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Chronic care management: What physicians and compliance officers need to know

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In 2015, the Centers for Medicare & Medicaid Services (CMS) implemented chronic care management (CCM) services in an effort to reduce the cost of medical care for Medicare beneficiaries and to improve clinical outcomes for individuals with two or more chronic conditions. In 2017, CMS relaxed some of the regulations in terms of documentation requirements; these changes were meant to encourage providers to begin offering chronic care services. Physicians had been discouraged from providing CCM services because of the complicated billing rules. Despite the revisions made to CCM documentation requirements, billing for CCM services remains problematic. Thus the Department of Health and Human Services Office of Inspector General (OIG) is keeping a close eye on improper payments for CCM services. This article will focus on the documentation requirements for billing CCM services, how to avoid denials, and how to stay in compliance with CCM regulation and documentation requirements. Compliance officers may also consider this as a potential risk area and integrate it into their auditing and monitoring plans.

Billing CCM services can be challenging

CCM service codes are not your typical evaluation and management (E/M) codes. CCM became a billable service under the physician fee service as of January 1, 2015, for healthcare providers helping patients with the management of multiple (i.e., two or more) chronic conditions. Current Procedural Terminology (CPT) codes 99490 and 99491 are in the E/M section of the CPT manual under Care Management Evaluation and Management Services.[1] Additionally, there are two CPT codes (99487 and 99489) to bill for complex chronic care management services, and these codes are for moderate-to-high complexity medical decision-making and require 60 minutes or more of non–face-to-face time per calendar month.

In order to bill for CCM services, the patient must meet the defined criteria for chronic care management. The patient must have two or more chronic conditions that are expected to last at least 12 months (or until the death of the patient), and those conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.[2] CPT code 99490 is defined as at least 20 minutes of non–face-to-face time by the clinical staff directed by a physician or other healthcare professional per calendar month. And, CPT code 99491 is a new CCM code as of January 1, 2019, and is defined as chronic care management services, provided personally by a physician or other healthcare professional, with 30 minutes of non–face-to-face time per calendar month.[3] Although these codes are under the E/M umbrella, the documentation requirements are unique and different from other E/M codes.

CCM documentation requirements are not so simple

Before billing for CCM services, it is important that physicians, coders, and billing staff understand the documentation requirements for CCM services. First, Medicare requires an initiating visit for new patients or for

patients not seen within one year prior to the start of CCM services.[4] The initiating visit is a face-to-face visit that is not part of the CCM service and should be billed separately.[5] Second, the physician must obtain advance written or verbal consent from the patient before providing or billing for CCM services. Lastly, providers that bill CCM services must use a certified electronic health record (EHR) and develop and implement a comprehensive care plan in order to manage the patient's chronic conditions. The patient must have 24/7 access to care and health information from their physician to address any urgent needs.[6] The supervising physician must document a time log of CCM non–face-to-face activities and should review and sign the record prior to submitting a claim for CCM.

Patient consent is necessary

Since the inception of CCM services in 2015, obtaining patient consent has been a requirement to bill for CCM services. Documentation of written consent was required until January 1, 2017, when CMS made changes to allow for verbal consent, as long as the physician or other qualified provider documented that the patient had agreed to receive CCM services.[7] Consent includes the explanation of the requirements related to the CCM services, and the patient must understand these requirements. The patient must also be made aware that they have the right to discontinue CCM services at any time.[8] It is important that physicians are aware of the guidelines, because consent is a condition of payment for CCM services.[9] Moreover, without proper patient consent for billed CCM services, claims can be denied or found in error during an audit. CCM services should not be billed until verbal consent is obtained and documented in the record by the physician.

Be careful to track non–face-to-face time

CCM services are timed codes, and all non–face-to-face time should be tracked and documented in the record. CCM services are considered independent of in-person visits and are performed typically by phone or through secure email.[10] Communication can be with the patient, the caregivers, or for coordination of care with other providers related to care or services needed. These activities can include review of medical records and test results, review and education of disease processes, self-management, coordination of care, and referrals for specialists as well as home and community-based clinical services.[11] A monthly time log should be kept of all CCM activities to ensure that the 20-minute requirement is met prior to billing for CCM.

Documentation: Take the time now, avoid denials later

Because CCM is a billable service based on non–face-to-face time, documentation is key to ensuring that the claim is payable. A monthly time log should be kept to document all non–face-to-face activities and to ensure accurate coding and billing. Ongoing updates to the care plan with the required elements (i.e., a problem list, expected outcomes and prognoses, measurable treatment goals, symptom management, planned interventions, medication management, and referrals for community-based services) should be documented in the medical record.[12] Detailed documentation of the tasks performed and which staff did them must include their input related to CCM services provided. The time spent should be clearly and concisely documented in the progress notes throughout the month. Physicians billing for CCM services should also be aware of the patient's other physicians who may also be providing CCM services. Only one provider per patient can bill for CCM services per month.[13] Good documentation practices are essential when billing for CCM services and can help to reduce CCM claim denials.