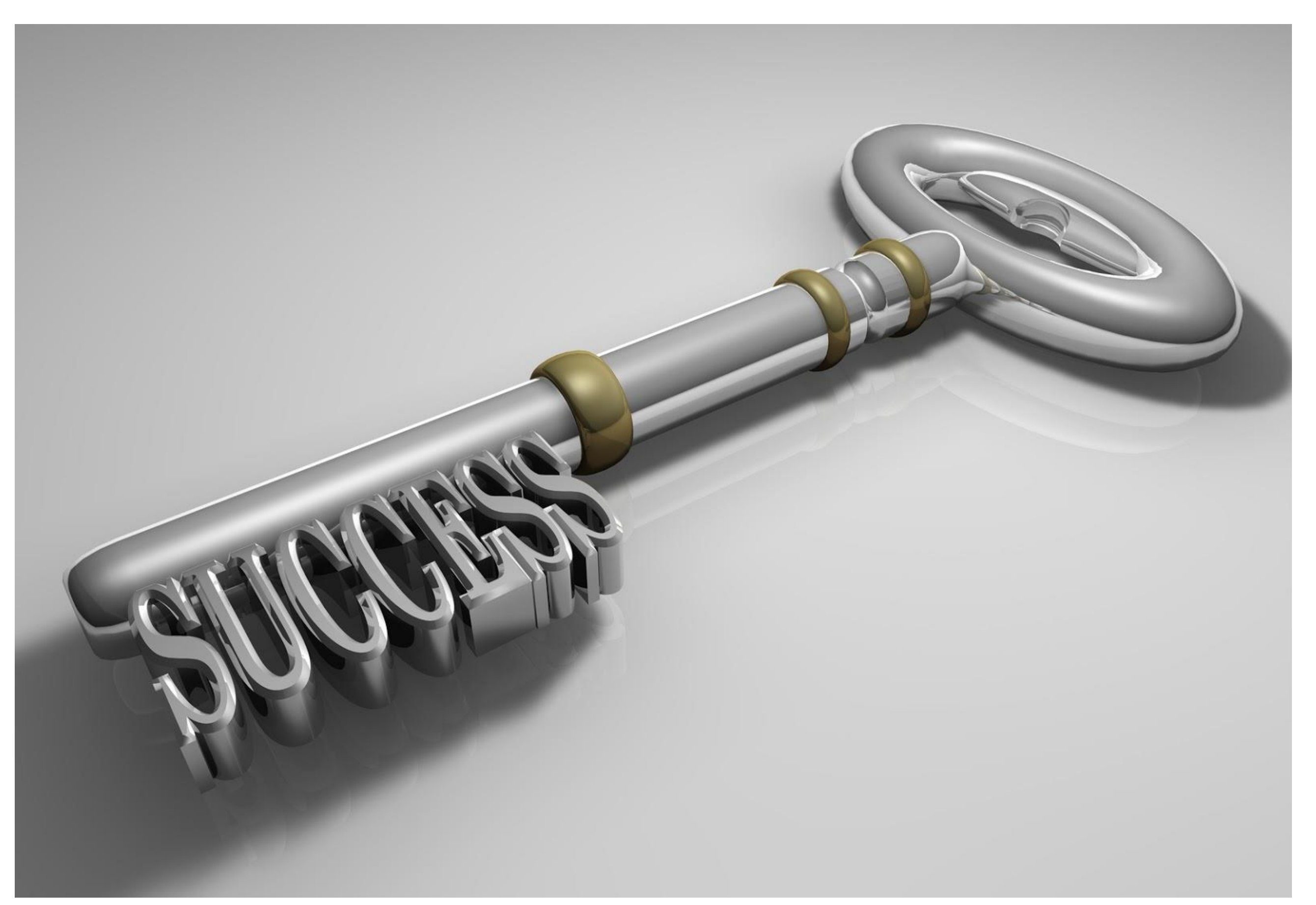
Pulling it all Together

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

Yes – but who?

