DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Chronic Care Management Services

The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals.

In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This fact sheet provides background on payable CCM service codes, identifies eligible practitioners and patients, and details the Medicare PFS billing requirements. Beginning January 1, 2017, the CCM codes are:

CCM	
CPT 99490	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: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Comprehensive care plan established, implemented, revised, or monitored
Assumes 15 minutes of work by the billing practitioner per month	

ICN 909188 December 2016

Complex CCM	
CPT 99487	Complex chronic care management services, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Establishment or substantial revision of a comprehensive care plan • Moderate or high complexity medical decision making • 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
CPT 99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.

CCM (sometimes referred to as "non-complex" CCM) and complex CCM services share a common set of service elements (summarized in Table 1). They differ in the amount of clinical staff service time provided; the involvement and work of the billing practitioner; and the extent of care planning performed.

Practitioner Eligibility

Physicians and the following non-physician practitioners may bill CCM services:

- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants

Only one practitioner may be paid for CCM services for a given calendar month. This practitioner must only report either complex or non-complex CCM for a given patient for the month (not both).

NOTE: CCM may be billed most frequently by primary care practitioners, although in certain circumstances specialty practitioners may provide and bill for CCM. The CCM service is not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, although practitioners may refer or consult with such physicians and practitioners to coordinate and manage care.

CCM services that are not provided personally by the billing practitioner are provided by clinical staff under the 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. The clinical staff are either employees or working under contract to the billing practitioner whom Medicare directly pays for CCM.

Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month in order to bill CCM services. Non-clinical staff time cannot be counted toward the threshold.

Supervision

The CCM codes (CPT 99487, 99489, and 99490) are assigned **general supervision** under the Medicare PFS. General supervision means when the service is not personally performed by the billing practitioner, it is performed under his or her overall direction and control although his or her physical presence is not required.

Patient Eligibility

Patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline are eligible for CCM services.

- Billing practitioners may consider identifying patients who require CCM services using criteria suggested in CPT guidance (such as number of illnesses, number of medications or repeat admissions or emergency department visits) or the profile of typical patients in the CPT prefatory language.
- There is a need to reduce geographic and racial/ethnic disparities in health through provision of CCM services. Table 2 provides a number of resources for identifying and engaging subpopulations to help reduce these disparities.

The billing practitioner cannot report both complex and regular (non-complex) CCM for a given patient for a given calendar month. In other words, a given patient receives either complex or non-complex CCM during a given service period, not both.

Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS

Initiating Visit

For new patients or patients not seen within one year prior to the commencement of CCM, Medicare requires initiation of CCM services during a face-to-face visit with the billing practitioner (an Annual Wellness Visit [AWV] or Initial Preventive Physical Exam [IPPE], or other face-to-face visit with the billing practitioner). This initiating visit is not part of the CCM service and is separately billed.

Practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code G0506 (Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services [billed separately from monthly care management services] [Add-on code, list separately in addition to primary service]). G0506 is reportable once per CCM billing practitioner, in conjunction with CCM initiation.

Patient Consent

Obtaining advance consent for CCM services ensures the patient is engaged and aware of applicable cost sharing. It may also help prevent duplicative practitioner billing. A practitioner must obtain patient consent before furnishing or billing CCM. Consent may be verbal or written but must be documented in the medical record, and includes informing them about:

- The availability of CCM services and applicable cost-sharing
- That only one practitioner can furnish and be paid for CCM services during a calendar month
- The right to stop CCM services at any time (effective at the end of the calendar month)

Informed patient consent need only be obtained once prior to furnishing CCM, or if the patient chooses to change the practitioner who will furnish and bill CCM.

Although patient cost-sharing applies to the CCM service, most patients have supplemental insurance to help cover CCM cost sharing. Also CCM may help avoid the need for more costly services in the future by proactively managing patient health, rather than only treating severe or acute disease and illness.

CCM Service Elements - Highlights

The CCM service is extensive, including structured recording of patient health information, maintaining a comprehensive electronic care plan, managing transitions of care and other care management services, and coordinating and sharing patient health information timely within and outside the practice. **Table 1 summarizes the CCM service elements, which apply to both complex and non-complex CCM unless otherwise specified.** CCM services are typically provided outside of face-to-face patient visits, and focus on characteristics of advanced primary care such as a continuous relationship with a designated member of the care team; patient support for chronic diseases to achieve health goals; 24/7 patient access to care and health information; receipt of preventive care; patient and caregiver engagement; and timely sharing and use of health information.

Structured Recording of Patient Health Information

- Record the patient's demographics, problems, medications, and medication allergies using certified Electronic Health Record (EHR) technology. This means a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31st of the calendar year preceding each Medicare PFS payment year. For more information, visit https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms.

