HealthTech

Care Coordination:

Empowering the Present, Shaping the Future

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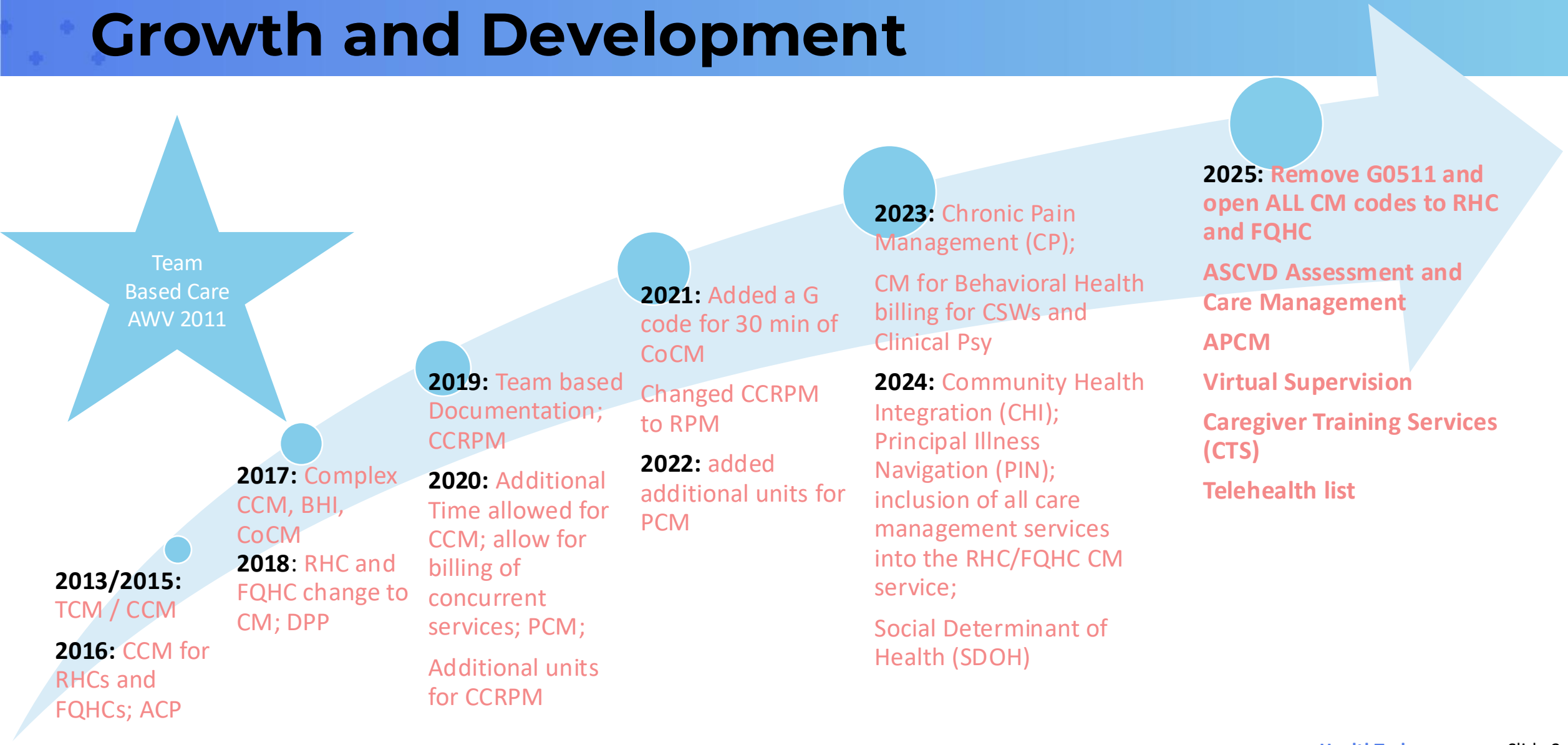
Marcella's nursing career has spanned over 30 years and includes consulting, acute care, home health, mental health, renal health, and academia. Marcella has a lifelong passion to provide whole person care, and the coordination of chronic illness. Her leadership roles have included clinical director, lead positions, and executive teams. Her knowledge and experience span various settings including nursing school classroom, clinical instructor, outpatient care, outpatient hemodialysis, hospitals, correctional, and home care. She has been a certified mental health nurse and a certified nephrology nurse, has been member of the American Nurses Association, American Nephrology Nurses Association, and the American Academy of Ambulatory Care Nurses. Marcella has a passion for community and population involvement and has dedicated hours to youth sports, agriculture, leadership, and church youth groups.

Care Coordination
Growth and Development



Care Delivery Models
The Mission

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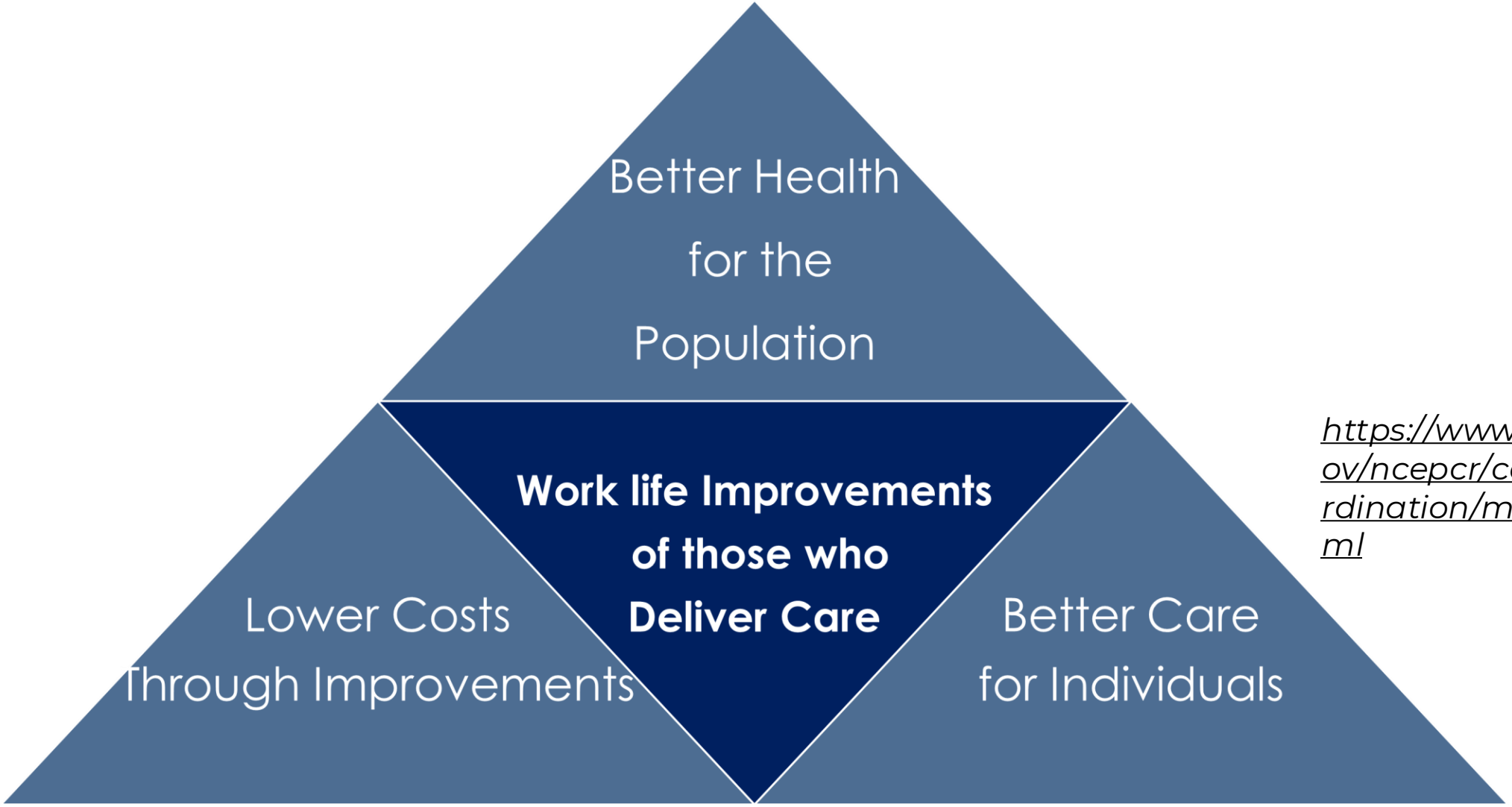
"...**new** and **evolving care delivery models**, which feature an increased role for non-physician practitioners (often as **care coordination facilitators** or in **team-based care**) have been shown to improve patient outcomes while reducing costs, both of which are important Department goals as 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."

