Chronic Care Management (CCM)

Eligibility and Requirements

Chronic Care Management (CCM) services are an effort by the Centers for Medicare & Medicaid Services (CMS) to offer separate payment, in addition to E/M reimbursement, to those providers who care for patients with multiple chronic conditions. **CCM services do not require a face-to-face visit** and have unique eligibility requirements for providers and patients.

Patient eligibility

Only Medicare Part B patients with multiple (meaning two or more) chronic conditions expected to last at least 12 months (or until the patient's death) are eligible for CCM services. The chronic conditions must be ones that place the patient at significant risk of death, acute exacerbation and/or decompensation, or functional decline. Examples of valid chronic conditions include but are not limited to: Alzheimer's disease and related dementia, arthritis, asthma, atrial fibrillation, cancer, depression, diabetes, hypertension, and chronic infectious diseases such as HIV/AIDS.

Patient consent

CMS requires that billing providers obtain verbal or written consent from the patient to begin CCM services. The consent must be documented in the medical record and must show that the patient was educated on CCM services and applicable cost-sharing, that only one provider may render and bill for CCM services each month, and that the patient has the right to stop CCM services at any time.

Provider eligibility

CMS will only pay one provider for CCM services for any given calendar month; either complex or non-complex CCM (see reverse for coding details) may be billed for one patient each month, but not both. The following provider types may bill for CCM services: **physicians, nurse practitioners, physician assistants, clinical nurse specialists,** and **certified nurse midwives.**

Physician specialty

CMS expects CCM services to be billed most frequently by primary care practitioners but does not restrict billing of CCM services exclusively to primary care specialties. However, CMS states that CCM is not billable by "limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists" because it is not within their scope of practice.

Incident-to billing

CMS does allow CCM services to be billed under its "incident-to" guidelines if all requirements for incident-to are met, and subject to any applicable state laws, licensure requirements, and scope-of-practice restrictions for non-physicians involved. Briefly, the incident-to requirements *for CCM* are that:

- A physician must first see the patient and create a plan of care for managing the chronic conditions;
- The non-physician clinical staff member must follow the established plan of care and cannot manage new problems unrelated to that plan;
- The CCM services must be performed under the overall direction and control of the billing physician, although their physical presence is not required during the performance of CCM, as per Medicare's definition of "general supervision" (incident-to normally requires the more restrictive "direct supervision" but CCM does not); and,
- The non-physician clinical staff member must be employees or working under contract to the billing physician whom Medicare will pay directly for CCM.

Chronic Care Management (CCM)

Coding and Documentation Guidelines

There is one code for "non-complex" CCM (**99490**) and one code for "complex" CCM (**99487**). The third code (**99489**) is an add-on code for additional time spent on CCM.

- **99490** (CCM services, at least 20 minutes of clinical staff time directed by a physician, per calendar month)
- **99487** (Complex CCM services, at least 60 minutes of clinical staff time directed by a physician, with moderate or high complexity medical decision making, per calendar month)
    - **99489** (Each additional 30 minutes of clinical staff time directed by a physician, per calendar month)

Initiating visit

New patients and those patients who were not seen within one year of the first CCM service, CMS requires that CCM be "initiated" during another face-to-face visit. This visit represents a separately billable E/M service and may be a Medicare Annual Wellness Visit (AWV) or Initial Preventive Physical Exam (IPPE), or any other face-to-face visit with the provider who will bill for CCM.

If the provider also performs an extensive assessment and CCM care planning that goes beyond the work associated with the separately billed E/M code, the provider may bill the HCPCS code **G0506** (comprehensive assessment of and care planning for patients requiring CCM services). G0506 is billable once for each provider initiating CCM.

CCM code requirements

- **Access to care management services 24/7 and continuity of care.** Patient must have access to providers 24/7 to address urgent needs, and a designated staff member who will provide continuity of care by allowing the patient to schedule successive routine appointments.
- **Comprehensive care management,** including systematic assessment of the patient's medical, functional, and psychosocial needs, ensuring patient receives all recommended preventive services, medication reconciliation with review of adherence and possible interaction, and oversight of patient's self-management of medications.
- **Creating and maintaining a comprehensive care plan,** with a written or electronic copy provided to patient. The plan should include all health issues with particular focus on the chronic conditions being managed.
- **Management of care transitions,** such as referrals or follow-up care after hospital or skilled nursing facility discharge. This includes the transitional care management code. Clinical summaries must be transmitted electronically, not faxed, to other providers.
- **Coordination with home- and community-based clinical service providers,** such as hospice, regarding the patient's psychosocial needs and functional deficits.
- **Enhanced communication opportunities,** meaning that the patient is given multiple ways to contact providers, including via phone, online patient portal, or by email.
- **Electronic capture and sharing of care plan information.** Providers must use a certified EHR, and the patient's records are to be available 24/7 to all providers within the practice who may provide CCM services. Providers outside the practice should be sent pertinent medical information electronically as well.