mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

Chronic Care Management Services

What's Changed?

- Added new codes describing chronic pain management and treatment (page 10)
- Added information about other care management services (page 11)

Substantive content changes are in dark red.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

Table of Contents

CMS recognizes chronic care management (CCM) as a critical primary care service that contributes to better Medicare patient health and care.

We pay for CCM services provided to patients with multiple chronic conditions under the Medicare Physician Fee Schedule (PFS).

As the billing practitioner, you don't need to offer face-to-face CCM services to Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) patients because CCM describes non-face-to-face services.

NOTE: Information in this publication applies only to the Medicare Fee-for-Service Program (also known as Original Medicare).

NOTE: In this booklet, **you** refers to practitioners. **We** refers to CMS.

Chronic Care Management Service Elements: Highlights

CCM services are extensive, including:

- Structured recording of patient health information
- Maintaining comprehensive electronic care plans
- Managing care transitions and other care management services
- Coordinating and sharing patient health information promptly within and outside the practice

CCM service elements apply to complex and non-complex CCM unless otherwise specified.

You'll typically provide CCM services outside of face-to-face patient visits and focus on advanced primary care characteristics like:

- Continuous patient relationship with a chosen care team member
- Supporting the patient with a chronic disease in achieving health goals
- 24/7 patient access to care and health information
- Patient getting preventive care
- Patient and caregiver engagement
- Prompt sharing and using patient health information

Chronic Care Management Service Practitioners

These physicians and non-physician practitioners may bill CCM services:

- Certified nurse midwives (CNMs)
- Clinical nurse specialists (CNSs)
- Nurse practitioners (NPs)
- Physician assistants (PAs)

NOTE: Primary care practitioners most often bill CCM services, but some specialty practitioners may also provide and bill them. CCM services aren't within the scope of practice of limited-license physicians and practitioners like clinical psychologists, podiatrists, or dentists, but CCM practitioners may refer or consult with these practitioners to coordinate and manage care.

For CCM services the billing practitioner doesn't personally provide, the clinical staff can provide them under 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. Clinical staff are employees or people working under contract with the billing practitioner, and we directly pay those practitioners for CCM services.

Supervision

We assign CCM codes describing clinical staff activities (CPT 99487, 99489, and 99490) as general supervision under the Medicare PFS. General supervision means when the billing practitioner doesn't personally provide the service, it's done under their overall direction and control. We don't require the physician to be physically present while the service is provided.

Patient Eligibility

Eligible CCM patients will have multiple (2 or more) chronic conditions that are expected to last at least 12 months or until the patient's death or that place them at significant risk of death, acute exacerbation or decompensation, or functional decline. These services aren't typically face-to-face and allow eligible practitioners to bill at least 20 minutes or more of care coordination services per month. Check Medicare eligibility.

Billing practitioners may consider identifying patients who require CCM services using criteria suggested in CPT guidance (like number of illnesses, number of medications, repeat admissions, or emergency department (ED) visits) or the typical patient profile in the CPT prefatory language.

CCM services can also help reduce geographic and racial or ethnic health care disparities.

Examples of chronic conditions include, but aren't limited to:

- Alcohol abuse
- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer (breast, colorectal, lung, and prostate)
- Cardiovascular disease
- Chronic kidney disease
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Diabetes
- Heart failure
- Hepatitis (chronic viral B & C)
- HIV and AIDS
- Hyperlipidemia (high cholesterol)
- Hypertension (high blood pressure)
- Ischemic heart disease
- Osteoporosis
- Schizophrenia and other psychotic disorders
- Stroke
- Substance use disorders

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

Initiating Visit

Before CCM services can start, we require an initiating visit for new patients or patients who the billing practitioner hasn't seen within the previous 1 year. The initiating visit can happen during a comprehensive face-to-face evaluation and management (E/M) visit, annual wellness visit (AWV), or initial preventive physical exam (IPPE).

If the practitioner doesn't discuss CCM during an E/M visit, AWV, or IPPE, it can't count as the initiating visit. A face-to-face initiating visit isn't part of CCM and can be separately billed.

Practitioners who personally provide extensive assessment and care planning outside the usual effort described by the initiating visit and CCM codes may also bill HCPCS code G0506 once, as part of an initiating visit.

Patient Consent

Get the patient's written or verbal consent for CCM services before you bill for them. This helps ensure patients are engaged and aware of their cost sharing responsibilities and also helps prevent duplicate practitioner billing. You must also inform the patient of these items and document them in their medical record:

- The availability of CCM services
- Their possible cost sharing responsibilities
- That only 1 practitioner can provide and bill CCM services during a calendar month
- The patient's right to stop CCM services at any time (effective at the end of the calendar month)
- That the practitioner explained the required information and whether the patient accepted or declined services

Patients need to provide informed consent only once unless they switch to a different CCM practitioner.

Electronic Recording of Patient Health Information

Record the patient's demographics, problems, medications, and medication allergies using a version of certified electronic health record (EHR) that's acceptable under the EHR Incentive Programs as of December 31 of the CY before each Medicare PFS payment year. Promoting Interoperability Programs has more information about EHR technology.

Comprehensive Care Plan

The comprehensive care plan for all health issues with a focus on managing chronic conditions should:

- Create, revise, and monitor (per code descriptors) a person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports
- Provide patients and caregivers with a copy of the care plan
- Electronically capture the care plan information, and make it available promptly both within and outside the billing practice with people involved in the patient's care, as appropriate

We have several care planning tools and resources.