Care Management Defined
Wellness and Prevention



https://www.ahrq.gov/ncepcr/care/coordination/mgmt.html

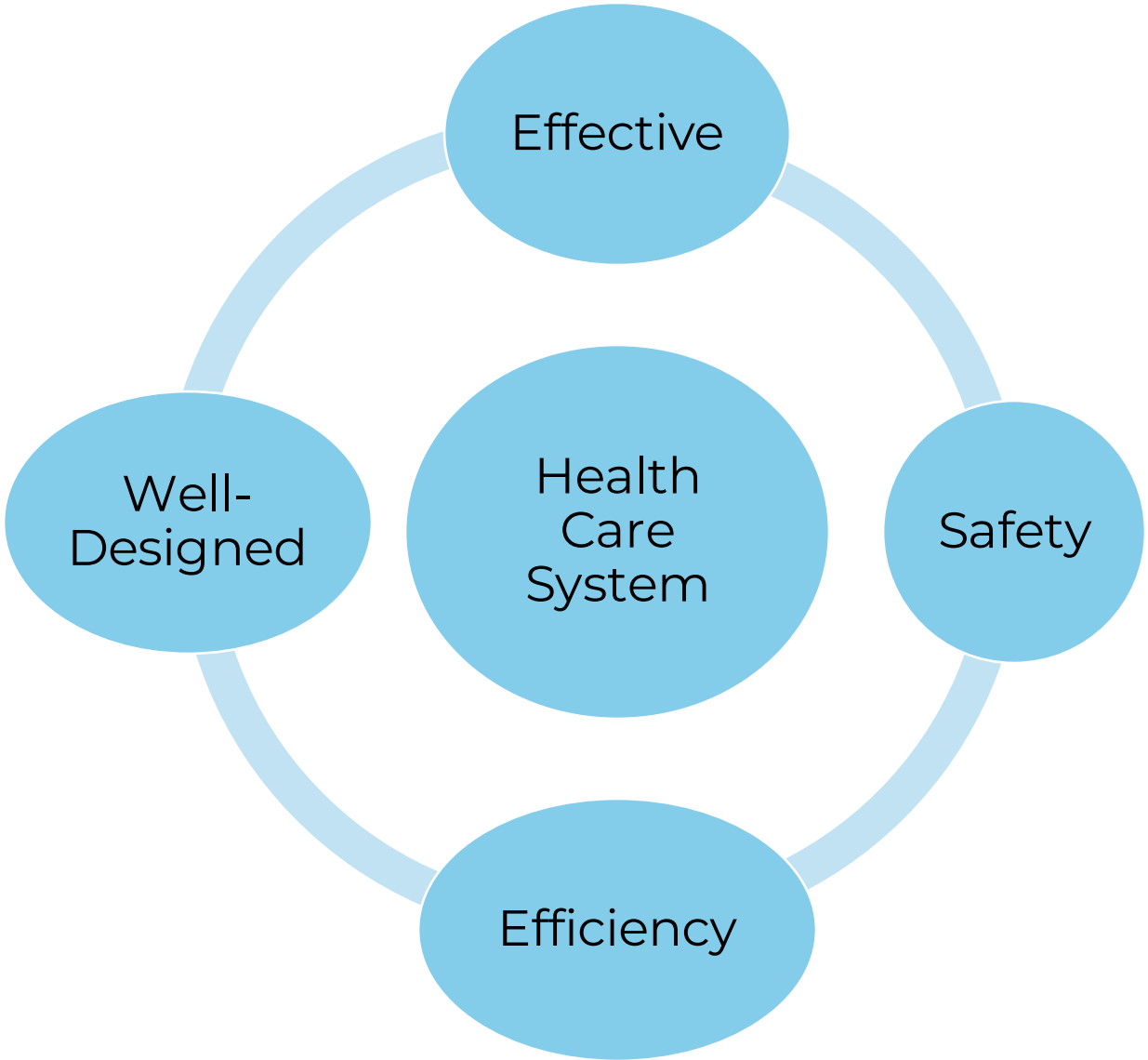
Care Coordination

Deliberate Key Elements

https://www.ahrq.gov/ncepcr/research/care-coordination/index.html

Institute of Medicine

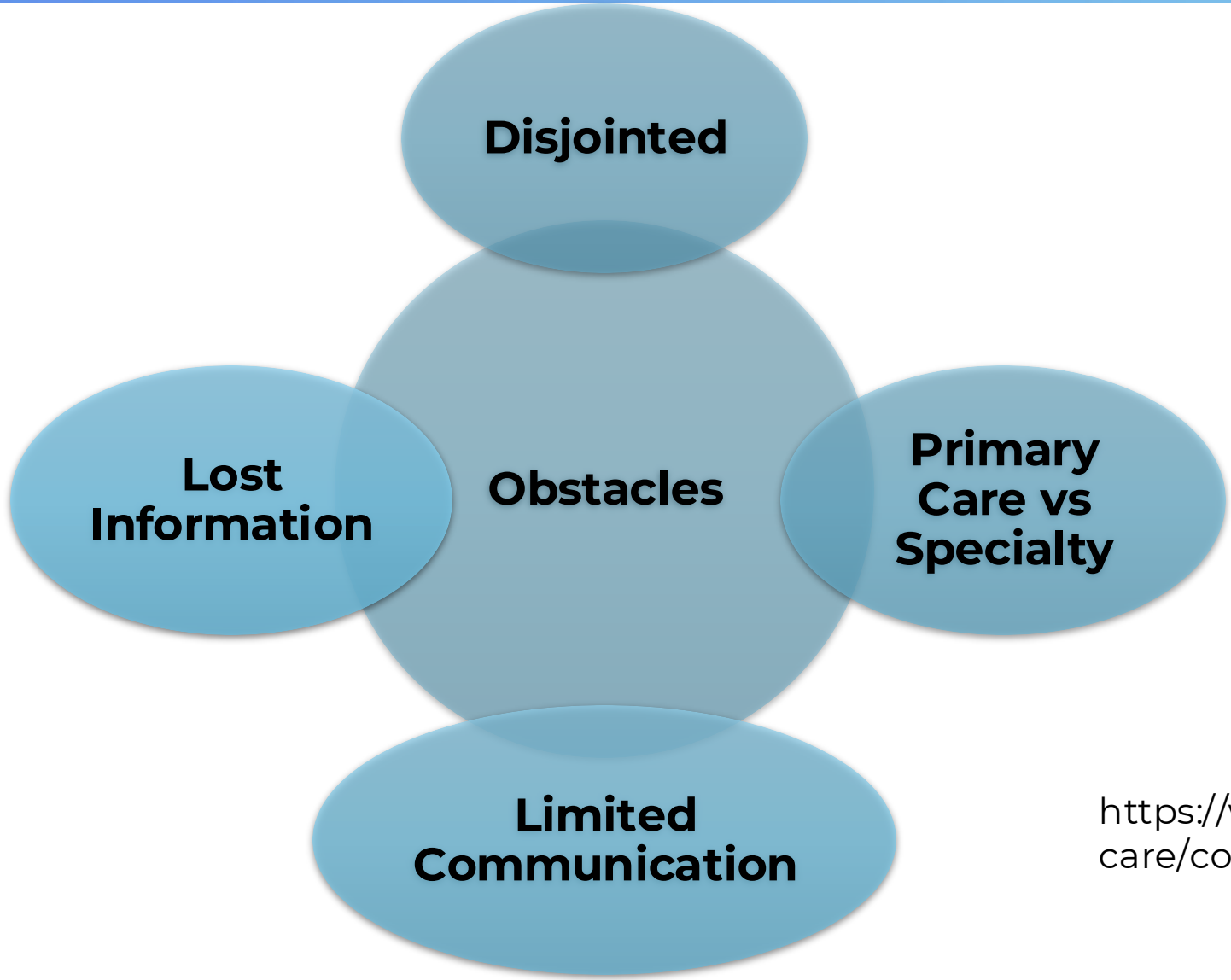
Key Strategy



