CCM Strategies for Diabetes, CKD and Hypertension in Rural Health Clinics

Presented by Jill Hewett, Savvy Jane LLC

INTRODUCTIONS:

- **Jill Hewett- Ozarks Community Hospital**
- **Medicare Programs & LTC Director**
- **1600 CCM patients monthly**
- **Savvy Jane Solutions LLC**
- **Currently working in Missouri, Illinois, West Virgina, Michigan and Montana**
- **Build CCM programs in house with current EMR. 340b, data analytics, boost value base programs and improve patient outcomes.**

Agenda:

*Creating effective care plans for diabetes patients- integrating CKD and hypertension management.

*Understanding and applying new CCM billing codes.

*Identifying and addressing missed billing opportunities.

*Handling CCM copays.

1. Creating Effective Care Plans

- Integrate diabetes, chronic kidney disease (CKD), and hypertension management
- Align treatment with current guidelines and patient preferences
- Set SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals
- Ensure comprehensive monitoring: labs, vitals, meds, lifestyle
- Use team-based care and clear follow-up protocols

The Power of a Patient-Centered Care Plan

EMPOWERS PATIENTS TO TAKE OWNERSHIP OF THEIR HEALTH.

BUILDS **TRUST AND STRONGER PROVIDER-PATIENT RELATIONSHIPS.**

ALIGNS CARE WITH **PATIENT VALUES, LIFESTYLE, AND GOALS.**

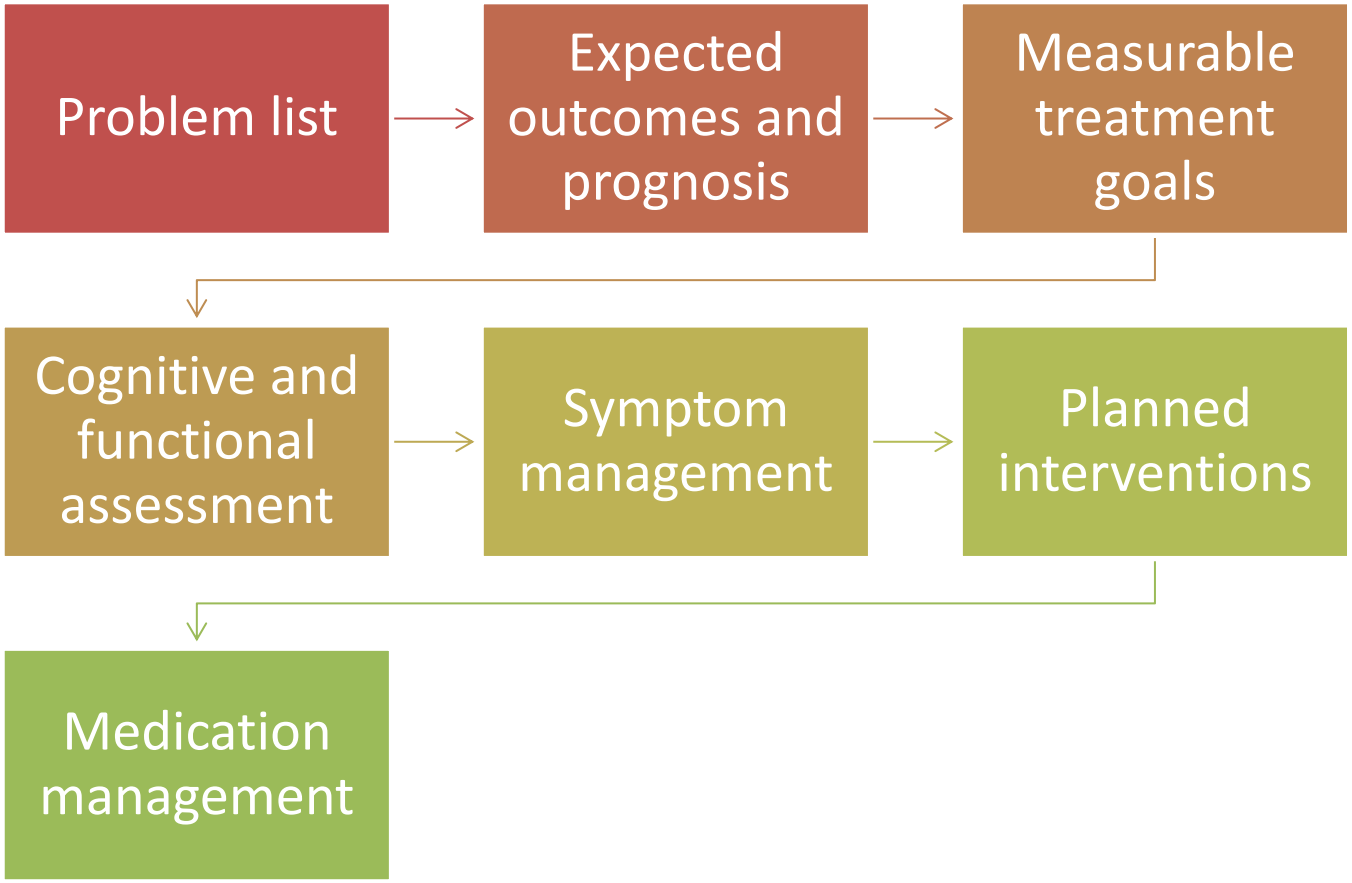
IMPROVES **ADHERENCE** TO MEDICATIONS AND SELF-MANAGEMENT.