Care Coordination Models

Creativity is the …



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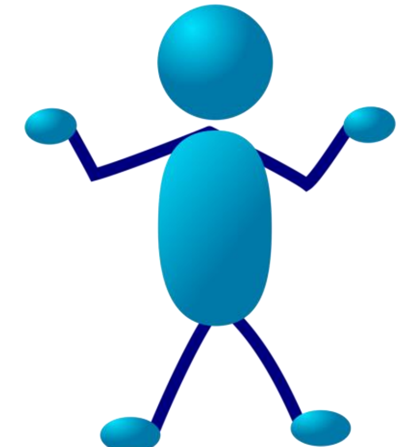
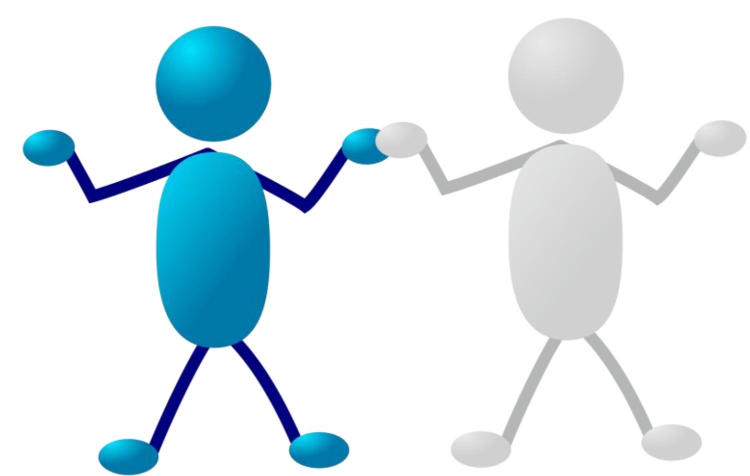
Care Coordination Models

- Care Coordinators can make home visits

OR

- Care Coordination Teams
  - Community Paramedics
  - Community Health Workers





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

Two Ways to Get Paid

- Care Management Programs (CCM, PCM)
  - Medicare
  - Cigna
  - Other commercial payers

- Community EMS Visits
  - Wyoming Medicaid

Elements of Chronic Care Management

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

Tracking Time

All time spent with the patient:

Calling, visiting 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 ✓
- Setting up telehealth ✓
- Talking to community resources ✓

Community Emergency Medical Services - Clinician

Wyoming Medicaid will reimburse for services provided as part of a plan of care established with the directing physician and must be:

- Within the scope of practice for the license held by the CEMS-C provider;
- Provided under the direct written or verbal order of a physician;
- Coordinated with care received by the client from other community providers in order to prevent duplication of services; and
- Identified in a written, well documented plan of care, which may include:
  - Health assessments;
  - Chronic disease monitoring and education;
  - Medication compliance;
  - Immunizations and vaccinations;
  - Laboratory specimen collection;
  - Hospital discharge follow-up care; and
  - Minor medical procedures.

Reimbursements for 2023

Team Based Care

Chronic Care Management

- Billed per calendar month for 20 min of care coordination
  - CPT Code 99490 RVU 1.0 National Average Allowable ~$61.16
- Billed with 99490 for each additional 20 min of care coordination – Max of 2
  - CPT Code 99439 RVU 0.7 National Average Allowable ~$46.28
- Billed per calendar month for 60 plus minutes of Complex Chronic Care Management
  - CPT Code 99487 RVU 1.81 National Average Allowable ~$129.93
- Billed with 99487 for additional 30 min per calendar month for Complex Chronic Care Management
  - CPT Code 99489 RVU 1.0 National Average Allowable ~$68.77

