HealthTech

Care Coordination:
How to use Principal Care Management in your Practice

April 21, 2022

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Director of Care Coordination and Lean Consulting

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People + Process + Technology = Results

Governance & Strategy

- Executive management & leadership development
- Community Health Needs Assessment (CHNA)
- LEAN culture

Finance

- Performance optimization & margin improvement
- Revenue Cycle & Business Office improvement
- AR outsourcing
- Optimum Financial Performance Package

Recruitment

- Executive and Interim recruitment
- CEOs, CFOs, CNOs
- VP and Department Directors

Clinical Care & Operations

- Continuous survey readiness
- Care Coordination
- Swing Bed consulting

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Financial performance technology platform

Optimum Financial Statements
Financial statement, budgeting & benchmarking package

Optimum Productivity
Productivity measurement & monitoring platform

Optimum Supply Chain
Productivity measurement & monitoring platform

Optimum BI
Basic business intelligence package focused on operations, volume & payment rate analytics

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Interim executive recruitment

It's more than just a placement!

Experience:

- More than 50 years of supporting executives & teams in hospitals and healthcare companies of all sizes

The right executive:

- Our experiences and understanding of your healthcare organizations is the key to placing the right executive

Support services:

- Our business is managing hospitals more efficiently. We provide comprehensive support services to all interim executives, including a peer network

Immediate response:

- Interim needs are typically immediate. Our bench strength allows us to find the right executive quickly to provide a seamless transition

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Instructions for Today's Webinar

- You may type a question in the text box if you have a question during the presentation
- We will try to cover all your questions – if we don't get to them during the webinar, we will follow-up with you by e-mail
- You may also send questions after the webinar to our team (contact information is included at the end of the presentation)
- The webinar will be recorded, and the recording will be available on the HealthTech web site: www.health-tech.us

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Presenter

Faith Jones is the Director of Care Coordination and Lean Consulting for HealthTech. She currently implements care coordination programs for the Medicare population 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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Objectives

Upon completion of the webinar, the participant will understand:

1. The elements of principal care management
2. The use case for using principal care management vs chronic care management
3. The reimbursement potential for principal care management.

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Care Coordination

Growth and Development

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Elements of Principal Care Management

PCM

Service Components

- Qualified EMR
- Availability of electronic communication with patient and care giver
- Collaboration and electronically communication with community resources & referrals
- After hours coverage
- Care Plan Access
- Billing Provider has general supervision of clinical staff

Patient Eligibility

- Medicare Patient (other Insurances)
- One serious chronic conditions or high-risk disease expected to last between 3 months and a year or until the death of the patient
- Condition may have led to a recent hospitalization or places patient at significant risk of death, acute exacerbation, decompensation, or functional decline without management
- Patient Consent
- PCM initiated by the provider
- Time tracking of at least 30 min per calendar month

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Original Intent of PCM

Specialty Practices

Vol. 84, No. 221/Friday, November 15, 2019/Rules and Regulations p.62692

"Although we did not propose any restrictions on the specialties that could bill for PCM, we expect that most of these services will be billed by specialists who are focused on managing patients with a single complex chronic condition requiring substantial care management."

"We anticipate that in the majority of instances, PCM services will be billed when a single condition is of such complexity that it cannot be managed as effectively in the primary care setting, and instead requires management by another, more specialized, practitioner."

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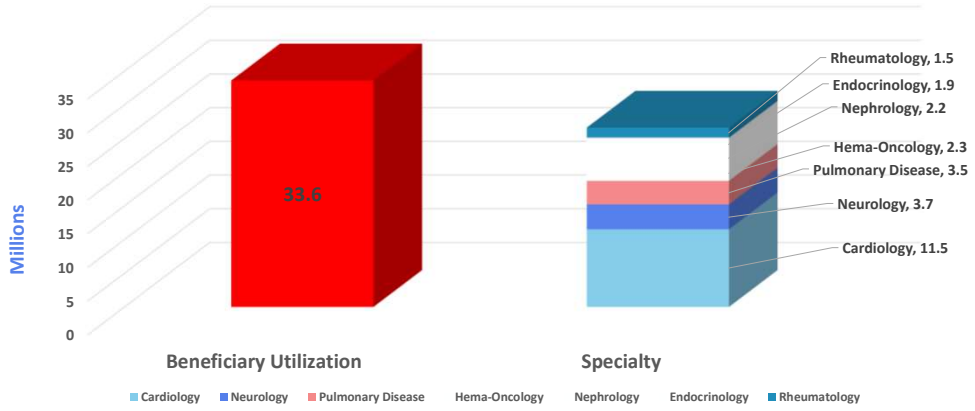
Medicare Utilization

