CAROLINA FAMILY HEALTH CENTERS, INC.
PROCEDURE

TITLE: CLN-600.02 Care Management Services for Medicare Patients

EFFECTIVE DATE: 10/15/2019

SECTION: Clinical
REFERENCE POLICY: CLN-600 Care Management and Support

RESPONSIBLE CHIEF OF STAFF: Chief Medical Officer
RESPONSIBLE COMMITTEE: Medical CIT

REVIEWED: 04/02/2024, 03/04/2025

I. PURPOSE

The purpose of this procedure is to outline the process of providing Care Management (CM) services to Medicare beneficiaries.

II. PROCEDURE

The Centers for Medicare and Medicaid Services (CMS) recognizes CM services as a critical component of primary care that contributes to better health and care for individuals. To be eligible for CM under Medicare, patients must have at least one chronic condition expected to last at least 12 months or until the death of the patient. These conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular disease
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS
- Obesity

For new patients or patients not seen within one year before the commencement of CM, Medicare requires initiation of CM services during a face-to-face visit with the billing

practitioner (i.e., an Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE), or other face-to-face visits with the billing practitioner).

Care Management Services

The CM service is extensive, including the recording of patient health information, maintaining a comprehensive electronic care plan, managing transitions of care and other care management services, and coordinating and sharing patient health information promptly within and outside the practice. CCM services are typically provided outside of face-to-face patient visits, and focus on characteristics of advanced primary care such as a continuous relationship with a designated member of the care team; patient support for chronic diseases to achieve health goals; 24/7 patient access to care and health information; receipt of preventive care; patient and caregiver engagement; and timely sharing and use of health information.

Care Management Services Summary

Initiating Visit – Initiation during an AWV, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of CM services.
Structured Recording of Patient Information Using Certified EHR Technology – CFHC, Inc. uses the structured recording of demographics, problems, medications, and medication allergies using certified EHR technology. A full list of problems, medications, and medication allergies in the electronic health record inform the care plan, care coordination, and ongoing clinical care.
24/7 Access & Continuity of Care ● CFHC, Inc. provides 24/7 access to a medical and/or dental provider to address urgent needs regardless of the time of day or day of the week. ● CFHC, Inc. ensures continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
Comprehensive Care Management – Care management for chronic conditions including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
Comprehensive Care Plan ● Medical providers create, revise, and/or monitor the electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed. ● Electronically captures the care plan information and makes this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the patient's care. ● A copy of the plan of care is given to the patient and/or caregiver.

Management of Care Transitions ● CFHC, Inc. manages care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities. ● CFHC, Inc. creates and exchanges/transmits continuity of care document(s) timely with other practitioners and providers.
Home- and Community-Based Care Coordination ● CFHC, Inc. coordinates with home- and community-based clinical service providers. ● Communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits are documented in the patient's medical record

Obtaining Consent for Care Management Services

CFHC, Inc. obtains patient consent before furnishing or billing CM. The consent and handout inform the patient about the availability of CM services and applicable cost sharing; that only one practitioner can furnish and be paid for CM services during a calendar month; and his/her right to stop CM services at any time (effective at the end of the calendar month). The staff gives the patient the *Care Management* handout (see attachment) for information on CM. Informed patient consent need only be obtained once before furnishing CM, or if the patient chooses to change the practitioner who will furnish and bill CM services. The *Care Management Consent* is available to staff on Carolina Family Health Centers, Inc.'s intranet. The following process is followed when obtaining consent. Consent can also be done verbally, the staff documents the verbal consent on the *Care Management Consent* form, which is scanned in patients' medical records.

Front Office Associate (FOA) Responsibilities:

- At check-in, the FOA identifies Medicare patients who are eligible for CM. Medicare patients with Medicare coverage qualify.
- If the patient qualifies, the FOA provides the patient with the *Care Management Flyer* (see attachment) and *Care Management Consent* form. The sliding fee schedule applies to CM fees.
- The patient holds on to the consent until they are called to the clinical area, at which time the form is given to the CNA/CMA/Nurse.