https://www.ahrq.gov/ncepcr/care/coordination.html

Care Coordination

Potential Obstacles



https://www.ahrq.gov/ncepcr/care/coordination.html

Care Coordination Development

Terminology

- Collaboration
- Team-Based Care
- Disease Management
- Continuity of Care
- Chronic Care Model

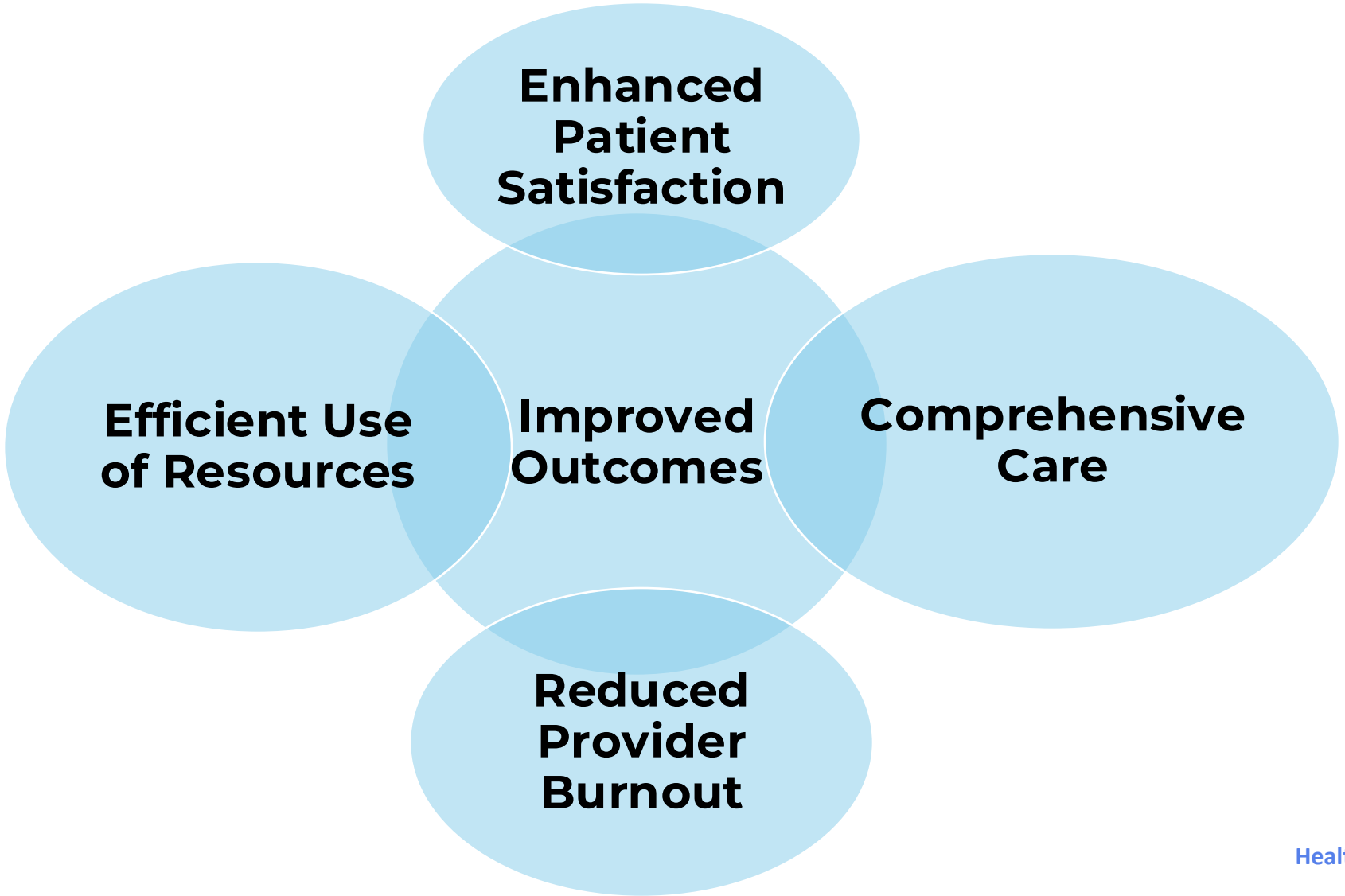
https://www.ncbi.nlm.nih.gov/books/NBK44012/