2018 Data



SOURCE: Centers for Medicare & Medicaid Services, Office of Enterprise Data and Analytics, CMS Chronic Conditions Data Warehouse

2022 Definition for PCM

Required Elements for PCM

Vol. 86, No. 221/Friday, November 19, 2021/Rules and Regulations p.65278

"One complex chronic condition expected to last at least 3 months, and which places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death;

- the condition requires development, monitoring, or revision of disease specific care plan;
- the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities;
- ongoing communication and care coordination between relevant practitioners furnishing care; "

Is PCM Just for Specialists?

Are Primary Care Practices excluded from using PCM in Primary Care?

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Elements of Chronic Care Management

CCM

Practice Eligibility

- Qualified EMR
- Availability of electronic communication with patient and care giver
- Collaboration and electronically communication with community resources & referrals
- After hours coverage
- Care Plan Access
- Primary Care Provider general supervision of clinical staff

Patient Eligibility

- Medicare Patient (other Insurances)
- 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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PCM in Primary Care

Under the Right Circumstances

One serious chronic conditions

or

high-risk disease expected to last between 3 months and a year or until the death of the patient

Condition may have led to a recent hospitalization or places patient at significant risk of hospitalization, death, acute exacerbation, decompensation, or functional decline without management

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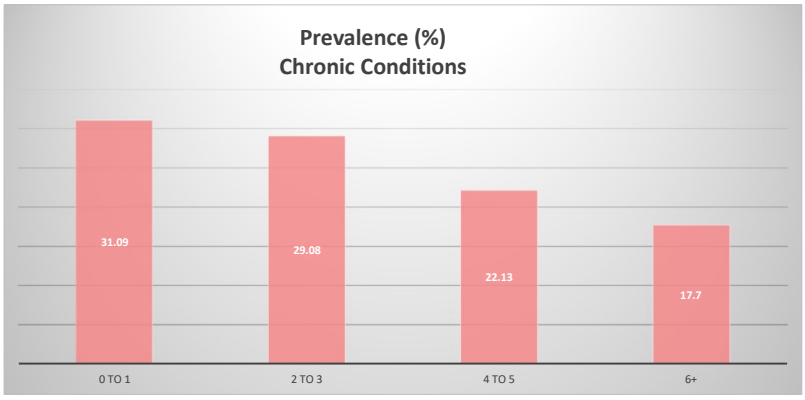
CCM or PCM

Percent of Beneficiaries – 2018 data

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CCDashboard



2 or More = 68.91%

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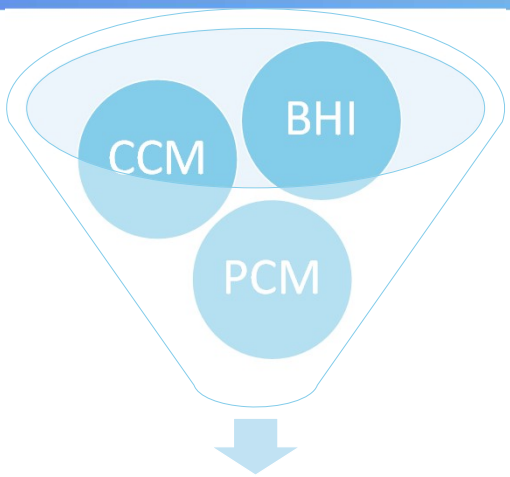
Rural Health & Federally Qualified Health Clinics

General Care Management



Care Management

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2022 Fee Schedule – RHCs/ FQHCs

Care Management

Care Management (CCM – BHI - PCM)

Billed per calendar month for 20 plus minutes of care coordination

CPT Code	G0511	National Average Reimbursement	$79.25

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2022 Fee Schedule – Fee for Service

Principal Care Management (PCM)

Principal Care Management

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

CPT Code 99426 National Average Reimbursement $63.33

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

CPT Code 99427 National Average Reimbursement $48.45

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2022 Fee Schedule – Fee for Service

Chronic Care Management (CCM)

