CivicHealth CHRONIC CARE MANAGEMENT

The Need

- Half of all adults — 117 million people — have one or more chronic health conditions.
- One of four adults has two or more chronic health conditions, including one in 15 children.
- Among Americans aged 65 years and older, as many as three out of four persons have multiple chronic conditions (MCC).
- Approximately two out of three Medicare beneficiaries have MCC.
- People with MCC are also at increased risk for mortality and poorer day-to-day functioning.
- Approximately 66% of total healthcare spending is for people with MCC.

Improving Chronic Care Management

Recognizing that chronic care management (CCM) contributes to better health for individuals and reduces healthcare expenditures, CMS established CPT code 99490 in 2015 to help cover the costs of CCM, with a strong focus on MCC. Through CPT code 99490, healthcare providers can be reimbursed by CMS for providing CCM services to qualifying Medicare patients with two or more chronic conditions.

Potential Provider Revenue

The new CPT code allows reimbursement at an average of $40/month for CCM services. Based on national data, the revenue potential for a single provider billing for CPT code 99490 is an additional $251,000. This amount increases with the number of providers per physician group.

	Average
Annual number of unique patients	3,279
% patients covered by Medicare	21.85%
Annual number of unique Medicare patients	716
Medicare patients with 2+ chronic conditions	68.6%
Annual number of unique CCM patients	491
CCM monthly payment	$42.60
Estimated gross revenue for family medicine physician	**$251,000**

Streamlining CCM Services with CivicHealth

While physicians may embrace the ability to receive reimbursement for time spent managing their highest risk patients, qualifying for the monthly payments requires demonstration and proof of non-face-to-face services.

CivicHealth's innovative software solution links with your EHR to capture and document the care management services you deliver. From the development of a comprehensive care plan to coordination and collaboration with other healthcare providers, CivicHealth's solution supports and streamlines each step, each month.

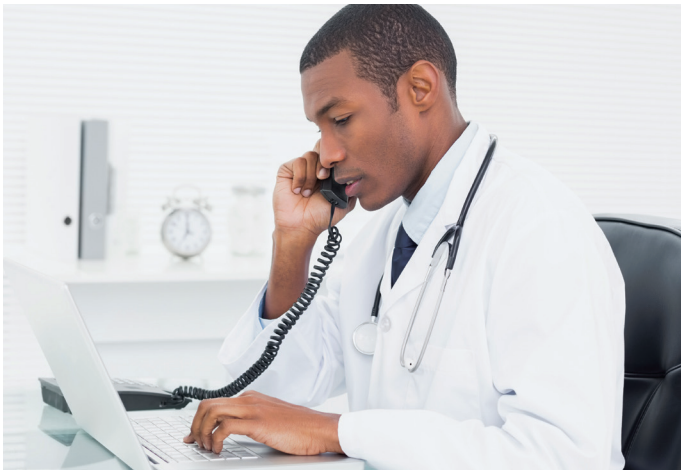
CivicHealth has more than a decade of experience in providing **innovative solutions to help healthcare providers address the management of chronic care patients.** These solutions go beyond the capabilities of EHRs to support coordination with community services, interoperability, referrals and patient engagement and compliance.

Qualifying for CCM Reimbursement

Chronic care management, as required by CMS to bill for CPT code 99490, involves providing non-face-to-face services for at least 20 minutes to each beneficiary once a month. These services must be performed by a physician or other qualified healthcare professionals.

Qualifying patients must have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation or functional decline.

Access to care is a key requirement. Providers must "ensure 24-hour-a-day, 7 day-a-week access to care management services," and patients must have "a means to make timely contact with health care practitioners in the practice who have access to the patient's health record to address his or her chronic care needs." An answering machine does not meet this requirement. Additionally, the patient must have continuity of care, with the ability to get successive routine appointments with a designated practitioner or care team member.



A comprehensive health plan is another important component, and typically includes problem list; expected outcome and prognosis; measurable treatment goals; symptom management; planned interventions; and identification of the individuals responsible for each intervention. The plan also would include medication management; community/social services ordered; a description of how services of agencies and specialists outside the practice will be directed/coordinated; schedule for periodic review; and, when applicable, revision of the care plan.

Not only does CivicHealth's software solution assist care providers with the development and execution of a care plan, but it also supports other requirements, including:

- Monitoring beneficiary's condition
- Ensuring beneficiary receipt of preventive care services
- Reconciliation of medications
- Oversight of beneficiary self-management of medications
- Follow up after ER visits
- Coordinating transitions of care
- Documenting time as either total time or start/stop times