REMOTE PATIENT MONITORING FOR CHRONIC CARE MANAGEMENT

BEST PRACTICES

Presented by: Michael Shaffer
CIO
Community Care of WV
Larry Steinberg
EVP/Co-founder
Cloud DX
On January 1, 2015, CMS began offering reimbursement for providers who actively manage care delivery for Medicare patients who have two or more chronic conditions.
CPT 99490

Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored.
Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer’s disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart failure
- Hypertension
- Ischemic heart disease
- Osteoporosis.
Practitioner Eligibility

Physicians and the following non-physician practitioners may bill the new CCM service:

- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants.

Only one practitioner may be paid for the CCM service for a given calendar month.
REQUIREMENTS:

• Patient Consent
• Structured Data Recording (Vitals)
• Certified EHR
• Patient-centered Care Plan
• Access to Care (24x7, continuity of care, patient communication to provider – telephone, secure messaging, secure internet, video consult)
• Manage Care (Systematic assessment – Vitals)
Thank You!

Michael Shaffer
CIO
Community Care of West Virginia
304-924-6262 x1125
Michael.Shaffer@ccwv.org

Larry Steinberg
EVP/Co-founder
Cloud DX
Larry.Steinberg@clouddx.com