Preparation Guide for Medicare’s Chronic Care Management Program
Medicare CCM Program Overview

What you Need to Know

Beginning on January 1, 2015, Medicare began paying for non-face-to-face services for Chronic Care Management (CCM). Physicians can now be paid via CPT Code 99490 for time invested outside of regular office visits, including phone, text or care coordination activities, to manage their patients with chronic conditions. In order to add a patient to the program, the following criteria must be met:

- Medicare patient diagnosed with 2+ chronic conditions.
- Participation must be initiated during an AWV, IPPE, or comprehensive E/M visit (billed separately).
- A comprehensive patient-centered care plan must be in place.
- The provider must obtain the patients written consent.
- Only one provider can bill per patient per month.
- 20 minutes of non-face-to-face clinical staff time invested per calendar month.
- The patient must be advised of their right to stop the service at any time.
- Been advised of their cost-sharing obligation.
- Been advised that only one practitioner can furnish and be paid for these services during a calendar month.
- Been advised of their responsibility.
- Been advised that only one practitioner can furnish and be paid for these services during a calendar month.

Eligibility Requirements

In order to be eligible for Chronic Care Management Services, the patient must meet the following criteria:

- 2+ chronic conditions expected to last at least 12 months or until death of the patient.
- Conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

Patient Consent Requirements

In order to begin providing CCM services, a consent form must be signed by the patient confirming that the patient has:

- Been advised of their cost-sharing obligation.
- Authorized electronic communication between providers.
- Been provided an electronic or written copy of the care plan.
- Been advised of their right to stop the service at any time.
- Been advised that only one practitioner can furnish and be paid for these services during a calendar month.

Patient Enrollment

Getting Started

- Identify eligible patients and those likely to enroll.
- Make sure everyone in the practice is educated about the program, how it helps patients, and the importance of their role in enrollment.
- Schedule AWV, IPPE, or comprehensive E/M to begin enrollment.
- Gain written consent, and start the care plan with information gained from AWV.

Scope of Services and Required Electronic Capabilities

Care Management

- Continuity of care with a designated practitioner or care team member.
- Systematic assessment of medical, functional, and psychosocial needs.
- System based approach to ensure timely receipt of recommended preventative services.
- Medication reconciliation with review of adherence and potential interactions.
- Oversight of self-management.

Coordination of Care

- Creation of comprehensive patient-centered care plan shared electronically with other providers.
- Communication with home and community based providers documented in EHR certified technology.
- Structured clinical summary within a CEHRT EHR must inform the care plan.

Transition of Care

- Management of care transitions within health care continuum, including referrals to other clinicians and discharge from any healthcare facility.

Electronic Access of Clinical Summaries (not by fax)

Electronic Exchange of Care Coordination (not by fax)

Patient Access

- Patients must have 24/7 access to address urgent chronic care needs.
- Enhanced (asynchronous) methods of communication in addition to phone.
- Continuity of care with a designated practitioner or care team member.
- Patient must sign a consent form.
CCM Critical Electronic Capabilities
Providers billing for CCM will not be able to meet the technology requirements with an EHR alone. Smartlink Mobile’s electronic referral management, care coordination, patient communication, and CCM program management capabilities ensure providers are able to operate a high quality CCM program that is both compliant and profitable.

Optimize Efficiency & Revenue
- Optimize workflow efficiency.
- Call planning ensures there is a reason to call that provides value to patients.
- Real time analysis of month to date time invested per patient ensures invested time is billable time.
- Reduce risk of failing a RAC audit with patient interaction time tracking on an actual basis (to the second, not estimated).

Electronic Transmission of Care Plans & Summaries
To all providers across the care continuum.

SaaS Referral Management & Coordination
- Universal clinical document delivery from and to any EHR, or even to providers with no EHR.
- True coordination between providers that improves quality of care, not just electronic access.
- Out of the box interoperability with your EHR.

Asynchronous Patient Communication
In addition to phone.

Mobile Patient Engagement
- Bi-directional clinical dialog via secure text messaging (broadcast or 1:1).
- Secure document exchange with patients.
- Appointment scheduling, pre-registration, check-in.

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