CHRONIC CARE MANAGEMENT

Effectively Navigating Program Compliance

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Introduction

Chronic Care Management (CCM) programs are necessary for better patient outcomes. However, there is a huge gap in written direction from Centers for Medicare and Medicaid Services (CMS) on how to effectively drive program quality and maintain compliance.

The complexities and somewhat unclear directions from CMS regarding CPT 99490 for Chronic Care Management have continued to be a concern for providers and will surely lead provider practices to inaccurate coding and/or documentation.

Recent CMS ADR provider audits have revealed results that mean it is highly likely that CCM will become even more subjected to audits from CMS due to this lack of understanding of documentation requirements.

To comply with Medicare's CCM billing requirements, even practices that already provide CCM-type services and have efficient systems in place will need to evaluate and give more attention to 1) how their staff and/or contracted service provider is documenting the patient enrollment, and 2) how they are documenting the monthly care provided in order to have a compliant program. In a letter dated September 25, 2018 by the AAFP, they urged CMS to work with Congress to reduce excessive CCM documentation requirements. Yet, to date, the requirements remain the same.

Most providers today are reluctant to offer CCM programs due to the lack of understanding of the program and, most importantly, how to comply with the CMS required program elements in order to avoid paying money back to CMS as a result of an audit.

Why Chronic Care Management?

There is obviously a huge need for chronic care patients to have additional support in managing their healthcare needs between office visits.

According to an article from National Center for Chronic Disease Prevention and Health Promotion dated August 14, 2018, one in four Americans has multiple chronic conditions, i.e., those that last a year or more and require ongoing medical attention or that limit activities of daily living.

That number rises to three in four Americans aged 65 and older. Having multiple chronic conditions is also associated with substantial health care costs.

Approximately 71percent of the total health care spending in the United States is associated with care for people with more than one chronic condition. Among Medicare fee-for-service beneficiaries, people with multiple chronic conditions account for 93 percent of total Medicare spending. People with multiple chronic conditions face substantial out-of-pocket costs of their care, including higher costs for prescription drugs.

The Centers for Disease Control and Prevention states six out 10 adults in America have a chronic disease and four out of 10 have two or more chronic diseases. Chronic disease is the leading cause of death and disability and leading driver of the nation's 3.3 trillion annual health care costs.

The evolution of care needs to move from reactive, which is focused solely on face-to-face care, to pro-active, which includes patient outreach, engagement and management of patients with chronic conditions that occur in between the normal brick-and-mortar office visit.

Accountability and Transparency

Offering a CCM program that maintains both quality and compliance and that will withstand any audit is key. There are certain program elements that CMS does offer some guidance on which include patient enrollment and care delivery and billing aspects.

Top Qualifications

- Patients qualify to participate in the program if they have two or more chronic conditions actively being treated by the billing provider.
- Patients must give consent to participate in the CCM program.
- Patient consent may be verbal if they have been seen face-to-face by the billing provider in the last 12 months.

Enrollment Required Elements

Before a patient can give verbal consent, they must have been seen by their Doctor within 12 months and:

- Be educated on the benefits of the program including how the program will support them individually.
- Be informed that the provider can charge for the program monthly and that cost sharing applies. This means that patients must understand the benefits for them and that, if they do not have any secondary coverage, they will be subject to monthly cost-to-participate in the program.
- Understand that a patient-centered care plan will be developed and their right to participate in the care plan as well as have access to the care plan or be given a copy.
- Understand the program gives them 24/7 access to designated members of their care team. This means providing beneficiaries with a way to make timely contact with health care providers in the practice to address the patient's urgent chronic care needs regardless of the day or time.

- Understand they can only enroll and participate in one CCM program. It's importance to be sure the patient in not already participating in CCM with another physician.
- Understand that should they decide they do not want to continue to participate in the program they may terminate at any time by verbally notifying the billing provider office.

If all the above are explained in detail and the patient understands each element, then at that time they can verbally consent to participate in the provider's Chronic Care Management Program.

- The verbal information / education and the patient's verbal consent to participate must be documented in the medical record.
- Please note that ALL elements are required before a valid patient enrollment in a Chronic Care Management program and for billing the program CPT code.
- Ask "Is the program in compliance?" on the enrollment aspects.
- Are the staff who are discussing this program utilizing a script or check list that covers all elements?

Required Elements for Enrolled Patients

Enrolled patients who have services delivered that meet the minimum 20 minutes non-face-to-face time, can be billed utilizing CPT 99490 if all other requirements are met.

