Banner Health Network

Chronic Care Management Components and Requirements

What is Chronic Care Management?

Chronic Care Management (CCM) services are generally non-face-to-face services provided to Medicare beneficiaries who have multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient.

Is there a list of qualifying conditions?

CCM is not limited to specific conditions.

a) The member has one chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death.

b) The member must have two chronic conditions expected to last longer than 12 months that cause significant risk to the patient.

CCM and transitional care management (TCM) cannot be billed during the same month. Does this mean that if the 30-day TCM service period ends during a given calendar month and a qualifying amount of time is spent furnishing CCM services on the remaining days of that calendar month, CCM service codes cannot be billed that month?

The CCM service code(s) could be billed under the Physician Fee Schedule (PFS) during the same calendar month as TCM, if the TCM service period ends before the end of a given calendar month, a qualifying amount of time is spent furnishing CCM services subsequently during that month, and all other requirements to bill CCM are met during the remainder of the month.

Are there any other services that cannot be billed under the PFS during the same calendar month as CCM?

Yes, Medicare does not allow the CCM service codes to be billed during the same service period as home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182) or certain ESRD services (CPT 90951-90970) because the comprehensive care management included in CCM could significantly overlap with these services. Also see CPT coding guidance for a list of additional codes that cannot be billed during the same month as the CCM service codes. There may be additional restrictions on billing for practitioners participating in a CMS model or demonstration program; if you participate in one of these separate initiatives, please consult the CMS staff responsible for these initiatives with any questions on potentially duplicative billing.

Can I bill for CCM services furnished to beneficiaries in skilled nursing facilities, nursing facilities, assisted living or other facility settings?

Yes. CCM is priced under the PFS in both the facility and non-facility settings.

Can I bill complex CCM and non-complex CCM for the same patient in a calendar month?

You cannot bill 99491 in the same calendar month as 99487, 99489 or 99490.

Can I bill CCM codes 99487, 99489, 99490 and 99491 by the same practitioner for services furnished during the 30-day TCM service period (CPT 99495, 99496)?

Yes.

Can I bill complex CCM codes and prolonged E/M codes in the same calendar month?

No.

Can I count time toward the CCM service for any other billed codes?

No.

Can Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) bill CCM and TCM services for the same patient during the same time period?

Yes, beginning January 1, 2022, RHC's and FQHC's can bill CCM and TCM for the same patient during the same time period.

For CPT codes 99490 and 99491, if I provided more than the minimum service time, can I bill more than one unit for the service period to account for this time?
CMS created 99439 as an add-on code for code 99490 to account for additional time. 99491 describes a minimum number of minutes of service (there is no maximum). Therefore, the practitioner may only bill one unit per calendar month.

What CPT codes do I use to report CCM?

99424 Principal care management services, for a single high-risk disease, with the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care
- first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month

99425 Principal care management services, for a single high-risk disease, with the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care
- each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

99426 Principal care management services, for a single high-risk disease, with the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care
- first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month

99427 Principal care management services, for a single high-risk disease, with the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care

99437 Chronic care management services, provided personally by a physician or other qualified health care professional, 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
- each additional 30 minutes by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

99439* Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

**Beginning 2022, G2058 was replaced with 99439*

99487 Complex chronic care management services, with the following required elements:

- multiple (2 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

99489 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 significant revision of comprehensive care plan
- moderate or high complexity medical decision making
- 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)

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 (2 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

99491 Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:

- multiple (2 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.
- 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)

How much does CCM reimburse?

99424 - $75.44*
99425 - $52.60*
99426 - $50.53*
99427 - $35.64*
99437 - $52.26*
99439 - $36.34*
99487 - $92.75*
99489 - $51.22*
99490 - $51.56*
99491 - $77.52*

*Based on 2022 MPFS. Allowable amounts may vary based on contract.

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Resources: MLN909188 – Chronic Care Management (cms.gov)
Information was accurate at time of publication. Please review CMS policies for updates.