Team-Based Approach
The Patients' Team

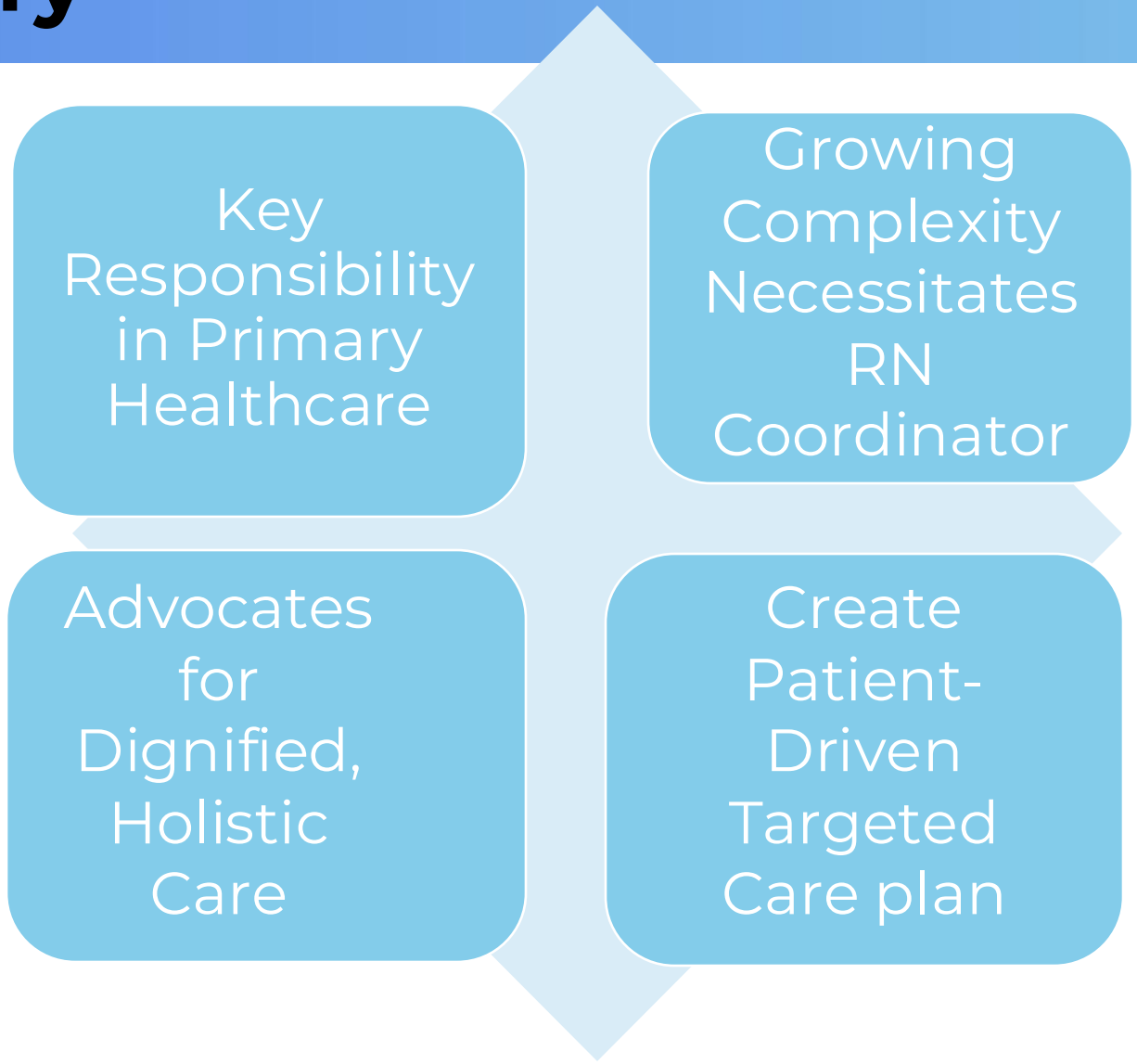
Multidisciplinary Team Composition			
Billing Providers (PCP, NP, PA) Specialists	Pharmacists, Social Workers, Dietitians	Specialists, Mental Health Professional	Care Coordinator

