Chronic Care Management Overview

NEBRASKA HEALTH NETWORK | METHODIST | Nebraska Medicine

What is Chronic Care Management?

Chronic Care Management (CCM) offers personal support to patients with complex needs. This added level of care and service leads patients to a healthier lifestyle by proactively managing their care and providing a trusted clinical resource they can reach around-the-clock.

CCM is designed for patients with two or more chronic conditions that are anticipated to last at least 12 months or until the patient's death. Patients enrolled in CCM services benefit from an entire care team focused on their needs, increased communication with their provider and improved care coordination.

CCM Benefits

Two thirds of patients on Medicare have two or more chronic conditions, which means many patients can benefit from CCM services. CCM can help your clinic deliver coordinated care to patients that need additional time and resources between appointments. Benefits to your clinic include:

Better Patient Outcomes

Patients gain a supportive health-care team dedicated to creating a comprehensive care plan. Patient care is focused on prevention to keep patients out of the hospital by supporting patients between visits.

Improved Care Coordination

Referral coordination helps keep patients out of the hospital and prevents patients from "falling through the cracks."

Improved Patient Satisfaction

Increased communication with their care team leads to greater peace of mind and independence knowing that help is just a phone call away.

Increased Revenue

CCM increases income for the clinic by billing CCM services.

Who can perform CCM services?

- Registered Nurses (RNs)
- Licensed Practical Nurses (LPNs)
- Medical Assistants (MAs)
- Medical Doctors (MDs) or Doctors of Osteopathic Medicine (DOs)
- Physician Assistants - Certified (PA-Cs)
- Advanced Practice Registered Nurses (APRNs)
- Contracted third party vendors

Note: CCM code 99491 requires that an MD, DO, PA-C or APRN personally provide the CCM service

*Clerical Staff (reception) cannot perform CCM services

**Only one provider can bill for each patient each month for CCM services

Requirements for Success in Chronic Care Management

Chronic Care Management will help your clinic deliver the coordinated care that your patients need and deserve. To be successful, providers, clinicians and patients need to understand the value of, and their role in, CCM services. With the focus of your entire clinic staff on CCM, patients with chronic illness will be able to pursue the next steps necessary to improve their care.

Best practices to help implement CCM services with your patients should follow this brief timeline:

1) Identify patients with two or more chronic conditions that may benefit from increased care coordination.

2) Discuss CCM services with patient and obtain consent to enroll.

3) Follow-up with the patient within three days of enrollment.

4) Document the patient's care plan in the EHR and continue CCM support and services. Patients must receive a copy of the care plan and associated updates as they occur.

5) Track time and bill accordingly each month.

Coordinating Patient Care

Chronic Care Management programs help patients take an active role in their health. Eligible patients are provided with 24/7 access to education, psychosocial support and care coordination. This coordination ultimately decreases the frequency of visits to the clinic, reduces hospitalizations and improves patient outcomes.

All of the following are considered non-face-to-face care coordination components:

- Phone
- Email
- EHR communication
- Coordination with patient's care team

Remember, you must obtain the patient's consent to enroll him or her in CCM and document the consent in the EHR. Check with your patient's insurer to determine whether verbal or written consent is required.

Learn More about Chronic Care Management

› Connect with Nebraska Health Network at nhn@nebraskahealthnetwork.com.

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