Reimbursements for 2023

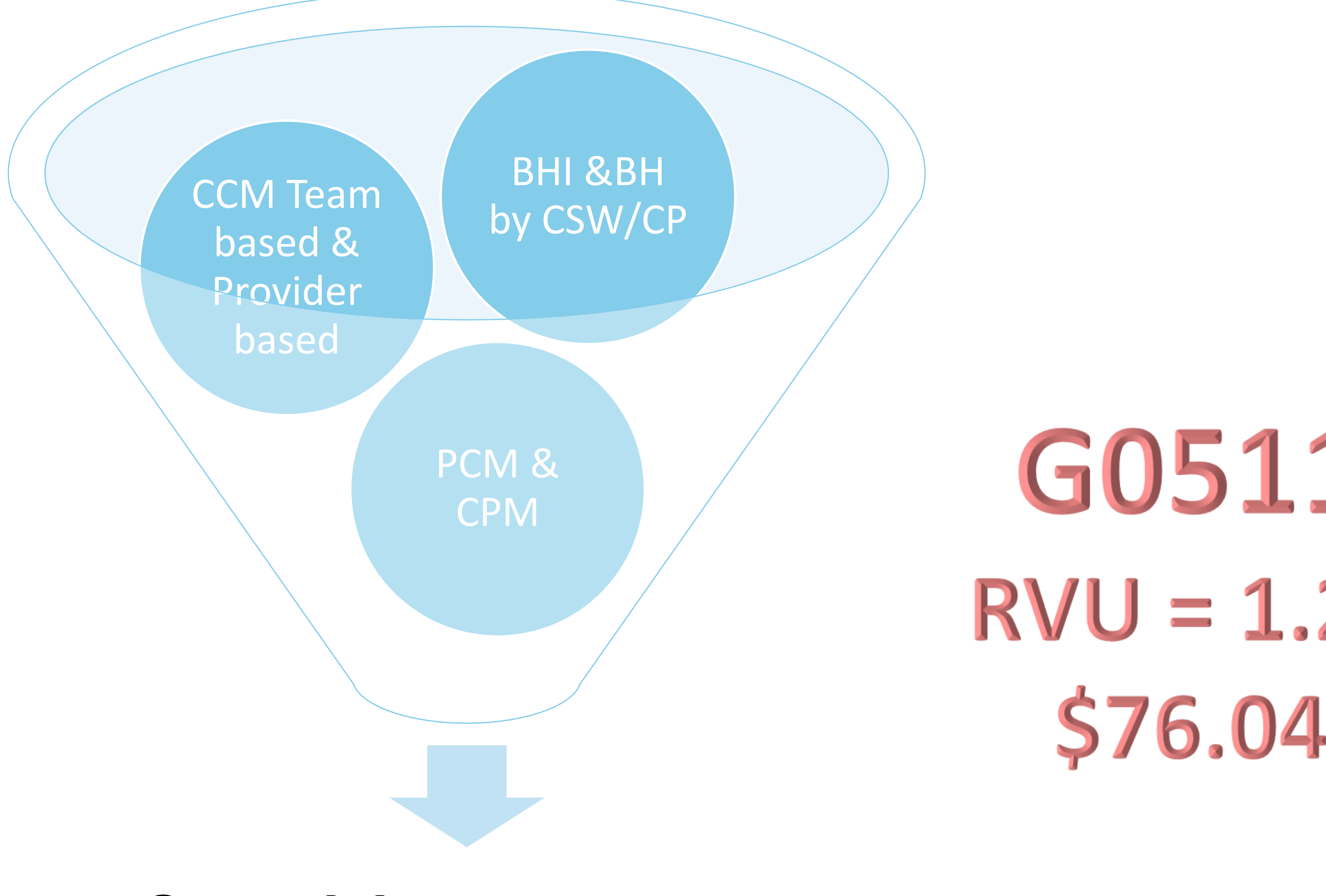
Team Based Care

Principal Care Management

- Billed per calendar month for 30 min of care coordination by clinical staff
  - CPT Code 99426 RVU 1.0 National Average Reimbursement ~$59.84
- Billed with 99426 for additional 30 min per calendar month of care coordination by clinical staff
  - CPT Code 99427 RVU .71 National Average Reimbursement ~$46.28

Rural Health & Federally Qualified Health Clinics

General Care Management



G0511

RVU = 1.23

$76.04

Care Management

Reimbursements for 2023

Wyoming Medicaid

Community EMS Visit

- Billed per visit
  - CPT Code 99600 ~$44.36

Billed by and paid to the Ambulance Service

Questions?

Thank You

Faith Jones is the Director of Care Coordination and Lean Consulting for HealthTech. She currently implements care coordination programs and teaches care coordination and team-based approach to care nationally. Ms. Jones began her healthcare career in the Navy 40+ years ago and her practice has spanned clinical, education, administration, and consulting. She is certified in Advance Care Planning, Lean for Healthcare and as a Nurse Executive Advanced. She is a fellow of the American Nurses Advocacy Institute and the ANA-PAC Leadership Society.

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