Meeting the challenge of monthly care coordination under Medicare
Today’s capacity-constrained practices need a better solution for managing their patients’ chronic conditions

Multiple chronic conditions are responsible for:

- 75% of typical primary care visits\(^1\)
- 70% of all inpatient stays\(^2\)
- 93% of Medicare spending\(^3\)

... and by default, cause primary care physicians to act as the care coordinator for multiple providers.

Patients with multiple chronic conditions need care coordination between office visits:

- To ensure they keep their appointments and that the appointments are productive
- To improve compliance and self-care support, and to track progress between office visits

Average primary care visit:

18 minutes
7.1 problems\(^3\)

Quest Chronic Care Management (CCM) Services can help your practices take better care of patients with chronic conditions

CCM Services include:

- A minimum of 20 minutes of monthly, non-face-to-face services to help meet the requirements for CPT 99490\(^*\)
- Care coordinator outreach (LPN/RN) to provide care coordination and navigation
- Development of comprehensive care plans that will be reviewed and approved by a practice physician(s)
- Medication reconciliation to help guard against error and support patient compliance
- Physician notification if patient reports an ER visit, hospital discharge, or skilled nursing facility stay
- Coordination with specialists and home- and community-based service providers

\(^*\) The CPT codes provided are based on American Medical Association guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.
Quest CCM: extending care to your patients in a non-face-to-face way between office visits

Staying close to the patient results in benefits for practices, patients, and healthcare organizations.

**For practices: fully CMS-compliant outreach**
- Every encounter is properly tracked
- Monthly reports document the 20-, 60-, and 30-minute time periods that are required to help meet the reimbursement requirements for CPT 99490, CPT 99487 (complex care), and CPT 99489 (add-on services)

**For patients: better outcomes, better experience**
- Being reassured by a trusted, nurse-led team of care coordinators
- Having progress monitored and positively reinforced
- Receiving disease-specific advice and education (e.g., Healthwise® series)
- Getting assistance with care navigation and coordination (e.g., scheduling, community services, talking to other providers, transportation)

**For organizations: help improve clinical and financial performance**
- Improved patient outcomes, quality metrics, and satisfaction ratings
- Fill gaps in care and patient adherence
- Improved practice economics and help increasing attribution
- Reduced administrative burden for practices
- Reduced physician burnout that results from limited capacity
- Broader economic value of CCM model (e.g., reduced complications, ER visits, readmissions)
- More productive office visits—improving provider satisfaction, as well
- A population health initiative addressing multiple chronic conditions, while potentially reducing the costs associated with care

An ideal solution for meeting MACRA/MIPS/APM requirements.
A strategic partner to keep everyone connected

Quest CCM Services can help your practices better manage patients with multiple chronic conditions and control costs by potentially reducing unnecessary office visits, ER visits, and hospital readmissions.

Trust Quest to be your capable, caring, and responsible partner. To learn more, visit QuestDiagnostics.com/CCM or contact your Quest sales representative.

References