Capture Billing
Medical Billing Services

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Chronic Care Management: 6 Tips for Documentation Success

As a medical billing company CEO, I have heard lots of physicians and practice managers complain about time spent on non-billable services, like chronic care management. “My staff and I spend an awful amount of time helping patients over the phone; is there any way I can get paid for that?”

Physicians also want to know if they can be paid for services provided in between patient visits, such as completing forms, medication refills, and telephone consults. My response has always been “no”; there was no reliable way to get paid for these types of services. Now however, some

of that has changed with Medicare's new willingness to pay for Chronic Care Management Code 99490.

In this blog post, I'll go over some rules and tips on how to document for this service.

Take Advantage of the Reimbursement Opportunity

According to the CDC, one-third of the U.S. population has at least one chronic disease, such as cancer, asthma, diabetes or heart disease. Chances are good that we, or people we love, have experienced the challenges of coordinating care for these complex conditions.

CMS has a list of about 22 things the practice needs to do to comply, including engaging with each patient over the phone for 20 minutes each month to coordinate care. It doesn't have to be one phone call, but could be a five-minute phone call each week, for example.

On these calls, clinicians find out what's going on with patients and help them figure out what care they need and where they can get it. In return, CMS will pay about $40 per member, per month.

CMS Says

CPT code 99490 is defined as: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

1. Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
2. Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
3. Comprehensive care plan established, implemented, revised, or monitored.

What constitutes a Chronic Condition?

According to the CDC, 66% of Medicare patients had two or more chronic conditions in 2015.

Chronic conditions include:

- Alzheimer's and related dementia
- Arthritis
- Asthma
- Atrial Fibrillation
- Autism
- Cancer
- COPD
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Ischemic Heart Disease
- Osteoporosis

Although this is not the complete list, practices see many patients with two or more of these diseases. So, it's safe to say many medical practices have a large population of patients eligible for this service.

Key CCM Definitions:

Clinical Staff: a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service; but who does not individually report that professional service.

Examples Include:

- Medical Assistants
- Nurses

- Therapists

Directed by a Physician: CMS allows a physician to bill for this service so long as the service is provided under his/her general supervision. This means the physician is present and/or accessible during the time of service, and is able to guide the care. *No direct contact between the physician and the patient is needed to bill this code.*

Comprehensive Care Plan: according to CMS, a Comprehensive Care Plan includes the following:

- Problem list;
- Expected outcome and prognosis;
- Measurable treatment goals;
- Symptom management;
- Planned interventions and identification of the individuals responsible for each intervention;
- Medication management;
- Community/social services ordered;
- A description of how services of agencies and specialists outside the practice will be directed/coordinated; and
- Schedule for periodic review and, when applicable, revision of the care plan.

These items should be documented in the patient's chart prior to billing for the CCM code.

6 Tips for Documentation Success

Tip #1: Medicare requires that the patient understands and agrees to the chronic care management services before they are offered and billed. It may be best to draft a basic letter that the physician can review with the patient during their face-to-face visit prior to billing for the CCM. This letter should be signed by the patient and recorded in the patient's record.

This letter should include:

- An explanation of the CCM and its availability
- An explanation that the patient can revoke the service
- A portion explaining that only one provider can bill for this service for each patient

- An explanation on what information may be shared between physicians

You can find tools & templates for CCM in the American College of Physicians CCM toolkit (free) and the CCM Toolkit from the American Academy of Family Physicians ($69 for AAFP members).

Tip #2: Medicare requires that an Annual Well Visit or Comprehensive Evaluation and Management code be billed prior to the CCM. During this first visit, document the discussion with the patient described above, his/her acceptance or denial, and the care plan that the CCM will follow.

Tip #3: Consider building a template in your EMR/EHR that you or your clinical staff can use to document each CCM service. This template should copy over some elements of the care plan documented during the initial face-to-face visit including: basic demographic information, medication and allergy info, the patient's consent to the service, and clinical summaries that can be shared with other physicians.

Tip #4: Set up a system that can keep track of time spent on non-face-to-face services provided, including:

- Phone calls and email communication with patient.
- Time spent coordinating care (by phone or other electronic communication) with other clinicians, facilities, community resources, and caregivers.
- Time spent on prescription management and medication reconciliation.

Tip #5: When billing for CCM make the date of service range the calendar month in which you are billing, for example – 01/01/2016-01/31/2016.

Tip #6: A practice can insource or outsource the delivery of CCM services for its patients. In either case, your practice will need to establish a consistent system of documentation based on your own physical, staffing, and EHR configurations.

Once your tools and processes are set up, documentation of these services will go smoothly.

About the Author

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Manny Oliverez, CPC, is a 20-year healthcare veteran and the CEO and co-founder of Capture Billing, a medical billing services company located outside of Washington, D.C. He teaches the nation's physicians, administrators, and medical practices how to maximize billing and revenue cycle management processes. Manny also frequently posts articles and videos on his award-winning healthcare blog. For more information on Manny and his company, please visit his website, or call (703)327-1800. And if you're on LinkedIn, please look for him there too. **READ MORE**

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