Improving Coordination of Care for Children with Special Health Care Needs (CSHCN) by Integrating Chronic Care Management into a Primary Care Practice

Wendy Hobson MD, Joni Hemond MD, Emily Navar RN, Lisa Smith RN, Jeremy Egusquiza MBA, Jason Fox MPA/MHA
University of Utah, Department of Pediatrics, Salt Lake City, Utah

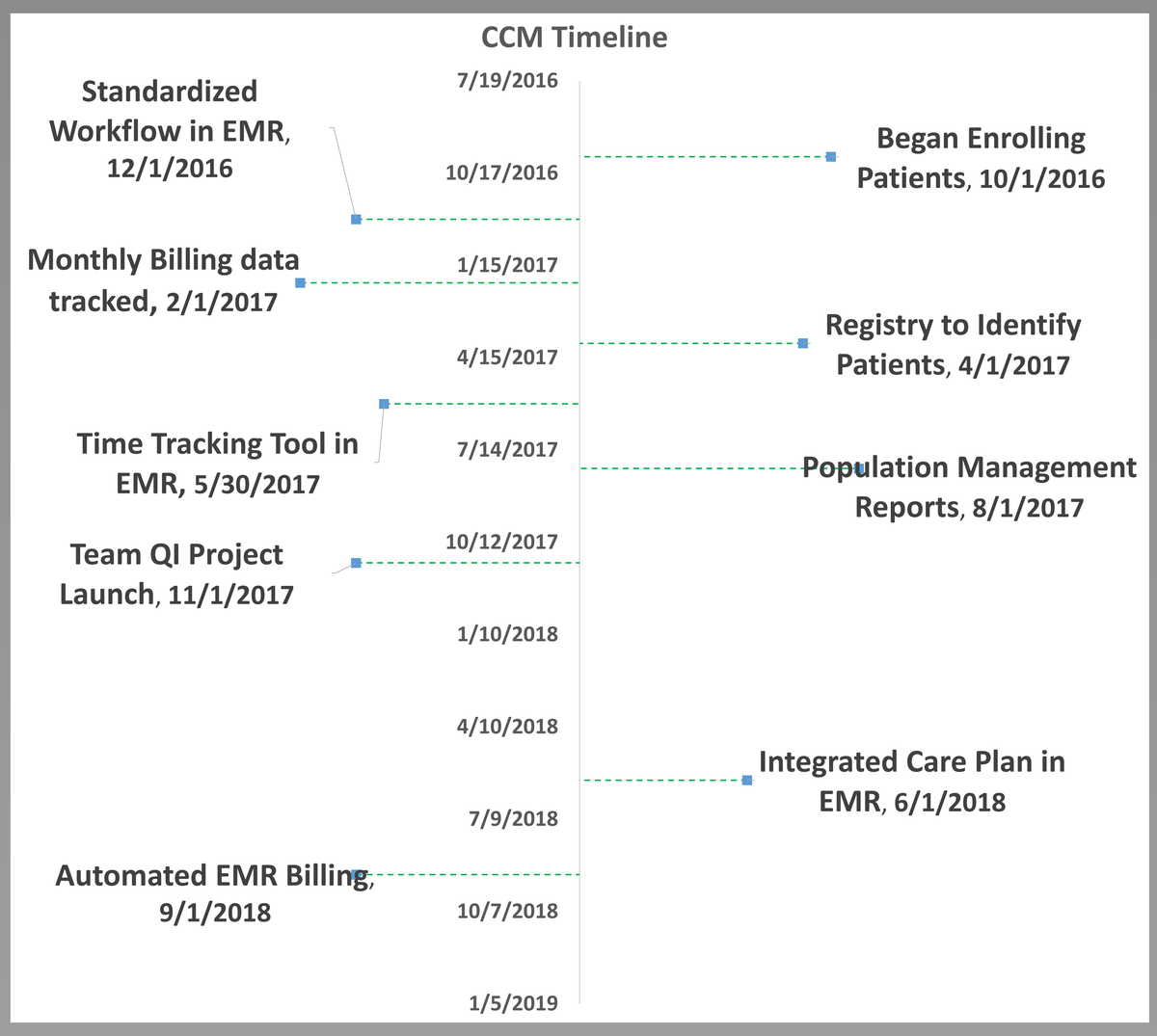
Background

An integral part of the medical home is care coordination, and for children with special health care needs (CSHCN), clinics must provide even more proactive management. Prior to 2015, no clear payment mechanism for care coordination existed. In 2015 Medicare began paying for Chronic Care Management (CCM) services furnished by the care team to patients with multiple chronic conditions. Medical home providers and their associated staff could bill for their time, using code 99490 for general care management services and 99487 or 99489 for complex chronic care management.