Team-Based Approach

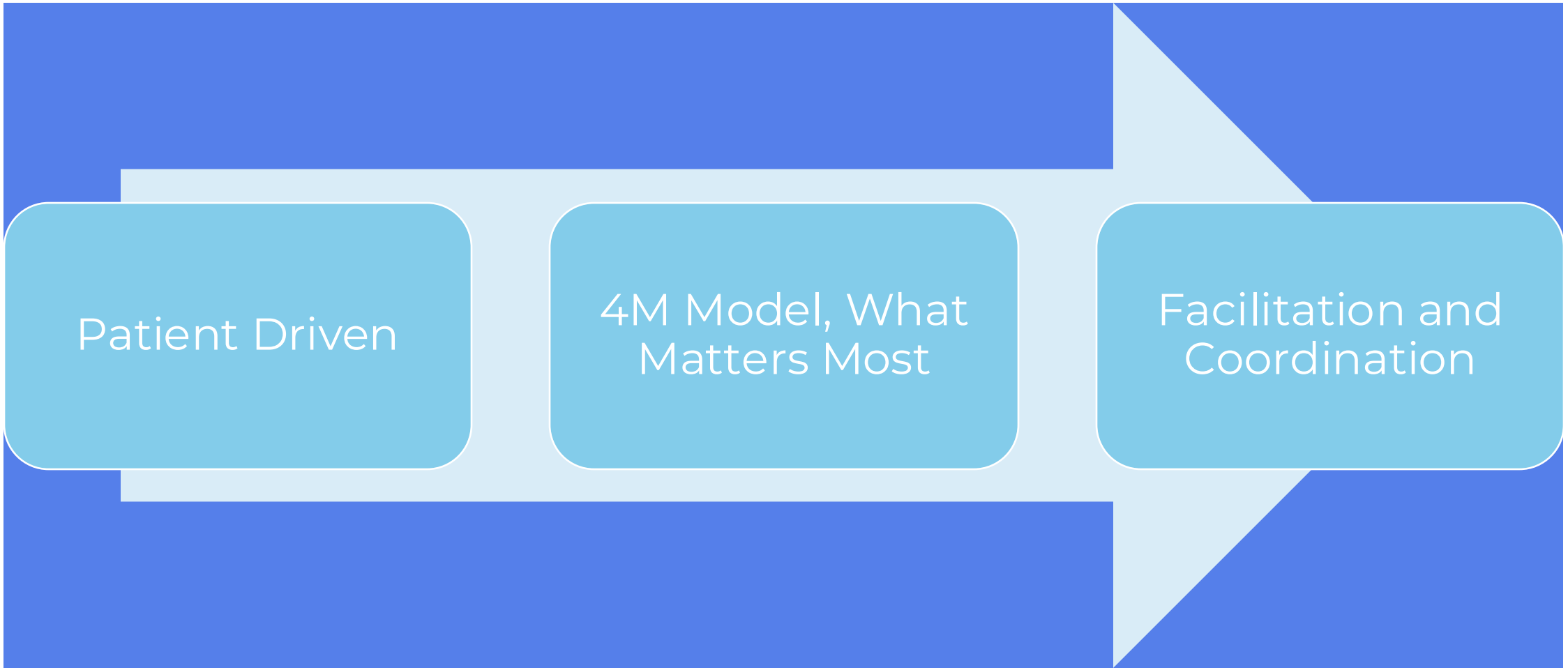
Holistic Management



Care Coordination
Care Delivery



Patient Specific Plan of Care



Care Coordination

Identifying Appropriate Patients

Regular Office Visit

Annual Wellness Visit (AWV)

Review EHR

Annual Wellness Visit
Introduced in 2011

Wellness Visit Goals

Health Promotion

Disease Prevention

Early Disease Detection

Coordination of Screening

Coordination of Preventive Services

Beneficiary Information
Annual Wellness Visit (AWV)

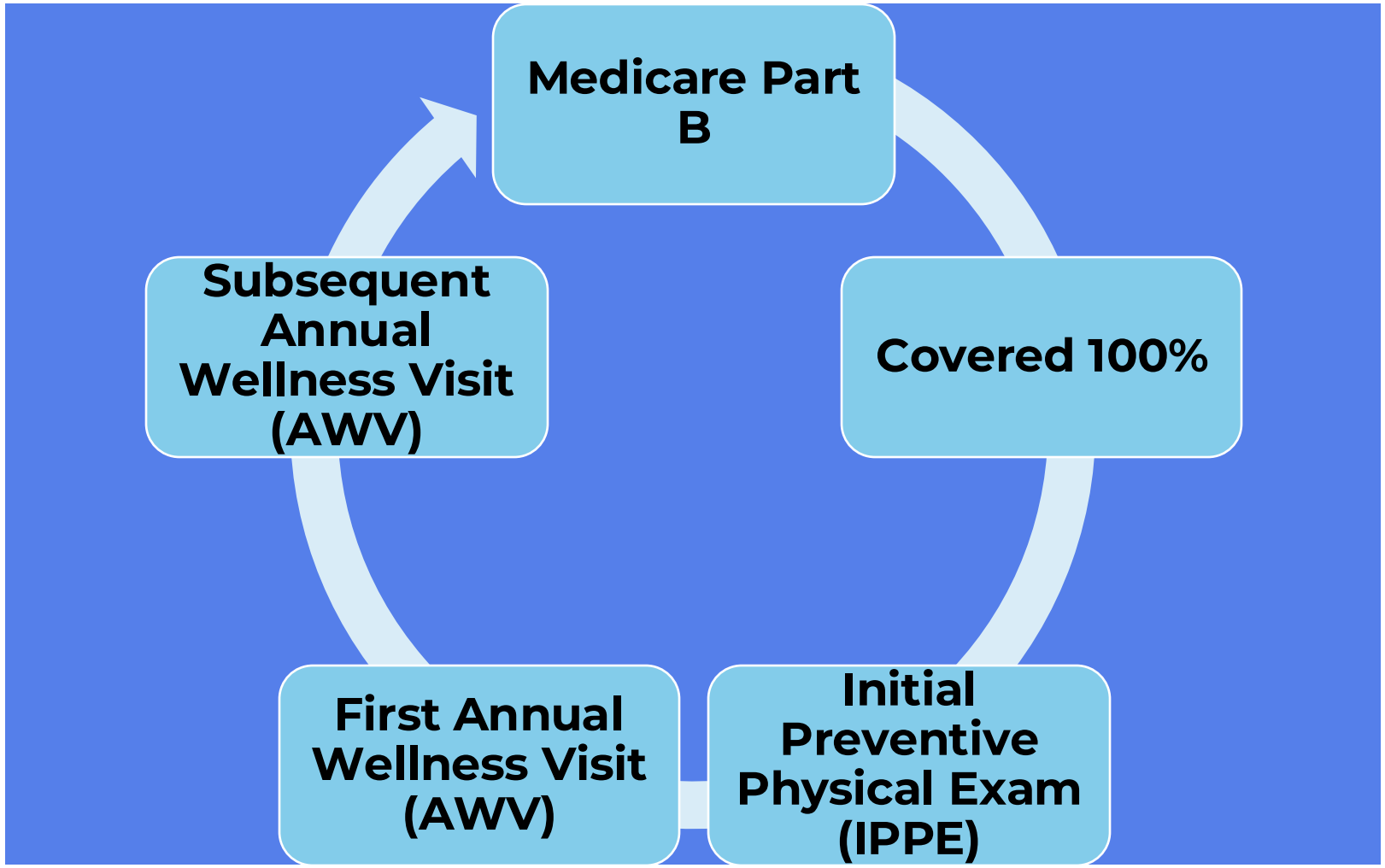
Preventive Visit

- **Prevent Disease or Disability, based Current Health and Risk Factors**
- **Yearly “Wellness” Visit is NOT a physical exam**
- **No Co-pay or Deductible for this Visit**

https://www.medicare.gov/coverage/yearly-wellness-visits

AWV Medicare Part B

3 Codes to Consider



https://www.medicare.gov/coverage/welcome-to-medicare-preventive-visit

ABC's of the AWV
Required Elements

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Personalized Plan of Care

What's Next?