Comprehensive Care Plan

- A person-centered, electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources (a comprehensive plan of care for all health issues, with particular focus on the chronic conditions being managed)
- Provide the patient and/or caregiver with a copy of the care plan
- Ensure the electronic care plan is available and shared timely within and outside the billing practice to individuals involved in the patient's care
- Care planning tools and resources are publicly available from a number of organizations (see Resources in Table 2)

Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- 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
- Schedule for periodic review and, when applicable, revision of the care plan

Access to Care & Care Continuity

- Provide 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified health care professionals or clinical staff, including providing patients (and caregivers as appropriate) with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week
- Ensure continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
- Provide enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care by telephone and also through secure messaging, secure Internet, or other asynchronous non-face-to-face consultation methods (for example, email or secure electronic patient portal)

Comprehensive Care Management

- Systematic assessment of the 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
- Coordinating care with home and community based clinical service providers

Transitional Care Management

- Manage transitions between and among health care providers and settings, including referrals to other clinicians, follow-up after an emergency department visit, or facility discharge
- Timely create and exchange/transmit continuity of care document(s) with other practitioners and providers

Concurrent Billing

The billing practitioner cannot report both complex CCM and non-complex CCM for a given patient for a given calendar month. CCM cannot be billed during the same service period as HCPCS codes G0181/G0182 (home health care supervision/hospice care supervision), or CPT codes 90951–90970 (certain End-Stage Renal Disease services). CCM should not be reported for services furnished during the 30-day transitional care management service period (CPT 99495, 99496). Complex CCM and prolonged Evaluation and Management (E/M) services cannot be reported the same calendar month. Consult CPT instructions for additional codes that cannot be billed concurrent with CCM. There may be additional restrictions on billing for practitioners participating in a CMS sponsored model or demonstration program. Time that is reported under or counted towards the reporting of a CCM service code cannot also be counted towards any other billed code.

Payment

CMS pays for CCM services separately under the Medicare PFS. To find payment information for a specific geographic location by code, access the Medicare PFS Look-Up tool at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup.

CCM and Other CMS Advanced Primary Care Initiatives

The CCM service codes provide payment of care coordination and care management for a patient with multiple chronic conditions within the Medicare Fee-For-Service Program. Medicare will not make duplicative payments for the same or similar services for patients with chronic conditions already paid for under the various CMS advanced primary care demonstration and other initiatives, such as the Comprehensive Primary Care (CPC) Initiative. For more information on potentially duplicative billing, consult the CMS staff responsible for demonstration initiatives.

Table 1. CCM Service Summary

Initiating Visit – Initiation during an AWV, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of CCM services.
Structured Recording of Patient Information Using Certified EHR Technology – Structured recording of demographics, problems, medications, and medication allergies using certified EHR technology. A full list of problems, medications, and medication allergies in the EHR must inform the care plan, care coordination, and ongoing clinical care.
24/7 Access & Continuity of Care • Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week • Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
Comprehensive Care Management – Care management for chronic conditions including systematic assessment of the 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; and oversight of patient self-management of medications.
Comprehensive Care Plan • Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed. • Must at least electronically capture care plan information, and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the patient's care. • A copy of the plan of care must be given to the patient and/or caregiver.
Management of Care Transitions • Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities • Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers
Home- and Community-Based Care Coordination • Coordination with home- and community-based clinical service providers • Communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits must be documented in the patient's medical record
Enhanced Communication Opportunities – Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.
Patient Consent • Inform the patient of the availability of CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM services at any time (effective at the end of the calendar month) • Document in the patient's medical record that the required information was explained and whether the patient accepted or declined the services
Medical Decision-Making – Complex CCM services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner).

Table 2. CCM Resources

Resource	Website
CCM Materials for Physicians (FAQs and other materials) - Click on "Care Management"	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched
CCM Materials for FQHCs and RHCs	https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html
CCM Materials for Hospital Outpatient Departments	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS
Care planning tools and resources	• https://integrationacademy.ahrq.gov/playbook/develop-shared-care-plan • http://www.ihi.org/resources/Pages/Tools/MySharedCarePlan.aspx • http://catalyst.nejm.org/making-the-comprehensive-shared-care-plan-a-reality/
Chronic Conditions	https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions
Chronic Conditions Data Warehouse	https://www.ccwdata.org/web/guest/home
Governing Regulation	• CY 2014 Medicare PFS Final Rule (CMS-1600-FC) pages 74414-74427: https://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28696.pdf • CY 2015 Medicare PFS Final Rule (CMS-1612-FC) pages 67715-67730: https://www.gpo.gov/fdsys/pkg/FR-2014-11-13/pdf/2014-26183.pdf • CY 2015 Medicare PFS Final Rule; Correction Amendment (CMS-1612-F2), page 14853: https://www.gpo.gov/fdsys/pkg/FR-2015-03-20/pdf/2015-06427.pdf • CY 2017 Medicare PFS Final Rule (CMS-1654-F) pages 80243-80251: https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf
Health Disparities & CCM	• Mapping Medicare Disparities Tool - Interactive map for the identification of disparities between subgroups of Medicare patients (for example, by geography, race/ethnicity) in chronic conditions, health outcomes, utilization, and spending. Can assist in targeting populations and geographies for CCM. https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities.html • Building an Organizational Response to Health Disparities Resource and concepts for improving equity and responding to health disparities. Concepts include data collection, data analysis, culture of equity, quality improvement, and interventions. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Health-Disparities-Guide.pdf
Medicare Administrative Contractor (MAC) Contact Information	http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map

www.spacinternational.com

This educational product was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This educational product was prepared as a service to the public and is not intended to grant rights or impose obligations. This educational product may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

P.S. SPAC International Logo is added with CMS consent.

Check out CMS on:

Twitter LinkedIn YouTube