Aim

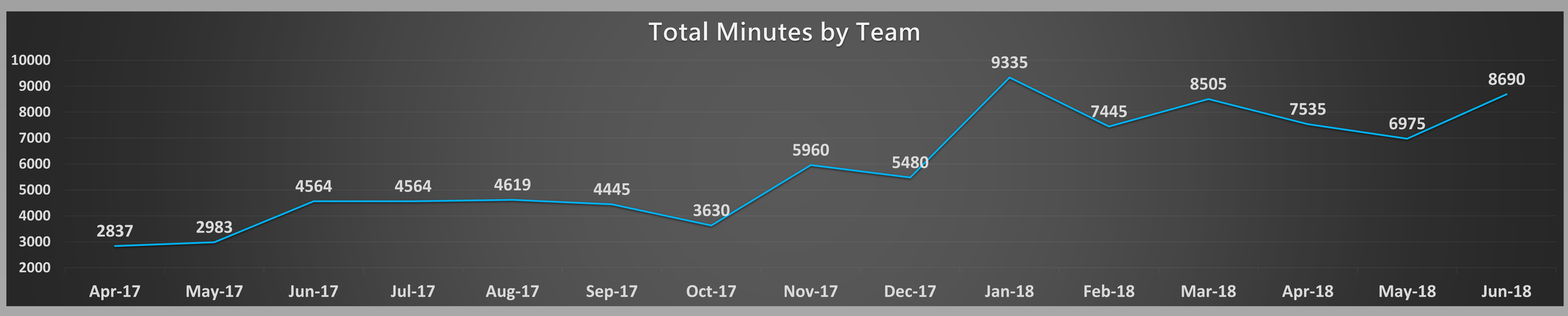
- Create and evaluate a process for documenting, tracking, and billing for CCM in a primary care pediatric clinic
- Analyze CCM codes for billing and payment to determine financial viability of CCM process

Methods

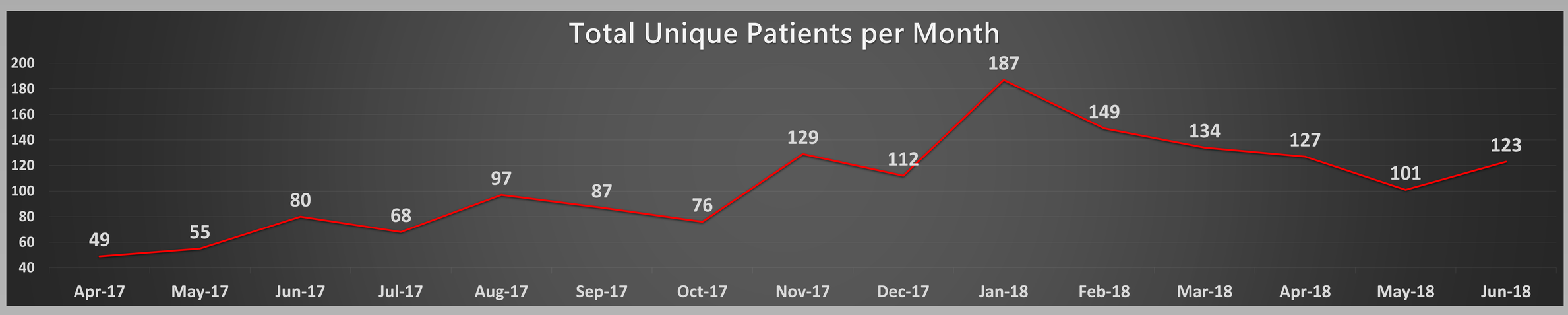


Results

- The combination of EMR implementations and monthly tracking of care coordination was associated with an increase in the number of billable encounters per month associated with Chronic Care Management



- Each month during the time period, April 2017 – June 2018, our clinic billed between 2,500 and 9,000 minutes or 42 to 150 hours
- MDs billed for 10% of monthly minutes (<1,000), RNs for 43% (2,500-3,000) and MAs for 47% (3,500-4,000)
- The significant increase in Total Minutes from Nov. 2017 to March 2018 can be attributed to EMR implementations creating patient identification and tracking.



- As of June 2018, of the 1276 patients eligible for CCM 711 (56%) are currently enrolled, with an average of 30 new enrollments each month.
- As of June 2018, of the 711 unique patients enrolled for CCM, an average of 21% (150) have care coordinated monthly
- 80% (125) of the billed CCM encounters were chronic care and 20% (25) were complex

Limitations

While successful at documenting and tracking eligibility, enrollment status, documentation of care coordination and time spent coordinating care, we have not yet created a method of tracking metrics of outcomes tied to objective measures, such as reduction of costs, ER visits, inpatient stays, etc.

Conclusions

Through an iterative process we were successfully reimbursed for the previously uncompensated work. Our process sheds light on how to provide the resources necessary to incorporate care coordination that can be billed for in a practice setting.

Implications

The results of this study underscore the importance of funding care coordination efforts so that practice teams can continue to provide comprehensive coordinated care in the primary care setting for CSHCN.