Completed Assessments and Screenings

Reviewed any Specialist Reports

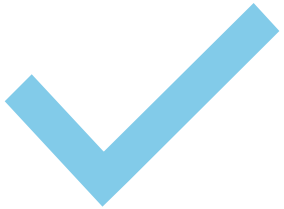
Reviewed Suppliers and Providers

Preventive Plan of Care

The 3 Key Components

1. Establish Written Screening Schedule

Take Home Copy



2. Identify Risk Factors and Conditions

With Interventions

3. Personalized Health Advice and Referrals

Promote Self Management

IPPE and AWV Reimbursements

IPPE- Within 12 months of Part B Coverage

CPT G0402 RVU 2.6	Allowable ~$160.76 (AIR)

AWV- Initial AWV, After First 12 months of Part B

CPT G0438 RVU 2.6	Allowable ~$160.44 (AIR)

AWV- Subsequent Years

CPT G0439 RVU 1.92	Allowable ~$126.47 (AIR)

Chronic Care Management (CCM)

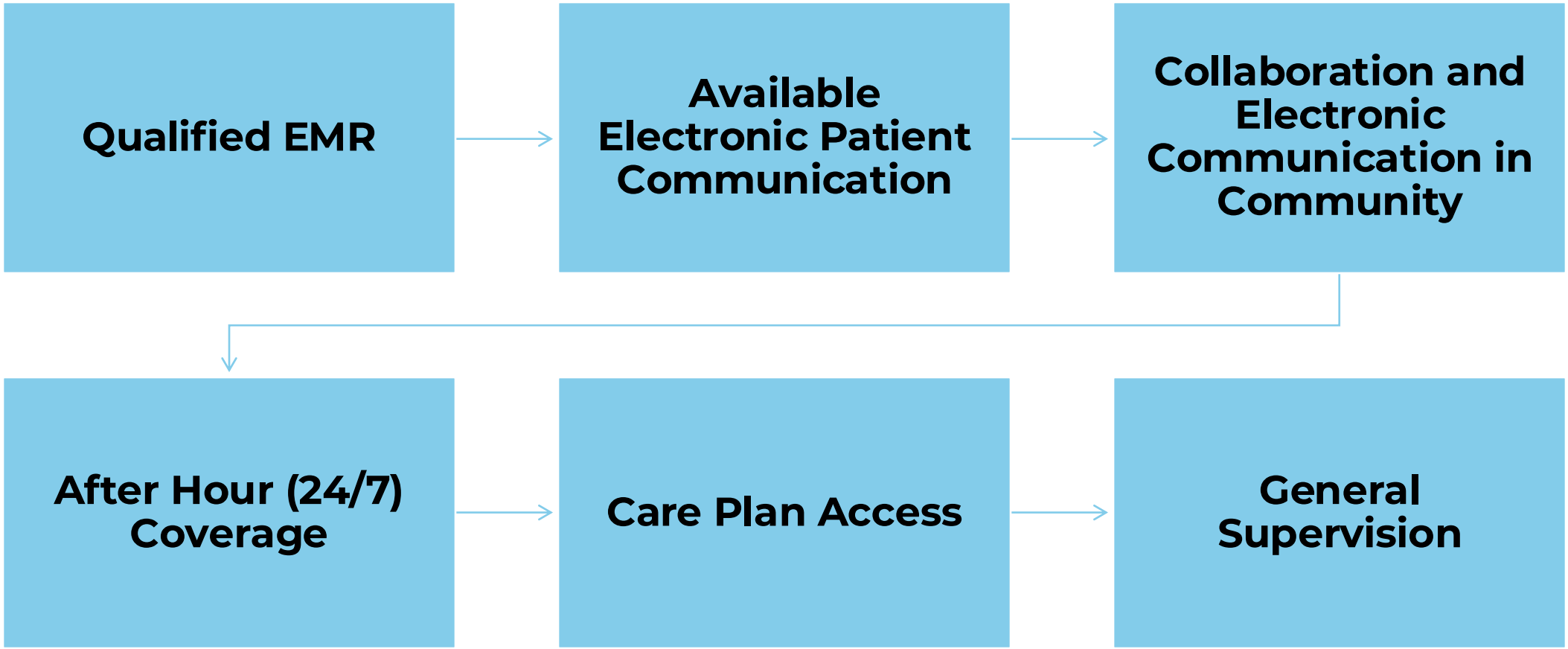
Primary Care

- Critical Component
- Allows Reimbursement for Time Outside Appointment
- Manage Traditional Medicare Patients' Health

https://www.ruralhealthinfo.org/care-management/chronic-care-management

Chronic Care Management (CCM)