CNA/CMA/Nurse Responsibilities:

- The clinical support staff discusses and encourages CM services with the patient. He/she checks the patient's Medicare plan to ensure he/she has Medicare coverage and verifies the patient has at least two chronic conditions.
- If the patient consents to CM services, he/she verifies that the patient has signed the CM consent form and notifies the medical provider.

- The support staff person gives the signed CM consent form to the Clinical Site Manager. He/she forwards this to the Population Health Manager-Medicare.
- If the patient declines CM services, he/she writes "Declined" on the consent form and gives the form to the Clinical Site Manager. He/she forwards this to the Population Health Manager- Medicare.

Population Health Manager-Medicare Responsibilities:

- The Population Health Manager-Medicare processes the CM consent forms:
    - He/she checks a patient's insurance status for Medicare coverage. Note: If the patient does not have Medicare coverage, then he/she does not process the CM consent. The patient does not qualify.
    - If a patient has both Medicare coverage **and** at least 1 chronic condition, the patient is enrolled in the Compass Rose CCM program, and the patient is assigned to a case manager.
    - The Manager assesses the patient for the most appropriate care management service, i.e., chronic care management (CCM) or advanced primary care management (APCM) and marks the chart appropriately. The Population Health Manager-Medicare initials the CM consent form and sends the consent form to medical records for scanning.
- For the declined consent forms, he/she activates the CCM refusal flag on the patient's chart and sends the form to medical records for scanning.

Case Managers' Responsibilities:

The assigned case manager reaches out to the patient to complete a comprehensive risk assessment and develop the care plan. Once the care plan is developed, the plan is sent to the patient, or the patient can access the care plan on the patient portal.

Documentation of Care Management Services

Documentation of the services provided (and time spent, if relevant) is documented in Compass Rose. Care Management services (CM) include case management and care coordination activities:

- Managing refill requests
- Completing medication or equipment prior authorizations outside of the patient visit.
- Chart review (e.g., after a transition of care, in preparation for an upcoming visit not performed on the date of the appointment, reviewing labs results, reviewing consults or other records)
- Phone education or instruction with the patient
- Coordination of referrals or linkage to community services
- Updating the care plan

The logging of CM minutes cannot occur until the patient has been seen by their PCP, the patient has consented to services, and a care plan is established with the patient.

Staff identify patients enrolled in CM services by viewing the storyboard in the electronic health record system, associates the encounter with the CCM program in Compass Rose, document their minutes, adds the diagnosis(es) to the encounter for which the care plan was created and signs the encounter.

For CCM, once the staff record an accumulative total of 20 minutes, the charge is dropped automatically in the electronic health record system. Billing for APCM codes is a manual process, and staff will have to place the appropriate code under the Level of Service (LOS) area to bill for services. Staff record all their time providing services, even if it extends beyond the minimum 20-minute mark, due to the opportunity to bill for additional time as allowed by CMS.

Care Management Services Summary

	Diagnosis	**Time Based**	**Staff Billing**	**Frequency of charge**
Chronic Care Management (CCM)	Two or more chronic conditions expected to last at least 12 months or until the death of the patient	20-minute increments required to bill (CPT 99490 or CPT 99439)	Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners, and Physician Assistants. CCM services are also provided by clinical support staff under the general supervision of the billing practitioner.	Once per month
Advanced Primary Care Management Services (APCM)	**Diagnosis**	**Time Based**	**Staff Billing**	**Frequency of charge**
G0556	The patient has 1 chronic condition. The condition 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	Not time based	Physician or non-physician practitioner (NPP), including a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS)	Once 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	Not time based	Physician or non-physician practitioner (NPP), including a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS)	Once Per month
G0558	The patient is a **Qualified Medicare Beneficiary** who 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	Not Time Based	Physician or non-physician practitioner (NPP), including a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS)	Once per month

*Auxiliary personnel can provide APCM services incident to the professional services of the provider who bills the initiating visit (if required) and associated APCM services. APCM is a designated care management service, and auxiliary personnel will work under general supervision.

III. ATTACHMENTS

- *Care Management* Handout (English/Spanish)
- *Care Management Consent* (English/Spanish)