Chronic Care Management

Maximize your CCM Revenue and Efficiently Manage at Risk Populations

The prevalence of chronic diseases – like cancer, diabetes, hypertension, stroke, heart disease, pulmonary conditions or mental illness – is continuously increasing and results in both financial and human cost. Studies have shown that care management reduces total cost of care for patients with chronic diseases and comorbidities in addition to improving their health. Still only few patients receive care management services today. Since January 1, 2015, Medicare has started to reimburse providers for Chronic Care Management (CCM).

KEY BENEFITS:

- Maximize CCM Revenue
- Decrease Adverse Events by Identifying Risk
- Engage Patients for Better Health Outcomes

KEY FEATURES:

- Manage Multiple Chronic Conditions
- Share Care Plan across Care Teams
- Time Tracking with Dashboard and Reporting
- Integration with HIEs and Secure Messaging

CCM addresses non face-to-face services provided to Medicare beneficiaries who have multiple significant chronic conditions. These services can include any kind of communication between eligible providers and their patients such as appointment scheduling, reminders or medication reconciliation. Through CPT code 99490, healthcare professionals can now **bill for an additional reimbursement of $40.39 from CMS.** The CMS requirements for billing include getting the beneficiary's written consent, providing at least 20 minutes of Chronic Care Management services per month and 24/7 care provider access.

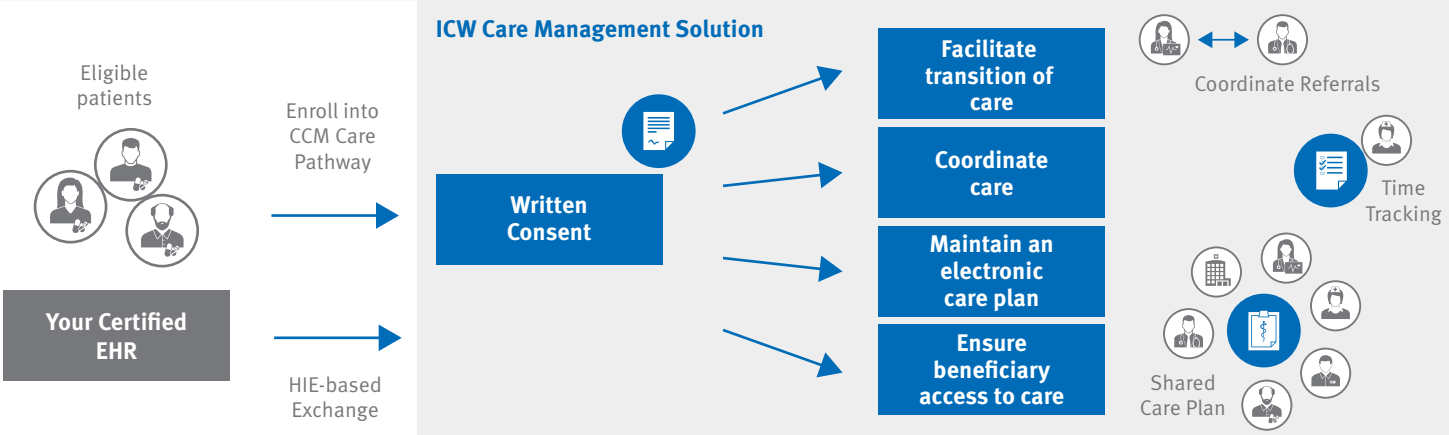
In addition to that, the creation and revision of an **electronic care plan** is one of the key elements of CCM. This patient-centered care plan is based on physical, mental, cognitive, psychosocial, functional, and environmental assessments and an inventory of resources. As such, it needs to provide an overview of all relevant problems, medications and planned interventions. The patient-centered care plan has to be shared with the patient and with everyone within the practice providing the CCM service. It ensures that everyone involved in the patient's care has the same information and contributes to the increase of the overall quality of care.

Potential Revenue for Your Organization

The calculation below outlines the additional revenue potential for an eligible provider billing for CPT code 99490. In group practices, the **revenue potential scales with the number of providers in the group.**

Annual Number of Unique CCM patients (with more than two chronic conditions) per provider	450
CCM Monthly Payment (including Co-Payment)	$40.39
Estimated Annual Gross Revenue per provider	$218,106

USING ICW SOLUTIONS TO PROVIDE CHRONIC CARE MANAGEMENT FOR YOUR ORGANIZATION



It is a very fair assumption that you already provide CCM services that are billable to CMS. But according to a survey from the Health Intelligence Network, just over one-third of respondents are currently reimbursed for CCM-related activities! By utilizing these reimbursements, physicians can further expand their services.

Chronic Care Management with ICW Care Management Solution

Any successful patient-centered care management service must be backed by a sustainable IT strategy. Providers need innovative tools with functionality that starts **where the average EHR reaches its limit.** In particular, such tools must furnish maximum flexibility to create individual care programs that meet the population's real needs. ICW Care Management was developed precisely to meet todays and future requirements of organizations that manage care. It is an efficient web based solution for team-oriented, cross-organizational care management. Dynamic work processes can be represented flexibly according to an organization's individual requirements.

ICW Care Management ships with a preconfigured yet fully customizable Care Pathway for Chronic Care Management that fulfills the CMS billing requirements. Working together with your certified EHR, our software helps you to maintain an electronic care plan, ensure beneficiary access to care, facilitate transitions of care and coordinate care efficiently. A workflow concept using tasks ensures that all necessary process steps are performed in time and properly documented. This includes getting a patient's **consent** and reminding you about the **annual care plan review.** Various assessments help to identify the individual needs of your patient.

The up to date **electronic care plan** provides all relevant information required by CMS:

- Problem list
- Medication list
- Symptom management and planned interventions with a responsible individual
- Plan for care coordination with other providers

The care plan can be easily **shared** with all of the patient's providers, family or caregivers.

ICW Care Management ensures that you **track all activities that count toward the 20-minute total** such as phone calls or emails to the patient, time spent on medication reconciliation or coordinating care with other providers. A **dashboard** view helps you to get a quick overview of the population and to identify **how much time** the care team members **spent on a patient.** Drill down functionality shows a patient's detailed record and helps to review and adjust the care plan.

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