E-BRIEF SERIES

Healthicity

Compliance Tips for Chronic Care Management

CJ Wolf MD, CHC, CPC, CCEP, CIA

In June 2024, a provider organization settled False Claims Act allegations with the government by agreeing to pay $14.9 million. Improper billing of chronic care management (CCM) was among the alleged improper billing schemes.

UNDERSTANDING CHRONIC CARE MANAGEMENT

CCM is a non-face-to-face service provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions (Alzheimer's disease, arthritis, cancer, diabetes, etc.) that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. These significant chronic conditions are expected to last at least 12 months or until the death of the patient.

The Centers for Medicare & Medicaid Services (CMS) recognizes CCM as a critical primary care service that contributes to better Medicare patient health and care. They pay for CCM services provided to patients with multiple chronic conditions under the Medicare Physician Fee Schedule (PFS).

THE IMPORTANCE OF CCM COMPLIANCE

Compliance with all the billing requirements is essential for providers billing for these services. In 2021, the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) published a report that concluded Medicare was continuing to make overpayments for CCM services and that this was costing the program and its beneficiaries millions of dollars.

They identified over 38,000 claims in which providers billed noncomplex or complex CCM services more than once for the same beneficiary for the same service period. They also identified over 10,000 claims in which the same provider billed for both noncomplex or complex CCM services and overlapping care management services rendered to the same beneficiaries for the same service periods. And lastly, they identified over 800 claims for incremental complex CCM services that were billed along with complex CCM services. All of these claims were identified as overpayments.

UNDERSTANDING CCM SERVICES

Clearly, providers who are billing for CCM services should become well acquainted with all the billing requirements.

CCM services are extensive, and include:

- Structured recording of patient health information
- Maintaining comprehensive electronic care plans
- Managing care transitions and other care management services
- Coordinating and sharing patient health information promptly within and outside the practice

The patient must provide consent for chronic care management services.

CCM service elements apply to complex and non-complex CCM unless otherwise specified. Clinicians typically provide CCM services outside of face-to-face patient visits and focus on advanced primary care characteristics like:

- Continuous patient relationship with a chosen care team member
- Supporting the patient with a chronic disease in achieving health goals
- 24/7 patient access to care and health information
- Patient getting preventive care
- Patient and caregiver engagement
- Prompt sharing and using patient health information

WHO CAN BILL CCM SERVICES?

CMS allows the following providers to bill CCM services: Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners, Physicians Assistants and Physicians.

For CCM services the billing practitioner doesn't personally provide, the clinical staff can provide them under direction of the billing practitioner on an "incident to" basis (as an integral part of services provided by the billing practitioner), subject to applicable state law, licensure, and scope of practice. Clinical staff are employees or people working under contract with the billing practitioner, and CMS directly pays those practitioners for CCM services.

The HHS OIG Identified:

38,000
claims in which providers billed noncomplex or complex CCM services more than once for the same beneficiary for the same service period

10,000
claims in which the same provider billed for both noncomplex or complex CCM services and overlapping care management services rendered to the same beneficiaries for the same service periods

800
claims for incremental complex CCM services that were billed along with complex CCM services

CCM ELIGIBILITY CONSIDERATIONS

To be eligible for these services, CCM patients will have multiple (two or more) chronic conditions that are expected to last at least 12 months or until the patient's death or that place them at significant risk of death, acute exacerbation or decompensation, or functional decline. These services aren't typically face-to-face and allow eligible practitioners to bill at least 20 minutes or more of care coordination services per month.

Before CCM services can start, CMS requires an initiating visit for new patients or patients who the billing practitioner hasn't seen within the previous one year. The initiating visit can happen during a comprehensive face-to-face evaluation and management (E/M) visit, annual wellness visit (AWV), or initial preventive physical exam (IPPE). If the practitioner doesn't discuss CCM during an E/M visit, AWV, or IPPE, it can't count as the initiating visit. A face-to-face initiating visit isn't part of CCM and can be separately billed.

The patient must also provide consent for these services. Providers should get the patient's written or verbal consent for CCM services before they bill for them. This helps ensure patients are engaged and aware of their cost sharing responsibilities and helps prevent duplicate practitioner billing.

Providers must also inform the patient of these items and document them in their medical record:

- The availability of CCM services
- Their possible cost sharing responsibilities
- That only one practitioner can provide and bill CCM services during a calendar month
- The patient's right to stop CCM services at any time (effective at the end of the calendar month)
- That the practitioner explained the required information and whether the patient accepted or declined services

A comprehensive care plan is required for all health issues with a focus on managing chronic conditions and should:

- Create, revise, and monitor (per code descriptors) a person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports
- Provide patients and caregivers with a copy of the care plan
- Electronically capture the care plan information, and make it available promptly both within and outside the billing practice with people involved in the patient's care, as appropriate

CCM is extensive and also includes certain levels of medical decision making, 24/7 access to care, and continuity of care. There are additional requirements related to expected services performed as part of comprehensive care management, managing care transitions, and certain restrictions about concurrent billing with other types of services.

If your organization bills for CCM, the compliance program should ensure there are regular audits and/or monitoring activities to ensure compliance.

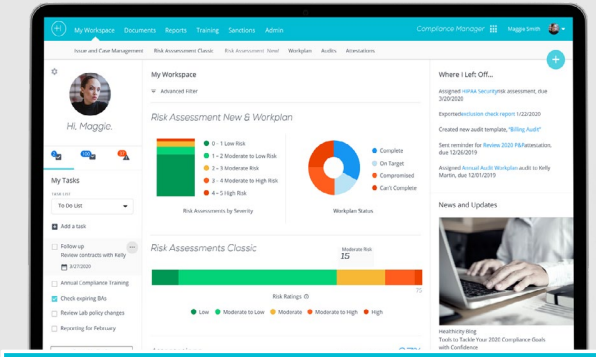
CJ Wolf

MD, CHC, CPC, CCEP, CIA

CJ Wolf is a healthcare professional with more than 20 years of experience in hospital and physician revenue cycle, practice management, compliance, coding, billing, and client services. He has provided healthcare consulting and solution services to hospitals and physician organizations throughout the country.

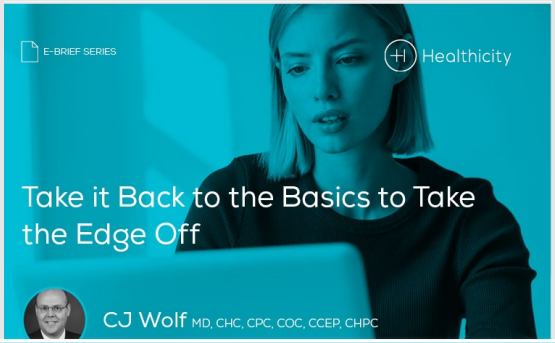
For more on Healthicity's Compliance Services and Solutions, please visit healthicity.com/compliance or call 877.777.3001

COMPLIANCE MANAGER



WATCH ON-DEMAND DEMO

RESOURCE CENTER



EXPLORE FREE RESOURCES