Care plans continued

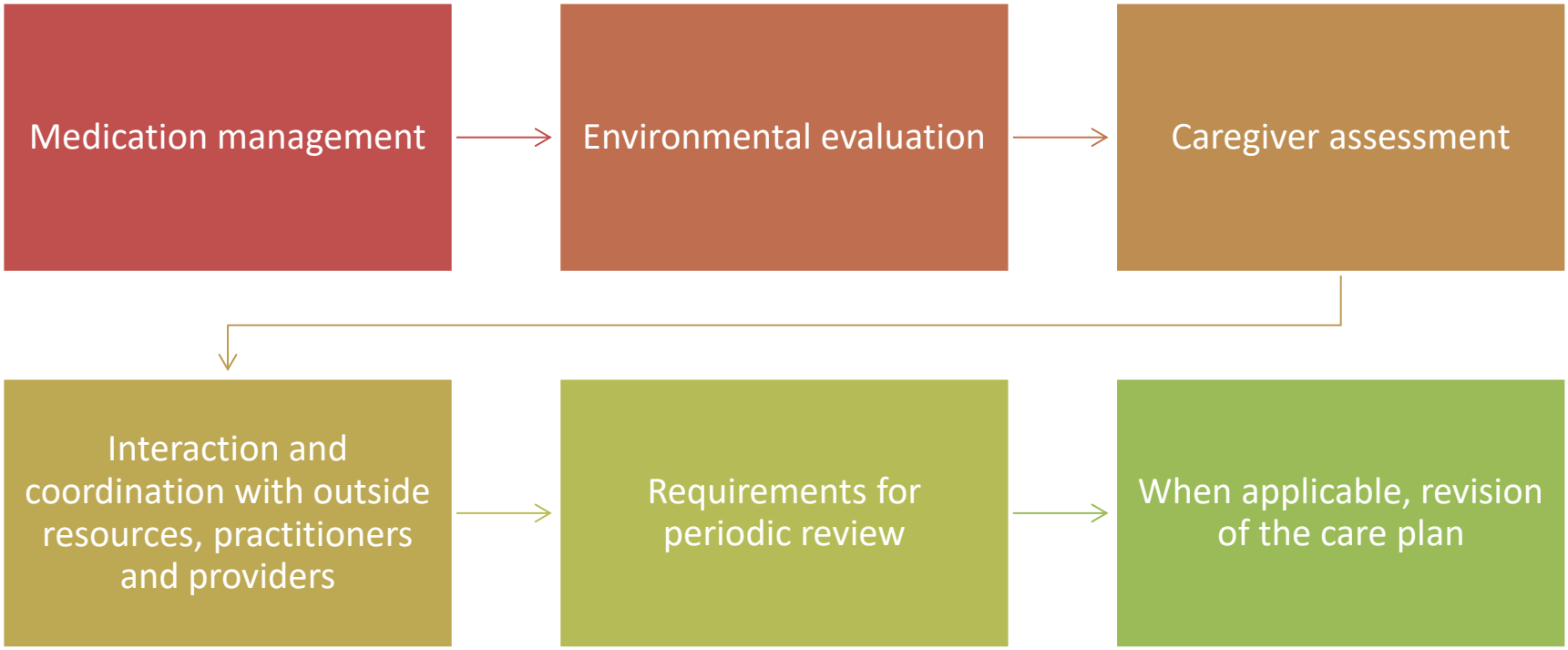
REDUCES **HOSPITALIZATIONS** AND
IMPROVES CLINICAL OUTCOMES.