Comprehensive Care Plan

A comprehensive care plan for all health issues typically includes, but isn't limited to:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers
- Requirements for periodic review
- When applicable, revision of the care plan

Medical Decision-Making

Complex CCM services require and include moderate to high complexity medical decision-making by the physician or other billing practitioner.

Access to Care & Care Continuity

Access to care and care continuity should include:

- Providing 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified practitioners or clinical staff, including providing patients or caregivers with a way to contact their health care practitioners to discuss urgent needs no matter the day or time
- Providing continuity of care with a designated care team member with whom the patient can schedule routine appointments and who's regularly in touch with the patient to help them manage their chronic conditions
- Providing patients and caregivers a way to communicate with their practitioners about their care by phone and through secure messaging, secure web, or other asynchronous non-face-to-face consultation methods (like email or a secure electronic patient portal)

Comprehensive Care Management

Comprehensive care management should:

- Assess the patient's medical, functional, and psychosocial needs
- Make sure the patient gets timely recommended preventive services
- Review medications and any potential interactions
- Oversee the patient's medication self-management
- Coordinate care with home- and community-based clinical service providers
- Communicate with home- and community-based providers about the patient's psychosocial needs and functional decline, and document it in the patient's medical record

Manage Care Transitions

You can manage care transitions between and among health care providers and settings by:

- Including referrals to other clinicians, or following up after an ED visit or after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Creating and exchanging or sharing continuity of care documents promptly with other practitioners

Concurrent Billing

Consider these guidelines when billing for concurrent services:

- You can't report complex CCM and non-complex CCM for the same patient in a calendar month (don't report 99491 in the same calendar month as 99487, 99489, or 99490)
- You can't bill CCM during the same service period by the same practitioner as HCPCS codes G0181 or G0182 (home health care supervision, hospice care supervision) or CPT codes 90951–90970 (certain ESRD services)
- You can report CCM codes 99487, 99489, 99490, and 99491 by the same practitioner for services provided during the 30-day transitional care management (TCM) service period (CPT codes 99495, 99496)
- You can't report complex CCM and prolonged E/M services in the same calendar month
- You can't count time toward the CCM service code for any other billed code
- RHCs and FQHCs can bill CCM and TCM services for the same patient during the same period
- Remote physiologic monitoring (RPM) and remote therapy monitoring (RTM) can be billed concurrently with CCM and TCM
  - Practitioners may bill either RPM and RTM, but not both, concurrently with any CCM or TCM service
- Consult CPT instructions for other codes you can't bill concurrently with CCM
  - Other provider billing restrictions may apply if you're taking part in a CMS-sponsored model or demonstration program

CCM service codes include care coordination and care management payment for a patient with multiple chronic conditions within Original Medicare. We won't duplicate payments for the same or similar services for patients with chronic conditions already paid under the various demonstration initiatives. Get more information on potentially duplicated billing by consulting the CMS staff responsible for demonstration initiatives.

Chronic Care Management Codes

Applicable CCM Codes

Code	Descriptor
99437	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 that 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 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 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)
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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, 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)

*CPT codes 99487, 99489, and 99490 include time spent directly by the billing practitioners or clinical staff. Time spent by the billing practitioner may also count toward the time threshold if not used to report 99491.

Applicable CCM Codes (cont.)

Code	Descriptor
99490*	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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99491**	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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
G3002	Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (when using g3002, 30 minutes must be met or exceeded.)
G3003	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (list separately in addition to code for g3002. when using g3003, 15 minutes must be met or exceeded.)

*CPT codes 99487, 99489, and 99490 include time spent directly by the billing practitioners or clinical staff. Time spent by the billing practitioner may also count toward the time threshold if not used to report 99491.

**CPT code 99491 includes only time that's spent personally by the billing practitioner. Clinical staff time doesn't count toward the required reporting time threshold code.

Other Care Management Services

Principal Care Management

Principal care management (PCM) provides CCM for patients with a single chronic condition or with multiple chronic conditions but focused on a single high-risk condition.

PCM services may be expected to last 6 months to 1 year or until the patient's death and require 30 minutes of service before billing.

PCM Codes: 99424, 99425, 99426, and 99427

Principal Illness Navigation & Community Health Integration

Principal illness navigation (PIN) services can be provided following an initiating E/M visit that addresses a serious high-risk condition, illness, or disease, with these characteristics:

- One serious, high-risk condition expected to last at least 3 months and that places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation or decompensation, functional decline, or death
- The condition requires developing, monitoring, or revising a disease-specific care plan and may require frequently adjusting the medication or treatment regimen or substantial assistance from a caregiver

PIN Codes: G0023, G0024, G0140, and G0146

Community health integration (CHI) services help patients who have unmet social needs that affect the diagnosis and treatment of their medical problems identify and connect with appropriate clinical and social support resources.

Practitioners may provide CHI services monthly, as medically necessary, following an initiating E/M visit (CHI initiating visit) where the practitioner identifies the presence of social determinants of health needs that significantly limit their ability to diagnose or treat the patient problems addressed in the visit.

Community health workers, care navigators, peer support specialists, and other auxiliary personnel may be employed by community-based organizations if the billing practitioner provides the required supervision for these services, like other care management services.

CHI Codes: G0019 and G0022

Resources

- CCM Materials for FQHCs
- CCM Materials for RHCs
- CCM Materials for Hospital Outpatient Departments
- CCM Materials for Physicians
- FAQs for CCM Billing