CDS

CHRONIC DISEASE SOLUTIONS

CHRONIC DISEASE SOLUTIONS, LLC

Focused on Quality | Built by Professionals |Designed for YOU

Dear Healthcare Professional,

We would like to thank you in advance for allowing us to introduce our company to you and your medical practice. It is with great pleasure to announce the creation of Chronic Disease Solutions! Our company is built to provide chronic care management services for you and your qualified beneficiaries with the highest level of professionalism. We appreciate the opportunity and are excited to present you with a little insight on what our company has to offer. The success of our company is achieved by three important standards.

1) **Improving quality outcomes for patients with chronic disease.**

Often times, patients with chronic disease attempt to manage their own needs while facing the challenges of illness. The monthly monitoring provided by our experienced clinical team can often minimize unnecessary suffering by means of early intervention. CMS identifies the following types of services performed on a beneficiary's behalf as counting towards the qualifying services that meet the Chronic Care Management 20-minute requirement. This list, however, is not exclusive; other types of services may count toward the 20-minute requirement. Here are a few examples of our chronic care management services:

1. Performing medication reconciliation and overseeing the beneficiary's self management of medications.
2. Ensuring receipt of all recommended preventive services.
3. Monitoring the beneficiary's condition (physical, mental, social).
4. Providing patient transitional care, clinical coordination and medical guidance appropriate to medical needs.

2) **Increasing Revenue for your medical practice!**

Beginning January 1, 2015, Medicare now reimburses for chronic care management, or CCM. All qualified beneficiaries, who are eligible to receive CCM, may be billed on a monthly basis after the services are rendered. We can provide a revenue calculator to estimate monthly and yearly projections for your medical practice!

3) **Provide a superior clinical staff and robust software technology.**

Managing the workload is our responsibility so that the burden of hiring and managing additional staff is unnecessary for your practice. The expense of the employees, computer software and technology, and compliance with CMS guidelines and regulations have proven to be more than most practices can endure. We have carefully selected RN's, LPN's and medical assistants to provide a consistently high level of service on your behalf. We provide all necessary managerial oversight to ensure that all standards are being met and our mutual goals are accomplished. Our CCM software is designed to meet CMS regulations as well as enhance the quality of documentation provided to your EHR system. Our CDS technology is a very robust software program that provides valuable clinical data so we may determine successful clinical pathways to ensure our patient goals are met. Additionally, our software provides a variety of communication methods to your EHR and office staff by way of secure messaging. The communication of clinical findings create a much needed bridge between patients with chronic disease and your office.

In closing, we would like to thank you for giving us this opportunity to work with you and your medical practice. We can arrange for a tour of our products and services at your convenience as well as discuss the levels of revenue we can provide. On behalf of Chronic Disease Solutions, we look forward to our working relationship with you for many years to come!

CDS Administration

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Enhanced Patient Care

Our system approach to chronic case management ensures a monthly interaction with beneficiaries to discuss and review compliance and adherence to the individual's care plan. The increased level of monitoring for patients with two or more chronic conditions has been proven to decrease hospitalizations and emergency room visits.

Increasing Revenue

Medicare has approved reimbursement for case management services being provided to patients with chronic care needs as of January 1, 2015. A medical practice with 350 qualifying patients can expect a $50,000 annual increase in revenue. **CDS** will provide all technology, overhead and resources necessary to establish our chronic case management service on behalf of your practice.

Chronic Case Management

Accessible health care management has been taken to a new level for Medicare beneficiaries. Our CMS approved case management company is built to deliver 24/7 service to patients with chronic care needs. **CDS** helps to create a comprehensive care plan that is based on a patient's physical, mental, cognitive, psychosocial, functional and environmental needs. When appropriate, **CDS** will communicate and share changes in the patient's care plan with other health care providers in an effort to enhance the quality of care across the healthcare spectrum.

Improving Patient Outcomes, Increasing Patient Satisfaction

Call us today for enrollment information! 1-844-920-9385

Built By Professionals

CDS has a combined 300 years of experience in direct patient care. Our physicians, nurses and health care executives have carefully researched, examined, and developed a service model that will change the way healthcare is delivered to patients with chronic conditions.

CDS's chronic care management company is a valued partner for physicians and medical practices. **CDS** provides everything necessary to fulfill Medicare regulations and requirements related to chronic care management. With the use of our customized auditing tools, the staff at **CDS** will evaluate your patient database for eligible recipients and facilitate the enrollment process. Our professionals will assist you in care plan development for continuous monitoring.

