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Chronic Care Management Services

What's Changed?

We added information about advanced primary care management (APCM) (page 11).

Substantive content changes are in dark red.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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Chronic care management (CCM) is managing a patient's multiple (2 or more) chronic conditions expected to last at least 12 months, or until their death. Chronic conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. CCM is a critical primary care service that contributes to better patient health and care.

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

Note: In this booklet, "you" refers to practitioners. "We" refers to CMS.

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: We require an initiating visit before you start CCM services.

CCM 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 both non-complex CCM (at least 30 minutes per month) and complex CCM (at least 60 minutes per month) unless otherwise specified.

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

- A continuous patient relationship with a chosen care team member
- Support for the patient to achieve health goals
- 24/7 patient access to care and health information
- Preventive care for the patient
- Patient and caregiver engagement
- Sharing patient health information promptly

CCM Service Practitioners

These practitioners may bill CCM services:

- Physicians (medical doctors (MDs) and doctors of osteopathy (DOs))
- 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 consult these practitioners, or refer patients to them, to coordinate and manage care.

For CCM services you don't personally provide, clinical staff can provide them under your direction on an "incident to" basis (as an integral part of services provided by the billing practitioner). This is 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, 99490, and 99439) as "general supervision" under the PFS. General supervision means the billing practitioner doesn't personally provide the service but it's done under their overall direction and control. We don't require you to be physically present during the service.

Patient Eligibility

Eligible CCM patients have multiple (2 or more) chronic conditions 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 (such as number of illnesses, number of medications, or repeat admissions or emergency department visits) or the profile of typical patients in the CPT language.

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

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid arthritis)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular disease
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Diabetes
- Glaucoma
- HIV and AIDS
- Hypertension (high blood pressure)
- 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 you haven't seen within the previous 1 year. Conduct the initiating visit during a comprehensive face-to-face evaluation and management (E/M) visit, annual wellness visit (AWV), or initial preventive physical exam (IPPE).

If you don'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.

If you personally provide extensive assessment and care planning outside the usual effort described by the initiating visit and CCM codes, you 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 make sure patients are engaged and aware of their cost-sharing responsibilities and helps prevent duplicate practitioner billing. Inform the patient of these items and document 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
- Their right to stop CCM services at any time (effective at the end of the calendar month)
- That you explained the required information and whether the patient accepted or declined services

Patients must 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 PFS payment year. Promoting Interoperability Programs has more EHR technology information.

Comprehensive Care Plan

Create, revise, and monitor (per code descriptors) a patient-centered, electronic comprehensive care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment and an inventory of resources and supports.

A comprehensive care plan focusing on managing chronic conditions may include:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Revision and monitoring (per code descriptors), when necessary
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners
- Periodic review

Note: Make the plan available promptly both within and outside the billing practice, and when necessary, give patients and caregivers a copy of the care plan.

We have several care planning tools and resources.

Medical Decision-Making

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

24/7 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 so patients can discuss urgent needs no matter the day or time
- Choosing a 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
- Giving 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 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 continuity-of-care documents and promptly exchanging or sharing them with other practitioners

Concurrent Billing

Consider these guidelines when billing for concurrent services:

- You can't report non-complex CCM and complex CCM for the same patient in a calendar month (don't report 99491 and 99437 in the same calendar month as 99487, 99489, 99490, or 99439).
- You can't bill CCM during the same service period as HCPCS code G0181 (home health care supervision), HCPCS code G0182 (hospice care supervision), or CPT codes 90951–90970 (certain ESRD services).
- You can report CCM codes 99487, 99489, 99490, and 99491 for services provided during the 30-day transitional care management (TCM) service period (CPT codes 99495 and 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.
- You can bill either remote physiologic monitoring (RPM) or remote therapeutic monitoring (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 for under the various demonstration initiatives. Get more information on potentially duplicated billing by consulting the CMS staff responsible for demonstration initiatives.

CCM Codes

Chronic care management codes are based on time per calendar month and if you're personally doing the services or your clinical staff does them under your supervision.