ENHANCES **CARE TEAM COMMUNICATION**
AND CONTINUITY OF CARE

A comprehensive care plan for all health issues **typically includes but isn't limited to:**



Care plan continued



How to highlight Diabetes, CKD and HTN within a care plan:

- **Create individualized Care Plans and Highlight Health Goals:**

  Diabetes: “Reduce A1c from 8.5 to 7.5 in 3 months through improved medication adherence and dietary changes.” Example Be sure to take Metformin twice per day. Avoid late night snacks.

  CKD- “Maintain stable eGFR at current level (45ml/(min) by managing blood pressure and avoiding nephrotoxins.” Example Dr. Smith wants your blood pressure at or below 140/90. Avoid Advil, Motrin, naproxen (Aleve).

Care Plans cont.

- Hypertension “Achieve average BP under 140/90 with medication and low-sodium diet. Example:” Take your blood pressure daily and avoid salty foods.”

- Mail out diabetic education, daily sugar logs, and food planner.
- Always send updated medication list.

Monitoring & Follow-Up Plan

- Set check-ins based on conditions:
  - **Diabetes** A1c every 3 months.
  - **CKD**: Labs (eGFR, creatinine, urine albumin every 3-6 months.
  - **HTN:** BP log review monthly

Use the plan to schedule labs, office visits, and monthly check ins.

Patient Education Needs:

- Tailor education:
  - **Diabetes**: carb counting, insulin use.
  - **CKD:** protein/ phosphorus education
  - **Hypertension**: label reading, stress management techniques

Behavioral Health & Motivation

Screen for depression/ anxiety that may interfere with condition management.

Add motivational strategies or behavioral health referrals as needed.

Documentation Format

- Use condition-specific subheadings in the care plan to make it easy to follow:
  - **Condition**: Diabetes Mellitus
  - **Goal**: Reduce A1C
  - **Plan**: medications, education, follow- up self-monitoring

The Role of Care Managers

- Care managers ensure comprehensive patient monitoring.
- Monthly reviews guarantee no patient is overlooked.
- They facilitate follow-through on treatment plans.
- Coordination allows for proactive problem-solving.
- Patient engagement is enhanced throughout the process.

2025 CCM Billing Codes and Reimbursement

- CPT 99490: 20+ min/month, $62–$65
- CPT 99439 (add-on): Each additional 20 min
- G0511: For RHCs/FQHCs – bundled rate (~$80) No longer in use after 7-1-2025

APCM program starting 1/1/2025 no time requirement, must be dual enrolled and QMB $110 per month

First 20 minutes clinical staff

- **99490*** Chronic care management services 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored**; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.**

Add on code clinical staff time

- **99439** Chronic care management services 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each **additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.**

60 minutes of Clinical staff time

- **99487*** Complex chronic care management services 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

APCM Program Introduction

- New APCM program starts on January 1, 2025.
- **No time requirement** for billing under new program.
- Eligibility criteria includes dual enrollment and QMB.

