ChronicCare

THE GUIDE

01 Services Provided

Chronic Care Management (CCM) & Remote Patient Monitoring (RPM)

- **PCM/CCM**: Provides patients with a personal Care Coordinator who will regularly check in with them to provide health and lifestyle support and assistance with medication management and care coordination.
- **TCM**: Supporting patients as they transition from one healthcare setting to another. Ensuring continuity and coordination to reduce hospital readmissions.
- **RPM**: Provides patients with a digital medical device to capture and monitor health data remotely.

02 How Does It Work

PCM, CCM, TCM, and RPM services are provided by ChronicCare's team.

- Patients engage through remote communication such as calls, emails, and texts.
- Monthly billing is based on cumulative time logged for all communication efforts (Calls, voicemails, texts, emails) and other program-related care/support/services (chart reviews, call prep, post-call documentation, and other educational information provided to the patient).
    - Dates of Service (DOS) correspond to the last date of the month that any program-related task was logged. DOS does NOT always correspond to the date of a phone call.

03 ChronicCare & the Virtual Care Team (VCT)

- ChronicCare is located in Dutchess County, NY, not far from New York City. Care Team members work remotely on behalf of the practice, under the general supervision of the practice's provider(s).
    - Care Coordinators: LPNs, MAs, RNs
    - Other Team Members: PharmDs, Dietitian, Patient Experience Team, and Quality Control Team
    - VCT is trained to follow any documented guidance listed in the patient's chart.
- ChronicCare has a Business Associate Agreement (BAA) with the practice, which allows VCT to access PHI securely. VCT follow the same HIPAA guidelines as the medical practice.

04 Patient Enrollment Process

- **Provider Initiates**: Providers can refer patients during an initiating visit. They can provide patients with ChronicCare Program flyers, and even contact ChronicCare to have our Care Coordinator reach out and explain the benefits of CCM.
- **VCT Outreach**: A Virtual Care Coordinator will follow up with patients via letter, email, text or phone call. ChronicCare reviews appointment reports in the last 12 months to help identify patients who potentially qualify for the program.

05 Patient Requirements for the Program

- Medicare or Medicare Advantage plan as primary insurance
- Dates of Service (DOS) with practice provider within the last 12 months
  - This only applies to the initial qualifying visit. Medicare does not require patients to "re-qualify" for CCM each year
- At least one chronic condition for patient to be eligible for Principal Care Management (PCM)
- At least 2+ or more chronic conditions that are expected to last at least 12 months or until the patient's death
- Have conditions that pose a significant risk of death, acute exacerbation, or functional decline
- Patient must provide verbal or signed informed consent to participate in the program

06 Provider Talking Points

- **Personalized Support**: This program offers personalized support tailored to your specific health needs.
- **Enhanced Communication**: You'll have regular access to a dedicated care coordinator who can answer your questions, concerns, and care
- **Improved Health Outcomes**: Studies show that participating in CCM can lead to better health outcomes, including less hospitalizations.
- **Education**: You'll receive educational materials and resources to help you understand your conditions better and learn to manage them effectively.
- **Proactive Monitoring**: We'll monitor your health more proactively, allowing us to catch any potential issues early before they become more serious.
- **Accountability**: Having a care coordinator means you'll have someone to help keep you accountable and motivated on your health journey.

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CPT Code	Type	Description
99424	PCM	30 minutes of service per calendar month
99425	PCM	Additional 30 minutes (use in conjunction with 99424, for 60-min encounters)
99490	CCM	20 minutes of service per calendar month
99439	CCM	Additional 20 minutes (in conjunction with 99490, for 40- and 60-min encounters)
99457	RPM	20 minutes of service per calendar month
99458	RPM	Additional 20 minutes (use in conjunction with 99457, for 40-min encounters)
99495	TCM	Post-discharge follow up for patients with low-complexity problems
99496	TCM	Post-discharge follow up for patients with high-complexity problems

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Billing Guidelines

- CMS guidelines for CCM services require a certain amount of clinical staff time directed by a physician or other qualified healthcare professional per calendar month.
  - This cumulative time can include various remote activities in addition to the phone call with the patient, such as care coordination, patient education, review of medical records, documentation, and other related virtual services and communication.
  - Medicare does not require the Care Coordinator to speak directly with the patient every single month in order to bill for CCM services.

- **For more Billing FAQs, please visit our Program Resources page.**

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Benefits to Your Patients

- **Your Own Personal Care Coordinator**: Monthly check-ins over the phone, as well as weekly texts and emails, which will provide:
  - Health and lifestyle support
  - Assistance with medication management
  - Assistance with coordination of doctor visits and appointment reminders
  - 24/7 emergency access
- **Comprehensive Care Plan**
  - Documentation of your health and lifestyle goals
  - More frequent communication and support in between office visits
  - Helpful resources and other educational information provided
  - Monthly review by your physician
- **Improved Quality of Life**
  - Healthier lifestyle
  - Weight loss
  - Possible reduction in needed medications
- **Long-Term Cost Savings**
  - Avoid more costly ER visits, hospital admissions, and higher level, more expensive care associated with worsening/prolonged health issues.

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Benefits to Your Practice

- Improved patient satisfaction
- Improved patient compliance with provider recommendations
- Reduced patient hospitalizations and emergency visits, including additional resources needed to care for high-risk, high-needs patients
- Improved clinician efficiency and reduced operational cost
- Increased physician revenue

11 Additional Practice Resources & Training

- For more information, including official CMS resources, program FAQs or other training resources, visit our Program Resources page.

12 Contact Info for Patients

- Please have patients call ChronicCare for the following:
  - New patients who are interested in learning more about the Chronic Care Program
  - Already enrolled patients who need to reach their Care Coordinators

13 The Patient App

- The Patient App is simple, HIPAA-compliant browser extension that allows providers and practice staff to have real-time visibility into the Chronic Care Program. The Patient App supports reading collected from connected Bluetooth and branded Cellular FDA devices, having secure chat and video conferencing capabilities with your Care Coordinator. The Patient App allows you to:
  - Monitor your complete health vitals
  - Add multiple Cellular & Bluetooth devices
  - Chat with a Nurse about any health issues with you
  - Have an accessibility to do a Voice or Video call with the nurse
  - View weekly/monthly vitals report on your fingertips
  - Keep track of your vitals for your care plan and alerts Care Coordinator if abnormal