Chronic Care Management (CCM)

Chronic Care Management services are a Part B benefit offered to patients with two or more chronic medical conditions that meet patient eligibility requirements. CCM allows the health care provider to be paid separately while providing care to these beneficiaries.

A chronic medical condition can be defined as:

- Medical condition that lasts 12 months or longer
- Requires ongoing treatment by a physician or other similar health care provider
- Places the affected individual at risk for death, recurring flare-ups, and/or decline in ability to function
- **Examples:** arthritis, cancer, COPD, diabetes, ischemic heart disease

Chronic Care Management services are proactive approaches to care for the patient with multiple chronic medical conditions. CCM services allow the health care provider and the patient/caregivers to work together in the management of the patient's chronic medical conditions.

What are Chronic Care Management Services?

- Care coordination services are done outside of the regular office visit.
- Care is either personally delivered by the billing health care provider or provided by clinical staff under the direction of the billing health care provider for at least 20 minutes or more per calendar month.
- Chronic Care Management services enable the health care provider to coordinate personalized services to assist the patient in managing his/her chronic diseases
- The health care provider works with the patient to develop a comprehensive care plan to meet his/her individual medical needs related to his/her chronic medical conditions.
- Care is coordinated between the health care provider and other medical providers such as the patient's pharmacy, specialists, diagnostic/testing centers, hospitals, etc.

What are the eligibility requirements for beneficiaries?

In order to enroll, the patient must have two or more chronic medical conditions that:

- Are expected to last at least 12 months or until death of the patient
- Place the patient at a significant risk of death, acute exacerbation/decompensation, or functional decline

Chronic Care Management Services are part of the beneficiary's Medicare Part B benefits. There is a monthly fee to enroll in Chronic Care Management services. If the beneficiary has supplemental insurance, it may help cover this monthly cost. The beneficiary will need to pay his/her Medicare Part B deductible and coinsurance.

What are the eligibility criteria for provider?

In order to qualify to bill for Chronic Care Management services, the health provider must be classified as one of the following:

- Physician
- Physician Assistant
- Certified Nurse Midwife
- Certified Nurse Specialist
- Nurse Practitioner

Health care providers considered limited-license physicians and practitioners (clinical psychologists, podiatrists, and dentists) are not eligible to bill for Chronic Care Management services since Chronic Care Management services is not within their scope of practice. These practitioners may refer and consult with physicians and qualified practitioners for the purposes of coordinating and managing care. Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and hospitals may also bill for CCM services.

The billing health care provider should provide at least 20 minutes of CCM services per calendar month.

- This care can be personally provided by the health care provider or provided by clinical staff under the direction of the billing health care provider.
- Chronic Care Management services that are not personally delivered by the billing health care provider need to be provided by clinical staff under the direction of the billing health care provider. This is considered general supervision.
- The clinical staff must be either employed by the billing health care provider or under contract to work for the billing health care provider.

In order to ensure continuity of care, the patient should have 24/7 access to Chronic Care Management services.

- This is to ensure that the patient can contact the health care provider when needed so issues can be addressed.
- It also allows for appointments to be scheduled in a timely manner, care planning to be effectively completed, and pertinent data (such as vital signs or changes in status) to be exchanged.
- Communication can be performed through phone calls, text, email, or other methods agreed upon by the patient and health care provider.
- Answering machines cannot be used for these purposes.

How does the health care provider bill for Chronic Care Management services?

The health care provider should ensure that the documentation in the patient's medical record supports that the patient is at significant risk of death, acute exacerbation/decompensation, or functional decline due to chronic medical conditions. The CCM services can be either non-complex care (at least 20 minutes of CCM services per calendar month) or complex care (additional time of 60 minutes or more of CCM services per calendar month). The following codes may be used when billing for CCM services:

- For CPT code 99490 (Non-Complex CCM) - at least 20 minutes of clinical staff time per calendar month of Non-Complex Chronic Care Management services provided by clinical staff under the direction of the billing health care provider
- For CPT code 99439 (Non-Complex CCM)- each additional 20 minutes of Non-Complex CCM services (per calendar month)
  - This code is to be used in combination with CPT code 99490
  - This CPT code should be reported separately in addition to the primary procedure code.
  - It may be used up to two times per month, (allows billing for up to 60 minutes of total time per calendar month)
- For CPT code 99491 (Non-Complex CCM) - at least 30 minutes of personally delivered care by the physician/health care provider per calendar month of Non-Complex Chronic Care Management services
  - Please note that billing health care provider cannot count clinical staff time towards the required time when reporting this code.
- For CPT code 99437 (Non-Complex CCM)- each additional 30 minutes by a physician or other qualified health care professional Non-Complex CCM services (per calendar month)
  - This code should be listed separately in addition to code for primary procedure.
- For CPT code 99487 (Complex CCM)- at least 60 minutes of clinical staff time per calendar month of Complex Chronic Care Management services provided by clinical staff under the direction of the billing health care provider
- For CPT code 99489 (Complex CCM)- each additional 30 minutes of CCM services (per calendar month)

  - This code is to be used in combination with CPT code 99487.
  - This CPT code should be reported separately in addition to the primary procedure code.
  - It should not be reported separately if complex CCM services are less than 60 minutes during the calendar month.
  - Do not use this CPT code for complex CCM services of less than 30 minutes along with the 60 minutes for CPT code 99487 during the calendar month
- May bill HCPCS code G0506 when applicable- Comprehensive assessment of and care planning by the billing health care provider for patients requiring chronic care management services

Time should be clearly documented in the medical record as either start and stop time or total time. The health care provider can only report either complex or non-complex Chronic Care Management services for the patient per month (cannot bill both). The health care provider also cannot bill the following services during the same month as Chronic Care Management:

- Chronic Care Management can be billed concurrently with Transitional Care Management services
- The health care provider also cannot bill the following services during the same month as Chronic Care Management:
  - Home healthcare/hospice supervision (HCPCS codes G0181/G0182)
  - Certain End-Stage Renal Disease services (CPT codes 90951–90970)
- Complex CCM and prolonged Evaluation and Management (E/M) services cannot be reported by the same healthcare provider during the same calendar month.

Refer to MLN Chronic Care Management Services Chronic Care Management (CPT code 99490) (https://www.cgsmedicare.com/partb/pubs/news/2015/0315/cope28756.html), MLN Chronic Care Management Services (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf), and Transitional Care Management Services (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf) for additional information regarding coding for CCM services.

What are the benefits of participating in Chronic Care Management services?

Chronic Care Management services provide the patient and the health care provider with several benefits that will assist with the management of the patient's chronic medical conditions.

- CCM services of at least 20 minutes per calendar month
- 24/7 access for the patient to his/her health care provider
- More opportunities for the health care provider to speak with the patient and his/her caregivers about the care and treatment of the patient's chronic medical conditions
- Coordination of all the patient's medical care needs with other health care providers
- Comprehensive medical assessments of the patient's physical as well as psychosocial needs
- Routine preventative care services on a regular basis
- Consistent and timely follow-up after emergency department visits and discharges from the hospital or other healthcare facilities
- Coordination of care with home health and other community based clinical service providers
- Assistance to the patient with management of medications
- More consistency throughout the medical system in managing the patient's chronic medical conditions

What are the CCM documentation requirements for Chronic Care Management services?

Electronic Medical Records

The medical chart needs to reflect care coordination, care planning, and continuous clinical care.

- The health care provider should ensure that data such as the patient's demographics, complete list of medical problems, medications, and medication allergies are recorded using certified Electronic Health Records (EHRs).

- The certified EHR must meet the standards of the Promoting Interoperability Programs (formally known as the Medicare and Medicaid EHR Incentive Programs) (https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms).

Start of Care Requirements

The health care provider can start the patient on CCM services if it has been determined that the patient qualifies.