Practice Eligibility



Supervision
General, CCM Requirement

CPT Codes 99487, 99489, 99490, 99439

Provider Does Not Personally Provide Service

Overall Direction and Control

Not Required Physically Present During Service

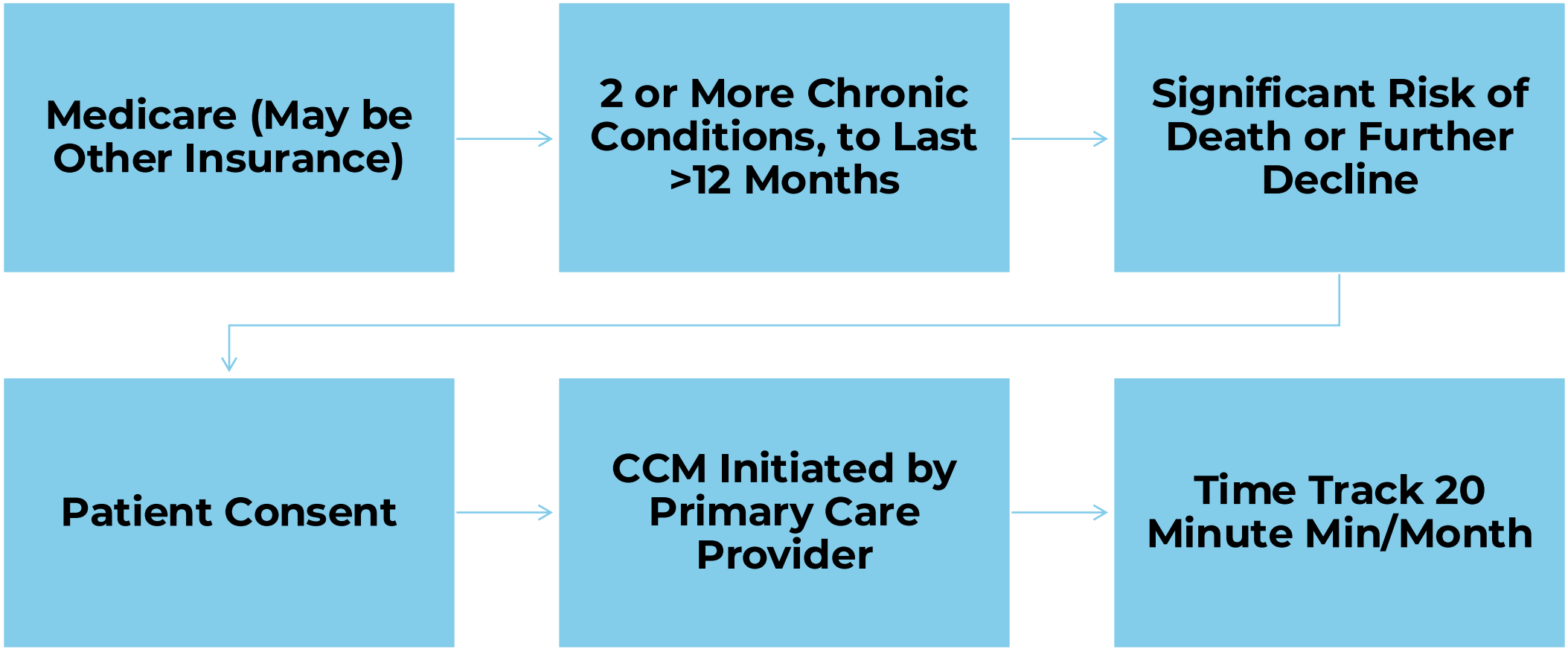
Direct Supervision

In Office Suite and Immediately Available

- Required for AWV at RHC
- Provider Must be Present in Office Suite
- Available to Furnish Assistance or Direction prn
- Does NOT Mean Present in Room

Chronic Care Management (CCM)

Patient Eligibility



Complex Chronic Care Management (CCCM)
RHCs and FQHCs are Eligible

All CCM Eligibility Requirements for Practice and Patient

60 Minutes Tracked Time/Month

Moderate or High Complexity

Medical Decision Making

2-Way Communication with Provider and Coordinator

CCM and CCCM Reimbursements

CCM- 20 Minutes/Calendar Month

CPT 99490 RVU 1.0 Allowable ~$60.49

CCM- Additional 20 Min/Calendar Month, Max of 2

CPT 99439 RVU 0.7 Allowable ~$45.93

CCCM- 60 Minutes/Calendar Month

CPT 99487 RVU 1.81 Allowable ~$131.65

CCCM- Additional 30 Min/Calendar Month, Max of 4

CPT 99489 RVU 1.0 Allowable ~$70.52

Types of Well-Being

Emotional –
Adapability
Resilience

Psychological –
Feeling good
Effective Functioning

Social –
Meaningful Communication
Supportive Relationships
Caring Network

What is Behavioral Health?
Layering Benefits of Care Coordination

Behavioral "health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act…

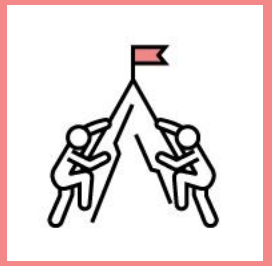
"It also helps determine how we handle stress, relate to others, and make healthy choices…

"Mental health is important at every stage of life, from childhood and adolescence through adulthood."

https://www.cdc.gov/mentalhealth/learn/index.htm

What is Behavioral Health Integration?

- Team-Based Approach to Care
- Direct Patient, Live or Virtual, Care
- Single Encounter, Monthly Service, or Both
- Time Tracked Care
- Addressing Specific Conditions



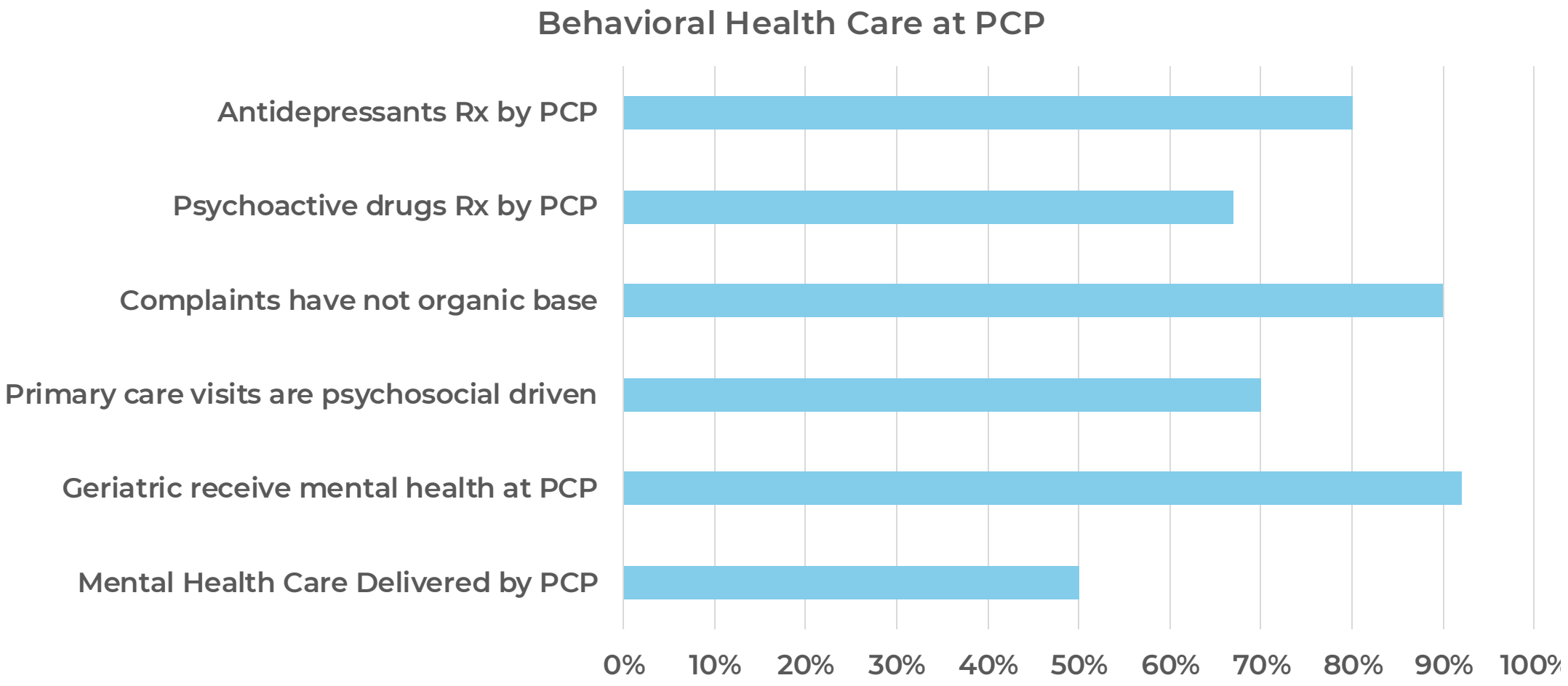
The Nurses Role in BHI

Utilized The Highest Level of Education

…"in care coordination, it is up to RNs to step up and draw attention to the integral part they play in improving patient care quality, satisfaction, and the effective and efficient use of healthcare resources."