Table 1 shows the differences between chronic care management and complex chronic care management as defined by CPT.

Table 1. CCM Required Elements

Required Elements	Chronic Care Management	Complex Chronic Care Management
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	N/A	✓

We also pay for **chronic pain management and treatment** as a monthly bundle that includes:

- Diagnosis
- Assessment and monitoring
- Administration of a validated pain rating scale or tool
- Development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and wanted 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
- Ongoing communication and care coordination between relevant practitioners providing care; for example, physical therapy and occupational therapy, complementary and integrative approaches, and community-based care

You need to provide the initial chronic pain management visit face-to-face with the patient for at least 30 minutes.

Table 2 tells you which code to use for each service based on who's doing the service and how long they're doing it each month. We show add-on codes with the + symbol in front of the code.

Table 2. Applicable CCM Codes

Code	Care Type	Staff Type	Time
99490	Chronic care management	Clinical staff	First 20 minutes
+99439	Chronic care management	Clinical staff	Each additional 20 minutes
99491	Chronic care management	Physician or other qualified health care professional	First 30 minutes
+99437	Chronic care management	Physician or other qualified health care professional	Each additional 30 minutes
99487	Complex chronic care management	Clinical staff	First 60 minutes
+99489	Complex chronic care management	Clinical staff	Each additional 30 minutes
G3002	Chronic pain management and treatment	Physician or other qualified health care professional	First 30 minutes (Must meet or exceed 30 minutes)
+G3003	Chronic pain management	Physician or other qualified health care professional	Each additional 15 minutes (Must meet or exceed 15 minutes)

Clinical Staff & Practitioner Time Requirements

CPT codes 99487, 99489, 99490, and 99439 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 codes 99491 and 99437 include 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

Advanced Primary Care Management

Advanced Primary Care Management (APCM) services combine elements of several existing care management and communication technology-based services you may have already been billing for your patients. They're billed once per calendar month. The benefit of these bundled services is that they don't require you to count minutes per month to bill. They were designed to reflect the reality that patient needs often change from month to month. This payment bundle includes the essential elements of advanced primary care, including:

- Principal care management (PCM)
- TCM
- CCM
- Interprofessional consultations
- Online digital E/M (e-visits)

APCM Codes

- G0556: Level 1, for people with 0 or 1 chronic condition
- G0557: Level 2, for people with 2 or more chronic conditions
- G0558: Level 3, for people with 2 or more chronic conditions and Qualified Medicare Beneficiary status

PCM

PCM services focus on a single, high-risk chronic condition expected to last at least 3 months that places the patient at significant risk of hospitalization, acute exacerbation or decompensation, functional decline, or death.

You can provide PCM services monthly if the patient needs them. After 1 year, we require another initial visit to continue the services. You can't bill for PCM services of less than 30 minutes per calendar month.

PCM Codes: 99424, 99425, 99426, 99427

Principal Illness Navigation

You can provide principal illness navigation (PIN) services following an initiating E/M visit that addresses 1 serious, high-risk condition, illness, or disease with these characteristics:

- This condition is expected to last at least 3 months and 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 also need to change medications or treatments regularly or get significant help from a caregiver

Auxiliary personnel who meet specific requirements perform PIN services. G0140 and G0146 are designed specifically for auxiliary personnel like peer support specialists to provide navigation for behavioral health conditions.

PIN Codes: G0023, G0024, G0140, and G0146

Community Health Integration

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

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

Community-based organizations may employ community health workers, care navigators, peer support specialists, and other auxiliary personnel if you provide the required supervision for these services, like other care management services.

CHI Codes: G0019 and G0022

TCM

TCM is a comprehensive set of services designed to make sure patients get coordinated and continuous care as they transition from an inpatient health care setting (like a hospital, skilled nursing facility, or rehabilitation facility) back to their community (which could be their home, an assisted living facility, or another outpatient environment).

We may cover transitional care services during the 30-day period that starts when a physician discharges a Medicare patient from an inpatient stay and continues for the next 29 days.

TCM Codes: 99495 and 99496

Resources

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