DIVISION OF MEDICAL SERVICES
PROVIDER BULLETIN

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Chronic Care Improvement

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CHRONIC CARE IMPROVEMENT PROGRAM

The Chronic Care Improvement Program (CCIP) is an enhanced primary care case management program that incorporates the principles of disease management, care coordination and case management to serve patients identified through a risk assessment and disease stratification model. APS Healthcare has been selected by the State of Missouri, Department of Social Services, Division of Medical Services (DMS) to administer the statewide CCIP serving **fee-for-service** patients. Included as a component of the CCIP is an Internet-based plan of care health information technology (HIT) system.

The goals of the CCIP are to improve health status and decrease complications for patients with chronic illness including asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes, cardiovascular disease and Gastroesophageal Reflux Disease (GERD). The program will increase involvement of a central primary health care provider, empower patients to perform self-management of their health status, and utilize existing community resources and health infrastructures through the coordination of care.

Once identified through the risk assessment tool, patients will be invited to participate. Every effort will be made to coordinate care for patients with their current primary care providers; however the patient's choice of a primary care provider will not preclude their use of other providers for specialized services.

PROVIDER INCENTIVE PAYMENT FOR CCIP

Providers will receive incentive payments for actively participating in CCIP. These payments will be in addition to the appropriate level Office Visit fee. The incentive payment is contingent upon the provider logging on to the APS CareConnection® Web site to view, adjust and approve the Web-based Plan of Care (POC), making changes to the POC as needed through ongoing patient assessment and communications with APS Care Coordinators.

In addition to a provider incentive payment for participation, the DMS is working to establish an additional payment for performance incentive to be implemented at a future date. This payment will give additional support to providers working to help their patients become healthier.

Provider Information and Procedure Codes for Physicians (Provider Type 20, 24) and Nurse Practitioners (Provider Type 42), including those employed by Independent Based Rural Health Clinics (Provider Type 59)

Codes billed by **physicians and nurse practitioners** (or the clinics where they are employed) shall be billed in addition to the codes billed for an Office Visit or other medical services. The following codes and payments are designated for these providers for purposes of the participation incentive payment:

99362 – Medical conference by a physician with interdisciplinary team of health professionals or representative of community agencies to coordinate activities of patient care; approximately 60 minutes (Initial visit).

1. Provider must log on to APS CareConnection® Internet based plan of care tool.
2. An SF-8 health survey must be completed (by health coaches, physicians, or pharmacists) if the provider is prompted to complete the survey with the patient.
3. The Plan of Care must be reviewed and approved.

- This service may only be billed one time per patient, per provider, per lifetime.

This code may be billed in addition to an Office Visit or other medical services.

Fee = $25.00 (Not subject to cost-sharing)

99361 - Medical conference by a physician with interdisciplinary team of health professionals or representative of community agencies to coordinate activities of patient care; approximately 30 minutes (Follow-up visit)

1. 99362 must have been billed and paid previously.
2. Provider must log on to APS CareConnection® Internet based plan of care tool at least once during the month in which 99361 is billed.
3. An SF-8 health survey must be completed if the provider is prompted to complete the survey with the patient.
4. Provider must review the Plan of Care.

- This service may only be billed one time per calendar month.
- This service may be delivered on the same day as an office visit or other medical services.

Fee = $10.00 (Not subject to cost-sharing)

Provider Information and Procedure Codes for Federally Qualified Health Centers (FQHC) (Provider type 50) and Provider Based Rural Health Clinic (RHC) (Provider Type 59)

The following codes and payments are designated for **FQHC** and **RHC** facilities:

99404 - Preventive medicine counseling and/or risk factor intervention(s) provided to individual (separate procedure); approximately 60 minutes (Initial visit).

1. Provider must log on to APS CareConnection® Internet based plan of care.
2. An SF-8 health survey must be completed if the provider is prompted to complete the survey with the patient.
3. The Plan of Care must be reviewed and approved.

- This service may only be billed one time per patient, per provider, per lifetime.
- This service may be delivered on the same day as an office visit or other medical services.

Fee Information:

FQHCs are reimbursed at 97% of billed amount and therefore should bill Medicaid $25.77 for a $25.00 fee payment (Not subject to cost-sharing)

RHC Provider Based (Specialty B1) payment will be $25.00 taken from the PDD file or the bill charged, whichever is lower. (Not subject to cost-sharing)

**** Note that RHC Independent Based** (Specialty A1) should not bill this procedure code. Physicians and/or Nurse Practitioners employed at these facilities should bill code 99362 as stated above, using the individual performing Physician's or Nurse Practitioner's Medicaid number. The same fee for code 99362 also applies. (Not subject to cost-sharing)

99402 - Preventive medicine counseling and/or risk factor intervention(s) provided to individual (separate procedure); approximately 30 minutes (Follow-up visit)

1. Provider must have logged into APS CareConnection® at least once during the calendar month in which 99402 is billed.
2. 99404 must have been billed and paid previously.
3. An SF-8 health survey must be completed if the provider is prompted to complete the survey with the patient.
4. The Plan of Care must be reviewed.