https://www.nursingworld.org/practice-policy/health-policy/care-coordination/

Rationale for BHI in Care Coordination



https://www.thenationalcouncil.org/integrated-health-coe/

Eligible Conditions for BHI Coverage

- Any Mental, Behavioral Health, or Substance Use Disorder
- Psychiatric Conditions Treated by Billing Provider
- Billing Provider will Treat Member Chronic Conditions
- Condition Either New or Pre-existing
- Anxiety, Depression, and Substance Abuse

Behavioral Health Integration (BHI)

The More You Know

Care Coordination

Eligibility

Chronic Care Management

Medicare and other insurance

2 chronic conditions identified by primary provider

Patient consent, provider initiated

Behavioral Health Integration

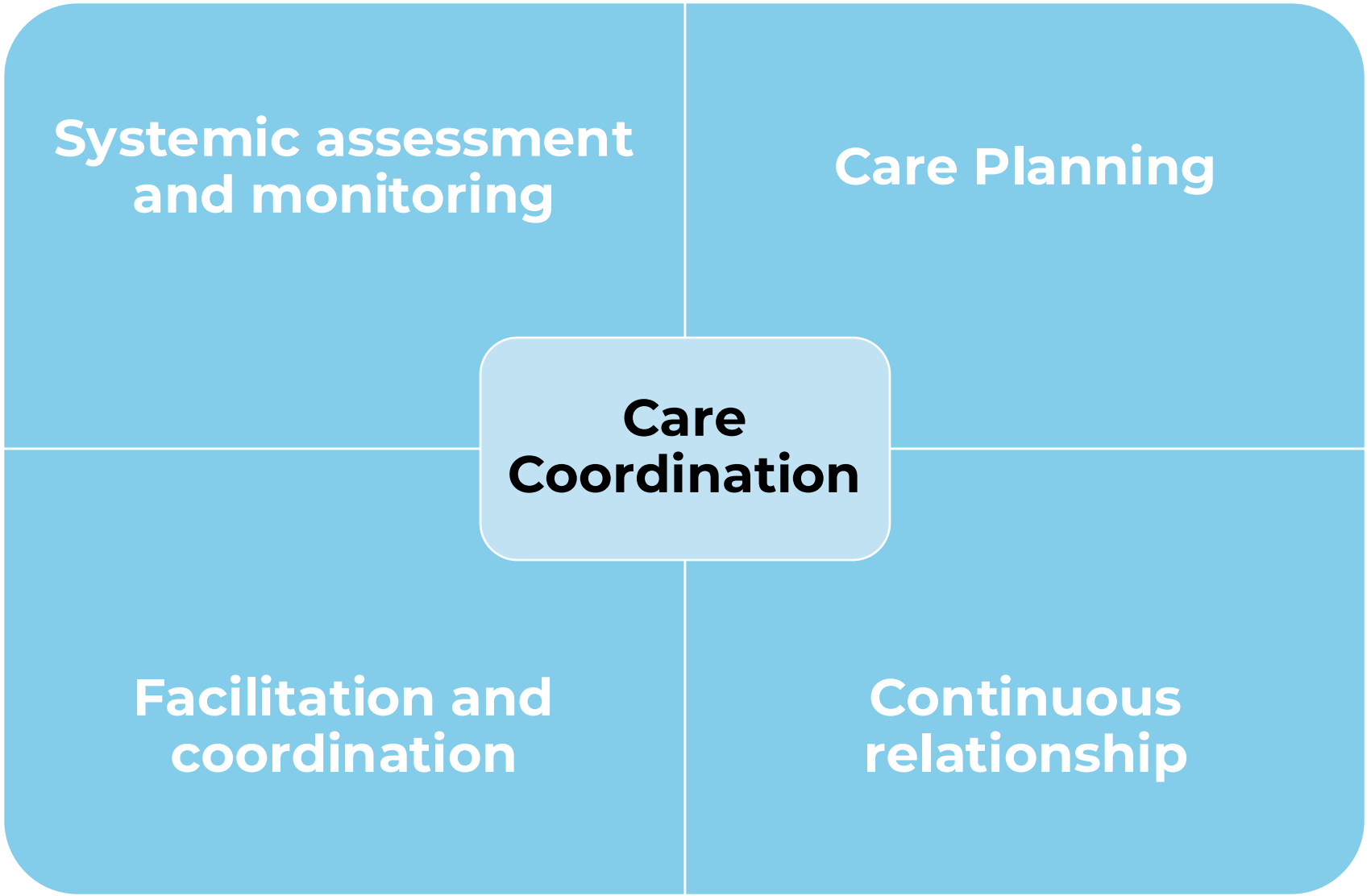
Medicare and other insurance

1 or more Behavioral Health condition

Patient consent, provider initiated, rating scales

General BHI Service Components

Long-Term Relationship



BHI Initiating Visit

Within 12 Months of BHI Start

- Billing Provider assess and identify condition
- Separate billable visit
- Establishes client provider relationship
- Administration of validated rating scales
- Client educated on BHI program
- Systemic assessment and monitoring

Tracking Time in General BHI

Minimum of 20 Minutes/Calendar Month

- Under general supervision of billing provider
- Formally educated in BHI, may track time
- DO NOT track Clerical or administrative time
- Patient vital team member
- Joint care planning

Continuity of Care

Within the Team-Based Approach

- Designated member of care team
- Well suited for the Registered Nurse
- Best use to highest level of education
- Integrated team relationship

Why Care Coordination?
Multiple Benefits

- Improve Patient Health Outcomes
- Streamline Across Providers
- Prevent Fragmented Care
- Contain Healthcare Costs
- Decrease Medical Errors
- Ensure Patient Needs are Communicated

2025 Changes

Atherosclerotic Cardiovascular Disease Risk Assessment (ASCVD)

Risk Assessment

- Billed once per 12 months for the completion of an ASCVD risk assessment using a valid reliable risk assessment tool during an E/M visit by a provider
- CPT Code G0537 RVU 0.18 National Average Reimbursement ~$18.44

ASCVD Risk Estimator Plus

https://tools.acc.org/ascvd-risk-estimator-plus/#!/calculate/estimate/

HealthTech University

https://www.health-tech.us/healthtech-university-courses/

Questions?

Thank you.

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