- Systematic assessment of patient'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
- Oversight of patient self-management of medications

Clinical staff time must be tracked in exact minutes and seconds and should avoid rounding time, which may raise questions around program minutes. Program time should be clearly documented, listing all details of the care management tasks that create the minutes.

Providers must develop, review and revise a patient-centered

care plan:

- Care plan must be made available to the care team and the patient.
- Care plan must include the patient's input when at all possible. The patient-centered care plan document is to assure that care is provided in a way that is congruent with patient choices and values.
- A plan of care is based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues.

Care management of the patient must include 24/7 access to the care team and timely response to issues. THis should include continuity of care with a designated practitioner or member of the care team with whom the patient can get successive routine appointments.

Management of care transitions between and among health care providers and settings including:

- Referrals to other clinicians
- Follow-up after a beneficiary visit to an emergency department
- Follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities.

Regardless of the program type (insourced or outsourced), make sure to ask:

- Is the program compliant with these elements for billing CCM?
- How can the practice confirm compliance upon audit?
- Is there a process in place that scales more than a few patients into the program?
- Is there a process in place to review CCM time tracking notes for compliance?
- Is there oversight on the bill submitted for payment that delivers the program elements set by CMS?
- Oversight on boxes that have been checked for each patient and the CPT code submission is valid?
- Can the practice prove that the submitted claims have valid supporting documentation?

Key Compliance Considerations

With the OIG 2017 workplan it is safe to say they will start to keep much better watch on payments for CCM. The workplan states the intention to conduct reviews to see if the payments for CCM services were issued according to CMS requirements.

From a compliance perspective, this means that if delivering and billing for CCM services, there should be airtight oversight to ensure following the required CMS elements and having the risk mitigating process and plan of action to support any audit.

Key audit factors include

- Determining patient eligibility
- Was there informed consent?
- Clear, established work flows and protocols

- Does CCM minutes documentation support CMS guidelines for CPT code billing
- Ongoing training for operating an effective CCM model
- Patient access to care plan clearly documented
- Documentation of provider collaboration and oversight of care management company including meeting incident to rules is required for billing CCM
- Must h clinical integration among the care team members providing CCM
- Must be overseen by the billing practitioner, which would need to be documented in the record.

Enrollment and Care Delivery Compliance

If the health system is considering OR already operating and overseeing a Chronic Care Management Program, then consider the following:

- Identifying and targeting eligible patients who meet the CMS qualifications to participate in CCM
- Bandwidth of current staff to consistently and effectively inform, enroll and service these patients where there is value to the patient with positive outcomes
- Monitoring and maintaining compliance
- Monitor CMS regulatory developments related to CCM and implement any necessary changes to avoid unintended consequences
- A plan in place to prepare and respond to audits so that the health system does not end up in a pay-back situation
- Technology platform that delivers a program compliance side to CCM services with the ability to review audio calls and documentation inside a platform with reporting analytics

- Licensed clinical staff who perform specific compliance reviews, are experienced at care coordination, and understand all program elements
- Clinical staff should be the backbone of the program and provide real-time review of every patient enrollment for 100 percent accuracy as well as an overall percentage of monthly care delivery services
- A robust training program for all staff that will contact patients or who may or may not enroll patients in the CCM program. Training should include all the required CMS elements, complete understanding of the program benefits and how to deliver and promote a compliant CCM program.

Conclusion

This is just a start to get the CCM program moving down the right path to be a compliant, patient-outcome driven program. Most EMR technology platforms do not offer any type of CCM compliance program. Most third-party vendors will state they will go at-risk with the health system, but what exactly does that mean?

It is the responsibility of the billing provider who submits the CPT code for billing to know that what is submitted meets all the CMS guidelines. There is a huge benefit to the patient to have the support services of CCM so that they can depend on help in between office visits and prevent exacerbations that lead to costly hospital stays, but there is also a good financial benefit to the providers if the program is performed compliantly and according to the guidelines set by CMS.

By setting high standards, not only will patients reap great benefits, but the office staff will appreciate the additional support, allowing them to focus more on patients that are in the office.

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Orb Health enables health systems to drive better patient outcomes and reduce the cost of value-based care for Chronic Care Management, Behavioral Health, and more. Through outsourced collaborative care services that act as a seamless extension of the health system, Orb Health expands patient access, drives efficient care coordination, and increases effective provider cooperation without additional staff.

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