Plan to Audit Your Chronic Care Management (CCM) Services

You finally have a way to be paid for all the coordination of care work your providers routinely perform thanks to Medicare's new chronic care management (CCM) service. But like all new paid services, CCM is subject to audits and overpayments, which means you need to be sure your CCM documentation is up to snuff.

Fortunately, auditing CCM services won't be difficult or time-consuming if you take the time to develop a plan and ensure your providers follow the rules for CCM.

First, let's quickly review the rules for CCM. Billed using CPT code 99490, CCM pays approximately $43 and is intended to providers for the work of coordinating and managing patients with chronic conditions, including communication with patients or other treating health care providers.

In order to bill for CCM, you must:

- Use an electronic health record (EHR) system.
- Have a unique care plan for each chronic patient, and obtain signed consent from patients to receive CCM.
- Be treating chronic patients, i.e. those with at least two chronic conditions that have lasted at least 12 months and place patients at risk of significant functional decline or death.
- Spend at least 20 minutes of work coordinating care (combined across your entire team including ancillary staff) on each eligible patient, performing tasks such as phone calls, prescription refills, lab or test orders, etc.
- Document in detail what tasks were performed for CCM, including a list of contributing staff and their contributions.
- Be the first provider to bill the CCM code for each chronic patient (Medicare will pay CCM once per 30 days per patient, and if more than one provider bills, the first one to submit gets paid).

The full CPT descriptor for 99490 is "chronic care management services, at least 20 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month."

Auditing CCM services

Now let's talk about what an auditor should look for in a properly billed CCM claim. Problems with CCM will generally involve patient eligibility or documentation. **Patient eligibility** problems have to do with whether they are "chronic," whether consent was obtained, and whether they already received CCM elsewhere during a calendar month. **Documentation** problems revolve around the description of the CCM services provided and who provided them (e.g. "Dr. Smith ordered a lipid panel and spoke to patient's cardiologist for input, Nurse Williams refilled patient's prescription for Warfarin").

Here are some tips to follow so your CCM services will pass muster:

- Communicate clearly and early with your patient, explaining why CCM is important and obtaining their written consent. A simple consent form can be created that explains the type of tasks that go into care coordination and why CCM improves outcomes.
- Ensure no other providers from other groups are billing CCM for the same patient. This again reinforces the need for communication with the patient.
- Ensure patients really are chronic. This means the presence of at least two problems qualifying as chronic, and here for the first time CMS is explicit in defining "chronic" - lasting 12 months or longer and placing the patient at significant risk of exacerbation, functional decline, or death.
- Create comprehensive care plans for managing patients' chronic conditions. This includes making sure the patient gets a copy, which is a requirement of CCM.
- Document the 20 or more minutes spent on CCM. No matter how minor the task might be, whether it's phone calls to other providers involved in care, writing prescription refills, or ordering and scheduling tests, you'll need to show CMS what you did and you can't rely on a generic statement.

Planning your CCM audits
Because CCM is a monthly service for each eligible chronic patient, your frequency will be fairly static over time. This makes scheduling audits for CCM services relatively straightforward. A monthly review of CCM services for each provider is the first step, and depending on how many errors you find, you may want to keep CCM audits a monthly affair or make them quarterly if all is well.

Early on in the process, watch out for these common issues:

- If more than one provider sees the same patient in your practice, make sure the CCM is billed only once that month for one provider.
- Not documenting contributions by members of your team (especially ancillary staff) who are not the primary provider for the patient.
- Not documenting as you go, even if informally. Your documentation must be detailed and thus you should be making a note of contributions to CCM as they happen rather than writing a generic statement when it's finally time to submit the claim.

This Week's Tip Provided by:

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