Advanced Primary Care Management (APCM)

- Starting January 1, 2025, the Centers for Medicare and Medicaid Services (CMS) introduced Advanced Primary Care Management (APCM) services. This initiative aims to support primary care providers in delivering comprehensive, patient-centered care, especially for those with chronic conditions.

G0556

- Clinical staff provide the APCM services
- A physician or other qualified health care professional who's responsible for all primary care directs the clinical staff and serves as the continuing focal point for all needed health care services
- The services include all the elements, as appropriate, listed below under "What Are the APCM Billing Requirements?"
- Approximately $15 per patient per month

G0557

	•The patient has 2 or more chronic conditions. These conditions must: • Be expected to last at least 12 months or until the death of the patient • Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline •The services include all the requirements for code G0556 •Approximately $50 per patient per month

G0558

- The patient is a Qualified Medicare Beneficiary with 2 or more chronic conditions. These conditions must:
  - Be expected to last at least 12 months or until the death of the patient
  - Place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- The services include all the requirements for code G0556
- Approximately $110 per patient per month

Qualified Medicare Beneficiary (QMB)

- If you are a provider or billing office, you can verify the QMB status through:
  - HIPPA Eligibility Transaction System (HETS) or your practice management software.

Medicare Administrative Contractor (MAC)- Look for QMB status in the eligibility response.

State Medicaid System

- Since QMB is administered by state Medicaid programs, a patient enrolled in QMB will also have Medicaid coverage.
- You can check with the state Medicaid provider portal to verify dual eligibility (Medicare + Medicaid).
- In some states, the Medicaid ID card or system will show “QMB” explicitly.

Maximizing Billing Codes 99490 and 99439

- Understand CPT 99490 requires 20+ minutes of care management.
- Ensure proper documentation for all non-face-to-face services.
- Track additional time spent to maximize CPT 99439.
- Conduct monthly audits to identify missed billing opportunities.
- Train staff on billing practices for effective service capture.

Strategies to Address Missed Billing

- Conduct regular training sessions for staff on billing practices.
- Utilize EHR templates to streamline documentation processes.
- Implement alerts for identifying eligible patients for billing.
- Monitor time tracking to ensure compliance with billing codes.
- Perform monthly audits to discover missed revenue opportunities.

3. Identifying and Addressing Missed Billing

- Common misses: inadequate time tracking, incomplete documentation
- Ensure consent and eligibility are documented
- Use EHR templates and alerts to flag eligible patients
- Train staff to capture non-face-to-face services
- Monthly audits to track compliance and missed revenue

4. Managing CCM Co-Pays and Patient Participation

- Educate patients on long-term value of CCM
- Offer sliding fee scales or charity care if eligible
- Consider waivers through financial hardship documentation
- Use plain language and visual aids to explain CCM
- Highlight improved outcomes and fewer ER visits

Impact of Billing Changes

- Review of billing practices is crucial for compliance.
- Monthly audits can identify missed opportunities.
- Staff training needed for effective service capture.

Building Trust for Better Outcomes

- Trust is foundational for effective patient-care manager relationships.
- Patients who trust their care managers are more likely to comply with treatment.
- Open communication fosters a supportive environment for patients.
- Trust enhances patient engagement and satisfaction with care.
- Improved trust leads to better health outcomes and reduced hospital visits.

The Power of Teamwork in CCM

- Collaboration enhances the effectiveness of chronic care management.
- All team members should be educated about CCM and co-pays.
- Clear communication fosters trust and understanding among staff.
- Regular training sessions can keep everyone updated on procedures.
- Understanding co-pay structures improves patient interactions and satisfaction.

Thank you!

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