- If the patient has not been seen by the health care provider within one year prior to starting Chronic Care Management services or is a new patient, the billing health care provider is required to start Chronic Care Management services during a face-to face visit.
- This face-to face visit can be an Annual Wellness Visit, Initial Preventative Physical Exam, Transitional Care Management, or any other qualifying face-to-face visit with the billing health care provider.
- This initiating visit is billed separately as it is not part of the Chronic Care Management services.
- If the health care provider who completed the Chronic Care Management services initiating visit personally performs an extensive assessment and Chronic Care Management services care planning outside of the usual requirements outlined in the initiating visit code, the health care provider 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).
- The HCPCS code G0506 is billed separately from monthly care management services and can only be reported once per CCM billing health care provider in combination with CCM initiation visit.

Patient Consent

Prior to starting or billing Chronic Care Management services for the patient, the health care provider will need to obtain patient consent.

- The patient consent can be verbal or written.
- It must be documented in the medical record and include information on the availability of the Chronic Care Management services, any cost sharing involved, notification that only one health care provider can provide and bill for Chronic Care Management services per calendar month, and information about the right to stop Chronic Care Management services at any time (to be effective at the end of the calendar month).

Care Plan

The health care provider needs to develop comprehensive care plan that addresses the patient's physical as well as mental, psychosocial, cognitive, and environmental care needs.

- The care plan should be electronic in nature so it can be accessible to all people involved in the care of the patient.
- The patient and associated caregivers should be given a copy of the care plan.
- The care plan needs to be reviewed and monitored on a regular basis.
- Modifications and/or revisions should be completed as needed related to the patient's changing care needs.
- Per page 8 of MLN booklet Chronic Care Management Services (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf), the care plan should include at a minimum the following components:
  - Problem list
  - Expected outcome and prognosis
  - Measurable treatment goals
  - Management of symptoms
  - Planning of interventions and identification of those responsible individuals for each intervention
  - Medication management
  - List of ordered community/social services
  - Plan for how services will be directed and coordinated for agencies and specialists outside the practice
  - Schedule for periodic review and monitoring of the care plan and modifications and/or revisions as needed

Resources

For further information, please refer to the following:

- MLN Chronic Care Management Services: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- Chronic Care Management Health Care Professional Resources: https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/ccm/hcpresources
- Chronic Care Management (CPT Code 99490): https://www.cgsmedicare.com/partb/pubs/news/2015/0315/cope28756.html
- Connected Care Toolkit (http://www.cms.gov): https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CCM-Toolkit-Updated-Combined-508.pdf
- Cognitive Assessment & Care Plan Services - CMS: https://www.cms.gov/cognitive
- Jumpstart Your Chronic Care Management Program - AAPC Knowledge Center: https://www.aapc.com/blog/52775-jumpstart-your-chronic-care-management-program/

References

- Centers for Medicare and Medicare services, Department of Health and Human Services (2021, November 19). Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-payment Medical Review Requirements. https://public-inspection.federalregister.gov/2021-23972.pdf
- Centers for Medicare and Medicaid Services. (2019, July). Chronic Care Management Services(ICN MLN909188) [PDF]. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- Centers for Medicare and Medicaid Services. (2021, July). Transitional Care Management Services (MLN908628) [PDF]. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
- *Chronic Care Healthcare Resources | CMS.* (n.d.). Centers for Medicare and Medicaid Services. https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/ccm/hcpresources
- *Chronic Care Management (CPT Code 99490).* (2015, March 24). CGS Administrators, LLC. https://www.cgsmedicare.com/partb/pubs/news/2015/0315/cope28756.html
- *Chronic Care Management Coverage.* (n.d.). (https://www.medicare.Gov). https://www.medicare.gov/coverage/chronic-care-management-services
- *Connected Care Toolkit – Chronic Care Management Resources for Health Care Professionals and Communities.* (n.d.). Centers for Medicare and Medicaid Services. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/connected-hcptoolkit.pdf
- *Jumpstart Your Chronic Care Management Program - AAPC.* (2021, February 1). American Academy of Professional Coders. https://www.aapc.com/blog/52775-jumpstart-your-chronic-care-management-program/
- *Medicare Learning Network: Chronic Management Services.* (2019, July). Centers for Medicare and Medicaid Services. https://www.cms.gov/Outreach-and-Education/Medicare-learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