Scope of Services

- Minimum 20 minutes of non face-to-face communication per month with qualifying patients
- 24/7 access to clinical care team
- Medication reconciliation and monitoring adherence
- Patient Satisfaction
- Quality Outcomes Reporting
- Patient Compliance with CQI
- Assist with care transitions among healthcare providers including follow up after ER visits and discharges from other health care facilities
- Develop comprehensive care plans
- Provide copy of care plan to patients
- Provide secure messaging communication to physician offices for EHR updates.
- Conduct patient assessments
- Provide continuity of care for the patients and physician practice

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Frequently Asked Questions

Q: ***What exactly IS the CCM requirement?***
A: 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.
- Initiation during an AWV, IPPE, or comprehensive E/M visit (billed separately).
- Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.
- Structured recording of demographics, problems, medications, medication allergies, and creation of structured clinical summary records using CCM certified technology.
- Access to care management services 24/7 (providing the beneficiary with a means to make timely contact with health care practitioners in the practice who have access to the patient's electronic care plan to address his or her urgent chronic care needs regardless of the time of day or day of the week).
- Continuity of care with a designated practitioner or member of the care team with whom the beneficiary is able to get successive routine appointments.
- Care management for chronic conditions including systematic assessment of the beneficiary's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of beneficiary self-management of medications.
- Creation of a patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues. Share the care plan as appropriate with other practitioners and providers.

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Frequently Asked Questions

Q: What is the CCM requirement? Continued..

- Must at least electronically capture care plan information; make this information available on a 24/7 basis to all practitioners within the practice whose time counts towards the time requirement for the practice to bill the CCM code; and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers.

- Provide the beneficiary with a written or electronic copy of the care plan and document its provision in the electronic medical record.

- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.

- Format clinical summaries according to CCM certified technology. Not required to use a specific tool or service to exchange/transmit clinical summaries, as long as they are transmitted electronically (other than by fax).

- Coordination with home and community based clinical service providers.

- Communication to and from home and community based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record using CCM certified technology.

- Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary's care through not only telephone access, but also through the use of secure messaging, Internet or other asynchronous non-face-to-face consultation methods.

- Beneficiary consent—Inform the beneficiary of the availability of CCM services and obtain his or her written agreement to have the services provided, including authorization for the electronic communication of his or her medical information with other treating providers.

- Document the beneficiary's written consent and authorization in the EHR using CCM certified technology.

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Frequently Asked Questions

Q: ***What does the typical Care Plan entail?***
A: Care Plan. A comprehensive Care Plan is established with the required elements:

List of problems, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social services ordered, coordination of other agency and specialist services, etc. The staff at CDS will obtain this information from the patient, the patient's care team, and the patient's active providers. The patients care plan is always available to every member of the patient's care team.

Q: ***Is your technology HIPAA-compliant?***
A: Absolutely. CDS abides by all Federal HIPAA requirements. CDS will produce signed HIPAA agreements with everyone enrolled into our system. Also, Electronic PHI has been encrypted as specified in the HIPAA Security Rule by "the use of an algorithmic process to transform data to a form in which there is a low probability of assigning meaning without use of a confidential process or key" (45 CFR 164.304 definition of encryption).

Q: Does CDS provide reports to my office?
A: You and your staff have unlimited access to your patients health information on the CDS software. We will provide updated health summaries each month. CDS will provide a monthly billing report that includes details for the patients who had 20 minutes or more of CCM services.

Q: What is the implementation timeline for CDS's CCM Program?
A: 30-60 days.

Q: Where can CDS perform services?
A: CDS is not geographically limited and can perform services anywhere in the country.

Q: What insurance plans will pay this code?
A: Medicare and Medicare Advantage plans. Private insurance companies such as BCBS and others, are evaluating now and plan to accept it very soon.

Q: What is the expected payment?
A: The average reimbursement is $42.60, depending on geographic calculations.

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Frequently Asked Questions

Q: Are Medicare beneficiaries who qualify for CCM services required to pay a copay?
A: Yes. There is a 20% coinsurance amount required, but if the member has supplemental insurance or is a dual-eligible (Medicare and Medicaid), the copayment may be covered.

Q: Is my patient responsible for any payment?
A: The same as any other billable code, the patient is responsible for deductibles, co-payments, and remainder amounts according to the patient's insurance agreement. Unfortunately 99490 is not exempt from cost-sharing rules, so Medicare Part B patients with no secondary coverage will be responsible for approximately $8/month. The intent of the code is toreduce costs for all parties, including the patient. Better coordination means fewer Hospital and Emergency Room visits, which in turn reduces the patient's overall out-of-pocket expenses.

Q: Is there a time when a patient covered by CCM is not eligible for the service?
A: Yes. There are four types of services that cannot overlap with CCM services on the same day, as some services provided in the care management component may be provided by another service.