Chronic Care Management and Complex Chronic Care Management

Billed per calendar month for 20 min of care coordination

CPT Code 99490 National Average Reimbursement $64.02

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

CPT Code 99439 National Average Reimbursement $48.45

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

CPT Code 99487 National Average Reimbursement $134.27

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

CPT Code 99489 National Average Reimbursement $70.60

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Combinations of Care Management

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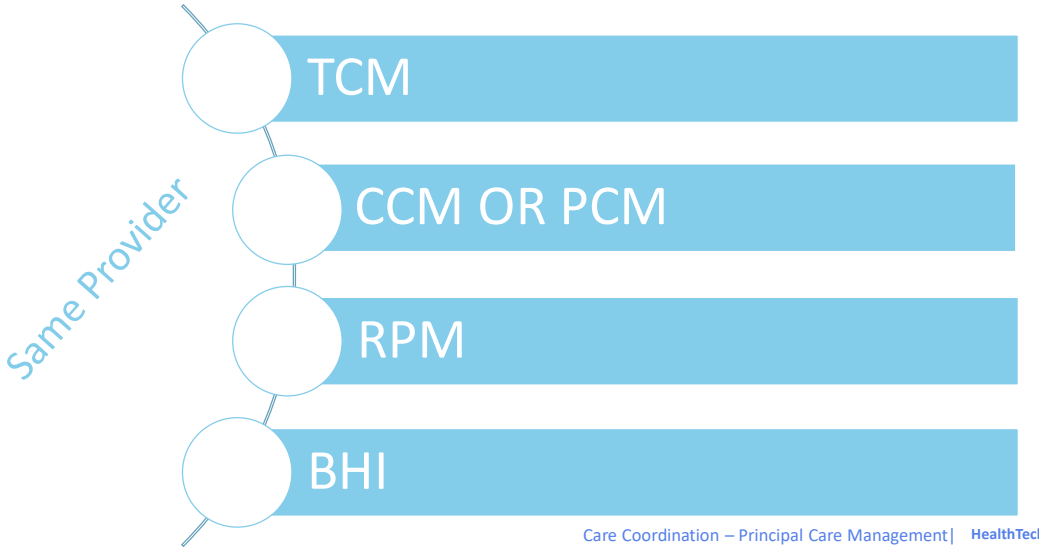
In a Fee For Service Clinic



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Questions?

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2022 Quarter 2 webinars

All webinars are recorded for on-demand viewing.

Care Coordination: How to use Principal Care Management in your practice

Presenter: Faith Jones, MSN, RN, NEA-BC – Dir. Care Coordination & Lean Consulting, HTS3
Date: April 21, 2022 | **Time:** 12pm CST
URL: https://bit.ly/3uDqcou

Strategies for reducing readmissions to Swing Bed

Presenter: Carolyn St.Charles, RN, BSN, MBA – Chief Clinical Officer, HTS3
Date: May 12, 2022 | **Time:** 12pm CST
URL: https://bit.ly/3DvvqH4

Practical benefits of implementing a hospital business intelligence platform

Presenter: Derek Morkel – CEO, GAFFEY Healthcare & HTS3
Date: May 13, 2022 | **Time:** 12pm CST
URL: https://bit.ly/3wU7dsl

Swing Bed: Evolution to compliance

Presenter: Cheri Benander, RN, MSN, CHC, C-NHCE
Date: June 10, 2022 | **Time:** 12pm CST
URL: https://bit.ly/3IWSZto

Care planning for Care Management services: Using a patient centered model

Presenter: Faith Jones, MSN, RN, NEA-BC – Dir. Care Coordination & Lean Consulting, HTS3
Date: June 16, 2022 | **Time:** 12pm CST
URL: https://bit.ly/3DsxEqn

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Online Certificate Courses Offered

Care Coordination and Lean

All provide Continuing Education Credit
Check out website: https://www.health-tech.us/certificate-courses/

Current listing:

- Care Coordination Fundamentals Self-Paced Certificate Course
- Annual Wellness Visit Self-Paced Certificate Course
- Advance Care Planning Self-Paced Certificate Course
- Behavioral Health Integration: What a Care Coordinator Should Know Self-Paced Certificate Course
- Lean Practitioner Self-Paced Certificate Course

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If you are interested learning how we can assist you with ----, please contact me.

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Thank you.

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