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Chronic Care Management Components and Requirements

Components and Requirements	Definition
What is Chronic Care Management (CCM)?	The non-face-to-face services provided to patients who have **multiple (two or more)** significant chronic conditions. These services include communication with the patient and other treating health care professionals for care coordination (both electronically and telephonically), as well as having 24-hour accessibility to office/providers. It also includes creation and revision of electronic care plans. Your patients will gain a team of dedicated health care professionals who can help them plan for better health and stay on track. Services such as monthly check-ins and ready access to their care team can help them connect the dots and improve their care coordination
Who can request CCM?	• Physician, nurse practitioner, physician assistant, certified midwife and clinical nurse specialists, clinical staff – Not within scope of podiatrists, clinical psychologists or dentists • Billing provider only required to furnish an Annual Wellness Visit (AWV), Initial Preventive Exam (IPPE) or comprehensive Evaluation and Management service for new patients or patients not seen within the last 12 months • CCM services must be provided by clinical staff under direction of billing practitioner on an "incident to" basis
Identify & Enroll Patients	Patients must have 2 or more chronic conditions (expected to last at least 12 months) with significant risk of death, functional decline, exacerbation or decompensation

Documentation for medical record	• Include narrative detailing need for CCM
	• Support beneficiary eligibility
	• Include comprehensive care plan with measurable goals
	• Established, implemented, revised or significantly monitored
	• Patient or caregiver must be given a copy of care plan. Medicare does not specify a certain format for care plan
	• Include the CCM discussion narrative with beneficiary and his/her prior permission acceptance: verbal for patients who have been seen in the practice within the past 12 months or written
	  ○ Verbal acceptance must be documented and must be explained to patient for transparency
	  ○ Beneficiary may terminate consent at any time
	  ○ Support services rendered
	  ○ Include time spent on CCM services
	  ○ Support provision of at least 20 or 60 minutes of CCM services for month billed (based on specific procedure code billed)

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Create a patient-centered care plan	• Physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports
	• Provide patient with the written or electronic copy of their comprehensive care plan. Consider patient portal as means of communication
	• As appropriate, share the comprehensive care plan with other clinicians and providers
	• Provide care management for chronic conditions, including:
	  ○ Systematic assessment of the patient's medical, functional, and psychosocial needs
	  ○ Timely recommendations of preventive care services
	  ○ Medication reconciliation with review of adherence and potential interaction

Billing and Coding	99487 Complex chronic care management services, with the following required elements: • multiple (2 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 +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) OR 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 (2 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 +99439 each additional 20 minutes (up to 2 units) 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) OR 99491 Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:

	• multiple (2 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
Document the time spent	• 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 ○ Validate that all the requirements were met for each CCM participant/patient each month ○ Submit CCM billing under appropriate CCMs codes (99490, etc.)

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Chronic Care Management Member Guide

What is Chronic Care Management?

If you have Medicare and live with two or more chronic conditions such as arthritis, diabetes, depression, or high blood pressure, chronic care management services can help connect the dots so you can spend more time doing what you love.

How will Chronic Care Management help me?

You will receive personalized assistance from a dedicated care team who will work with you to create your care plan.

What type of services will I receive?

At least 20 minutes a month of chronic care management services

Personalized assistance from health care professionals who will work with you to create your care plan

Coordination of care between your pharmacy, specialists, testing centers, hospitals, and more

Phone check ins to make sure you are on track

24/7 emergency access to health care professionals

Expert assistance with setting and reaching your health care goals

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Chronic Care Management Discussion Guide

Prior to contacting the patient, review recent care plan goals, lab results, and health care needs related to the patient's chronic conditions. This is a discussion guide, so please modify this to how you speak with your patients while getting the same information.

(You may take notes on this to record information given by the patient)

Hello Mr./Mrs./Ms./Dr. _____.

My name is_____and I am a (name of role) with Dr._____.

We would like to assist you in managing (circle at least 2 chronic conditions)

- Diabetes Mellitus
- Congestive Heart Failure
- Dyslipidemia
- Rheumatoid Arthritis
- Asthma
- Hypertension

Is there another practice that is assisting you with your chronic conditions?

Is this something that you would like to proceed with? (verbal consent) ☐Yes ☐No

- Do you know which *prescription medications* you're taking?
  - What are they?
  - What is the name of your pharmacy?
  - When did you last get have your prescription medications filled?
- (If applicable) What is the date of your appointment with_____(lab/specialist)?
- Are you having any other difficulties right now? I can assist in connecting you with additional services if you need them (Transportation, food banks, Meals on Wheels, etc.)?
- How would you like to receive a copy of your care plan? _____

Thank you for taking the time to talk with me today. Please call our office if you have any questions or any concerns. (Provide office phone number).