CPT code 99490 cannot be billed during the same service period as CPT codes 99495–99496 (transitional care management), Healthcare Common Procedure Coding System (HCPCS) codes G0181/G0182 (home health care supervision/hospice care supervision), or CPT codes 90951–90970 (certain End-Stage Renal Disease services). Also consult CPT instructions for additional codes that cannot be billed during the same service period as CPT code 99490. There may be additional restrictions on billing for practitioners participating in a CMS sponsored model or demonstration program**.**

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Medical Practice Revenue

100% of Beneficiary Copayments Received

Qualifying Patients	Medical Practice Revenue
100	$16,800.00
200	$33,600.00
300	$50,400.00
500	$84,000.00
700	$117,600.00
1000	$168,000.00
1500	$252,000.00
2000	$336,000.00

50% of Beneficiary Copayments Received

Qualifying Patients	Medical Practice Revenue
100	$12,000.00
200	$24,000.00
300	$36,000.00
500	$60,000.00
700	$84,000.00
1000	$120,000.00
1500	$180,000.00
2000	$240,000.00

0% of Beneficiary Copayments Received

Qualifying Patients	Medical Practice Revenue
100	$7,200.00
200	$14,400.00
300	$21,600.00
500	$36,000.00
700	$50,400.00
1000	$72,000.00
1500	$108,000.00
2000	$144,000.00

This Medical Practice Revenue sheet is based off an average reimbursement of $40.00

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Annual Wellness Visits

Medicare AWV's

CDS can implement a Medicare Annual Wellness program located in your office. We can manage everything from scheduling the wellness appointments to performing the examinations. Our staff is qualified and trained to meet all of the Medicare guidelines and requirements related to annual wellness visits for your Medicare population. Additionally, CDS can offer mini mental examinations, and alcohol and depression screenings in conjunction with the annual wellness visit. The average reimbursement for a Medicare AWV is **$111.00**. The AWV reimbursement does not include the additional available examination reimbursements.

Private Insurance Wellness

CDS offers a variety of diagnostic testing in the office that will broaden the scope of service capabilities as well as enhance patient satisfaction and add revenue to the practice. Most insurance companies cover the below preventative testing as part of the patient's annual wellness visit. The average reimbursement for a patient taking two to three of these tests is approximately **$350.00** per patient.

Vendys – A non-invasive diagnostic test for early detection and monitoring of cardiovascular disease.

ANSAR – ANSAR testing is a painless, non-invasive diagnostic procedure that determines how well a patient’s autonomic nervous system is functioning.

Pulmonary Function Test – non-invasive tests that show how well the lungs work. This includes how well a patient is able to breathe and how effective the lungs are able to bring oxygen to the rest of the body.

MedGem – The MedGem indirect calorimeter is a FDA 510K-cleared Class II medical device that accurately measures oxygen consumption (VO2) to determine resting metabolic rate (RMR).

Sudoscan - Sudoscan is a new method for sudomotor function assessment which measures sweat composition to detect deviations in the ionic balance of the sweat. This non-invasive test is used by medical practitioners to analyze sweat gland dysfunction associated with small nerve fiber neuropathy.

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Advance Care Planning

Medicare ACP

When life presents challenging events, especially serious illness, we need to have the opportunity to express our concerns and wishes about end-of-life issues. Chronic Disease Solutions (CDS) offers this opportunity for a conversation with understanding and a compassionate presence. Advance Care Planning (ACP) helps to design a medical treatment plan for healthcare providers, our families, and caregivers to know our wishes during a terminal illness when we are no longer able to make decisions for ourselves.

Advance Care Facilitator

CDS provides an Advance Care Facilitator (ACF) to present voluntary Advance Care Planning during a medical visit such as an AWV or E/M visit. During the visit, the ACF will explain what ACP is in general, discuss the ACP documents, and provide options for how and when the individual may complete these documents if they wish.

Living Will

The Living Will is a legal document specifying what kind of medical treatment should be given to us when we are no longer able to make decisions for ourselves and are terminally ill. It is written according to our personal wishes and may be vague or specific. It is also to be written while we are able to make decisions. Therefore, the advance directive is often completed prior to a known serious illness. It must be signed by the individual and witnessed by two people. It does not need to be notarized.

Healthcare Power of Attorney

The Healthcare Power of Attorney designates an individual of our choice who is authorized to make decisions for us when we are no longer able to make decisions for ourselves. It is recommended that the Healthcare Power of Attorney be completed prior to a known serious illness. It must be signed by the individual designating and witnessed by two people. It does not need to be notarized.

Medicare reimburses $86.00 for the first thirty (30) min and $75.00 for each additional thirty (30) min face to face visit.