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How to make chronic care management pay

By Chris Hayhurst | October 20, 2016

When CPT code 99490 went into effect on January 1, 2015, it was touted as a boon for medical organizations: They would finally be reimbursed for coordinating care for Medicare patients with chronic conditions.

The code allots medical practices about $41 per month for every patient that receives at least 20 minutes of "non-face-to-face care coordination services." It's meant to encourage out-of-office patient monitoring and is part of the Centers for Medicare and Medicaid Services' push to compensate providers for value-based care. Through 99490, physicians are now paid not only to treat the sick, but also to do what it takes to keep populations healthy.

There's just one problem: Some providers have looked at the code and decided the numbers don't add up.

"Especially if you're a smaller practice, you might not have the resources to meet all of the code's requirements," says Sarah Hurty of Willamette Heart and Family Services, a two-clinic operation in McMinnville, Oregon.

Making CCM pay

Among other things, providers must use their EHRs to create a structured recording of each patient's health information, says Hurty, who runs Willamette Heart with her husband, cardiologist Alan Hurty, M.D.

Providers also have to develop an electronic plan of care to address "all health issues" the patient faces, and make it available to other healthcare professionals outside of the practice as appropriate, Hurty says. And they must ensure that every patient has 24/7 access to a full range of care management services, from oversight and review of prescribed medications to facilitation of care transitions between various providers and settings.

Still, Hurty says, she and her husband decided from the start they had to find a way to make 99490 pay.

"Which is how we wound up partnering with CareSync," she says. The Florida-based company, which helps medical practices meet the various requirements of chronic care management (CCM) billing, gives them "turnkey access to reimbursement for CCM," she notes, "and also to value-based reimbursement in general."

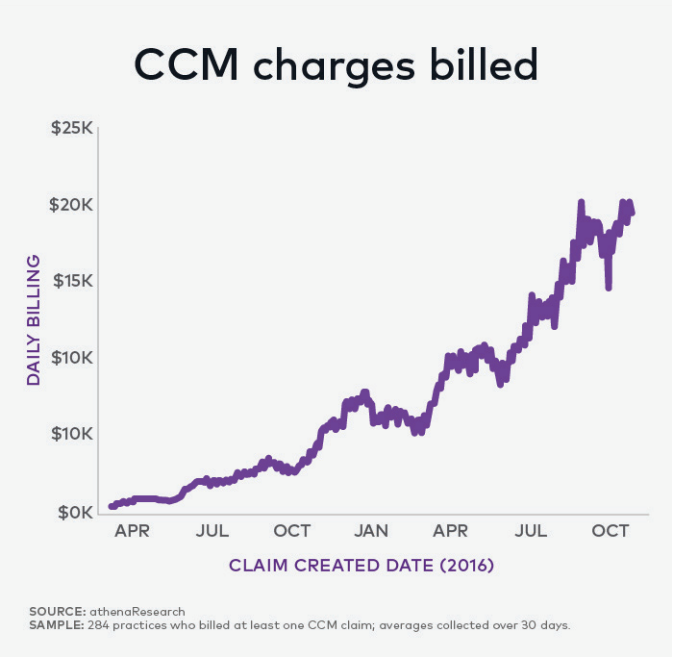
CareSync, a member of athenahealth's More Disruption Please program, was founded in 2011 by Travis Bond after his friend — current COO Amy Gleason, RN — faced struggles caring for a child who had been diagnosed with a rare autoimmune disease. Their aim was to help chronic care patients navigate a fragmented healthcare system."

The introduction of a CMS reimbursement code, four years later, created a new business opportunity. Now, CareSync is one of several growing companies that provide software and services for chronic care management, integrating with an organization's existing workflow and EHR to automate the time tracking, documentation, and other in-clinic tasks that CMS mandates for successful reimbursement.

CareSync takes a cut for each patient a practice sees, but administrators like Hurty feel that's money well spent.

"We don't have the staff or the time to do this work on our own, so for us it makes sense," she says.

Indeed, according to data from the athenahealth network, a growing number of providers are reaching the same conclusion. Billing for CCM claims is on the rise, especially among those practices using services like CareSync's.



'Clinical safety net'

CareSync CEO Travis Bond describes his company's service as a "clinical safety net program" that not only manages chronic care patients, but also reduces anxiety among providers. CareSync employs clinicians who serve as care managers, he explains. They engage with patients — typically by phone — to track their progress, ensure care plan adherence, and assist as necessary with care coordination.

One CareSync client, Thomas Wiggins, M.D., said he relies on the service "as an extension of the practice" he owns and operates in Anchorage, Alaska. Ten to 12 percent of Medical Park Family Care's patients are on Medicare, Wiggins says, and many have chronic conditions that require them to utilize a wide range of healthcare services.

"It used to be that their care was disjointed. They'd go to all these different people, and they'd get all these tests, and sometimes you wouldn't know if a test had already been done, or what medications other doctors had prescribed," Wiggins says.

Now, he says, all of those interactions are recorded, so "when a patient leaves Alaska to winter in Arizona, their care and information follow them wherever they go."

New sources of revenue

It's a similar story at Willamette Heart, Hurty says. "Now, if a patient doesn't pick up a med that we had prescribed, our CareSync care manager finds out why and then follows-up with us to figure out what we need to do." Or if a patient is prescribed a drug by another physician that happens to conflict with one she's already taking, "we're alerted right away when CareSync sees that in their system."

Today, Hurty adds, her practice counts on a profit of about $10 per month for every patient enrolled in its chronic care management program. There are currently 500 patients on that list, "and another thousand or so who should be" by early 2017.

That adds up to real money, Hurty notes, but the way she sees it, it's also just the start. CMS has proposed a number of new codes around chronic care management that are slated for rollout within the next year. When that happens, she says, Willamette Heart will be among the first to put them to work.

"We see CCM as a huge opportunity," she says. "We're finally being paid for providing better care."

Chris Hayhurst is a writer based in Northampton, Massachusetts.