Provider FAQ's

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What is Care Management?

Care Management is a way for doctors and practitioners to get an additional care plan, care team, and access to more information about patients in between visits. Since CCM and PCM are provided by Medicare, strict guidelines and requirements govern the actions that must take place. The majority of these actions will be done under doctor and practitioner oversight and will not require changes in your day-to-day operations.

Who can be enrolled?

Medicare patients who have been diagnosed with either one complex, high-risk chronic condition or at least two chronic conditions may be eligible for the care management program. Care Management is eligible to Medicare original and Medicare Advantage and replacement plans, and many commercial payers also support reimbursement of the program.

What do patients receive?

For CCM, Medicare requires that at least 20 minutes of Care Management Activities be performed during a single calendar month to be compensated for CCM (CPT Code 99490). As PCM is more focused, it benefits from 30-minute intervals of care.

Each month, all efforts will be made to ensure that your patients are receiving the care plan oversight, care transition management and care coordination opportunities that are provided during this service. Like other time-based codes, the time that is spent on the patient will be documented in full detail and submitted to Medicare for reimbursement.

How does this benefit practitioners?

Patients get in-between-visit care management using evidence-based models, leading to healthier outcomes. Practitioners get additional revenue from Medicare as the CPT code is billed for each patient during the months care management services are completed.

How much time will this take?

There are no hard time requirements for physicians/clinicians, apart from providing the usual care to patients.

What does Care Management cost the patient?

Although patient cost sharing applies, most patients either have supplemental insurance or have already met their deductible to help cover any possible out-of-pocket cost. If patients do have an out-of-pocket cost, it's usually no more than a $10 copay each month.

Can my patients cancel the service?

Yes, enrolled patients can cancel at any time. Care Management services will end at the beginning of the next calendar month.

How do I get my patients started?

Services begin once your patient gives their verbal or written consent to participate in the program. Once you notify us of this consent, we'll take it from there.

What on-boarding services do you offer?

We know how to effectively on-board small and large organizations, matching activities to your existing workflow with minimal impact to clinical operations and staff. We fully cover patient population analysis, eligibility identification, and enrollment activities.

Once enrolled, we recommend care plan assignments according to clinical direction from providers, document care delivery and communicate escalations in your EHR, and provide individual patient and population cohort reporting to track outcomes on a regular basis.

Optionally, even month-end support to enter timely billing claims is seamlessly available. Finally, overall program status and improvement reviews are scheduled by a dedicated performance manager to ensure the program value meets or exceeds overall practice objectives.