- This service may be billed one time per calendar month, per provider, per patient.
- This service may be delivered on the same day as an office visit or other medical services.

Fee Information:

FQHCs are reimbursed at 97% of billed amount and therefore should bill Medicaid $10.31 for a $10.00 fee payment (Not subject to cost-sharing)

RHC Provider Based (Specialty B1) payment will be $10.00 taken from the PDD file or the billed charge, whichever is lower. (Not subject to cost-sharing)
**** Note that RHC Independent Based** (Specialty A1) should not bill this procedure code. Physicians and/or Nurse Practitioners employed at these facilities should bill code 99361

as stated above, using the individual performing Physician's or Nurse Practitioner's Medicaid number. The same fee for code 99361 also applies. (Not subject to cost-sharing).

CCIP START-UP ACTIVITIES

The CCIP will initially be implemented along the I-70 corridor of the state, including Jackson County and the City of St. Louis, and will be moved statewide over time. APS will implement its community-based care management model, which places health coaches and nurse care managers in community health centers and provider locations throughout the state. APS uses a decentralized, collaborative model to improve Medicaid recipient and provider engagement in care management programs, increase compliance with recommended care plans and improve care coordination.

APS will also deploy and train providers in the use of an Internet-based plan of care tool called APS CareConnection®- for health and care management. The Internet-based plan of care enables all participants – patients, providers and health coaches – to work more effectively together using a collaborative medical record. Updated information including patient demographics will also be made available through the plan of care. In addition to physicians and nurse practitioners, DMS plans to include a multidisciplinary team of participating providers in the near future who will augment patient education and help to empower a patient's self-care. These additional providers would potentially include specialists, pharmacists, dieticians and therapists.

APS CARECONNECTION® INTERFACE WITH CYBERACCESS℠

The DMS recently notified providers of another Web-based tool called CyberAccess℠ that allows providers to prescribe medications electronically, view diagnosis data, select preferred medications, and electronically request drug and medical prior authorizations for their Medicaid patients. Also integrated into CyberAccess℠ is Direct Care Pro℠, a tool that will enable targeted clinical interventions based on best practice standards. Please note that CyberAccess℠ will be electronically linked to the new APS CareConnection® Internet plan of care tool, so that providers will not be required to log-on to each tool separately.

ACS Heritage, the contractor for CyberAccess℠ will be working closely with APS to set up and train providers to use both tools. These two Web-based tools together will offer providers a vast resource of patient-specific information enabling more informed treatment decisions.

Program Documentation

Current policy requires Medicaid providers to accurately document services provided to a Medicaid patient in the patient's office medical record, and specifies that these medical records may be reviewed and audited by the state at any time. This policy applies to CCIP as well. To validate payment for the above codes, all CCIP services must be documented in the patient's office medical record. The state may request a provider submit a patient's medical record to the state for review and auditing at any time. Depending on the type of service provided, providers must for example, verify that they performed a complete medical history, performed a review of the patient's current medication therapy, monitored compliance with therapy, made a referral if warranted, performed needed interventions, communicated with other health care providers, provided medical education to the patient and/or his or her caregiver, or provided follow-up care.

For detailed information on documentation and minimum retention of records requirements, providers should reference the Code of State Regulations, 13 CSR 70-3.030 as well as Medicaid Provider Bulletin, Volume 28 Number 35, dated January 25, 2006.

PROVIDER PARTICIPATION AND ASSISTANCE IN CCIP

To participate in CCIP, providers must be actively participating in the Medicaid program. Providers may enroll on-line with the Provider Enrollment Unit thru the http://peu.momed.com Web site.

Providers wishing to participate in CCIP or those desiring more information or assistance regarding the program should contact APS Healthcare, Inc. at: www.showmehealthnet.com or by calling **866-464-7147** (toll-free, 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday except for official state holidays), or in writing at:

Fax: 1-800-461-9184 (toll-free)
Mailing Address: APS Healthcare
205 Jefferson Street,
Jefferson State Office Building, Suite 1015
Jefferson City, MO 65101

Provider Bulletins are available on the DMS Web site at http://dss.mo.gov/dms/providers/pages/bulletins.htm. Bulletins will remain on the Provider Bulletins page only until incorporated into the provider manuals as appropriate, then moved to the Archived Bulletins page.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Web site at http://dss.missouri.gov/dms/global/pages/mednewssubscribe.htm to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via E-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896