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KNOWLEDGE • RESOURCES • TRAINING

Chronic Care Management Services

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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What's Changed?

- Beginning 2022, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can bill Chronic Care Management (CCM) and Transitional Care Management (TCM) services for the same patient during the same time period (page 9)
- In 2021 we added 5 codes to report staff-provided Principal Care Management (PCM) services under physician supervision (pages 10–11)
- Beginning 2022 we replaced G2058 with 99439 (page 11)

You'll find substantive content updates in dark red font.

CMS recognizes Chronic Care Management (CCM) is a critical primary care service that contributes to better patient health and care.

This booklet provides background on payable CCM service codes, names eligible billing practitioners and patients, and details the Medicare Physician Fee Schedule (PFS) billing requirements.

In 2014, we started paying for CCM services furnished to patients with multiple chronic conditions under the PFS. The Medicare Physician Fee Schedule Look-Up Tool has code-specific payment information by geographic location.

Note: "You" refers to practitioners.

As the billing practitioner, you no longer 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).

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the CMS Office of Minority Health:

- Health Equity Technical Assistance Program
- Disparities Impact Statement

Chronic Care Management Service Elements: Highlights

CCM services are extensive, including:

- Structured recording of patient health information
- Keeping 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. See Chronic Care Management Service Summary section for more information.

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

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

Chronic Care Management Service Practitioners

These physicians and Non-Physician Practitioners (NPPs) 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 furnish and bill them as well. 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.

CPT code 99491 — Time only the billing practitioner spends. Clinical staff time doesn't count toward the required reporting time threshold code.

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

For CCM services the billing practitioner doesn't personally furnish, the clinical staff furnish them under direction of the billing practitioner on an incident to basis (as an integral part of services furnished by the billing practitioner), subject to applicable state law, licensure, and scope of practice. Clinical staff are employees or working under contract with the billing practitioner and we directly pay that practitioner 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 furnish the service, it's done under their overall direction and control
- We don't require the physician's physical presence while service is furnished

Patient Eligibility

- Eligible CCM patients will have multiple (2 or more) chronic conditions expected to last at least 12 months or until the patient's death and or that place them at significant risk of death, acute exacerbation and 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
- 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 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:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Hypertension
- Infectious diseases like HIV and AIDS

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 1 year
- Initiating visit can occur during comprehensive face-to-face Evaluation and Management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE)
- If practitioner doesn't discuss CCM during an E/M visit, AWV, or IPPE, it can't count as the initiating visit
- Face-to-face initiating visit isn't part of CCM and can be separately billed

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 patient health, rather than only treating severe or acute disease and illness.

Practitioners who personally furnish extensive assessment and care planning outside the usual effort described by the initiating visit and CCM codes may also bill:

- **HCPCS code G0506** — Comprehensive assessment of and care planning by the physician or other qualified health care practitioner for patients requiring CCM services (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service)
  - Billing practitioners can bill G0506 only once, as part of 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. This also helps prevent duplicate practitioner billing. You must also inform the patient of these items and document it in their medical record:

- Availability of CCM services
- Possible cost sharing responsibilities
- Only 1 practitioner can furnish and bill CCM services during a calendar month
- Patient's right to stop CCM services at any time (effective the end of calendar month)

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

Recording Patient Health Information

Record the patient's demographics, problems, medications, and medication allergies using certified Electronic Health Record (EHR) technology. This means a version of certified EHR that's acceptable under the EHR Incentive Programs as of December 31 of the Calendar Year (CY) preceding each Medicare PFS payment year. Promoting Interoperability has more information.

Comprehensive Care Plan

- Person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and inventory of resources and supports
  - Comprehensive care plan for all health issues with focus on managing chronic conditions
- Provide patients and or caregivers with copy of the care plan
- Make electronic care plan available and shared promptly both within and outside the billing practice with individuals involved in patient's care
- Several organizations make care planning tools and resources publicly available

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

Access to Care & Care Continuity

- Provide 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 health care practitioners in the practice to discuss urgent needs no matter the time of day or day of week
- Provide continuity of care with a designated practitioner or member of the care team with whom the patient can get successive routine appointments
- Provide patients and caregivers enhanced opportunities 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 secure electronic patient portal)

Comprehensive Care Management

- Assess the patient's medical, functional, and psychosocial needs
- Make sure the patient receives 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

Manage Care Transitions

- Manage care transitions between and among health care providers and settings, including referrals to other clinicians, or follow-up after an emergency department visit or after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Create and exchange or share continuity of care document(s) promptly with other practitioners

Concurrent Billing

- 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 furnished during the 30-day TCM service period (CPT 99495, 99496)
- You can't report complex CCM and prolonged Evaluation and Management (E/M) services in the same calendar month
- Consult CPT instructions for other codes you can't bill concurrently with CCM
  - Other practitioner billing restrictions may apply if you're taking part in a CMS-sponsored model or demonstration program
- You can't count time toward the CCM service code for any other billed code
- Beginning CY 2022, RHCs and FQHCs can bill CCM and TCM services for the same patient during the same time period

Principal Care Management

- Beginning CY 2020, we introduced Principal Care Management (PCM) services to furnish 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–1 year or until patient's death
  - PCM services require 30 minutes before billing
- CCM codes require patients have 2 or more chronic conditions expected to last 12 months or until their death
  - CCM services require 20 minutes before billing

Chronic Care Management & Principal Care Management Codes

In 2021, we added 5 new CPT codes describing PCM services furnished by clinical staff under the supervision of a NPP.

Table 1. Applicable CPT Codes

CPT Code	Descriptor
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)

Table 1. Applicable CPT Codes (cont.)

CPT Code	Descriptor
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; 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)
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 we replaced G2058 with 99439.

Table 1. Applicable CPT Codes (cont.)

CPT Code	Descriptor
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 place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of comprehensive care plan, 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 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 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; 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, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of physician or other qualified healthcare professional time, per calendar month, 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

Chronic Care Management & Medicare Demonstrations

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 Service Summary

Initiating Visit

- ☐ Face-to-face E/M visit, AWV, or IPPE for new patients or patients who the billing practitioner hasn't seen within 1 year before CCM services start.

Structured Recording of Patient Health Information Using Certified EHR Technology

- ☐ Record the patient's demographics, problems, medications, and medication allergies using certified EHR technology. A full EHR list of problems, medications, and medication allergies must inform the care plan, care coordination, and ongoing clinical care.

24/7 Access & Continuity of Care

- ☐ Provide 24/7 access to physicians or other qualified practitioners or clinical staff, including providing patients or caregivers with a way to contact health care practitioners in the practice to discuss urgent needs no matter the time of day or day of week.
- ☐ Provide continuity of care with a designated practitioner or member of the care team with whom the patient can get successive routine appointments.

Comprehensive Care Management

- ☐ Assess the patient's medical, functional, and psychosocial needs.
- ☐ Make sure the patient receives timely recommended preventive services.
- ☐ Oversee the patient's medication self-management.

Comprehensive Care Plan

- ☐ Create, revise, and or monitor (per code descriptors) a person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, environmental (re)assessment, and inventory of resources and supports.
  - ☐ Comprehensive care plan for all health issues with focus on managing chronic conditions.
- ☐ Provide patients and or caregivers with copy of the care plan.
- ☐ Electronically capture care plan information and make it available promptly both within and outside billing practice with individuals involved in the patient's care, as appropriate.

Manage Care Transitions

- ☐ Manage care transitions between and among health care providers and settings, including referrals to other clinicians, or follow-up after an emergency department visit or after discharges from hospitals, skilled nursing facilities, or other health care facilities.
- ☐ Create and exchange or share continuity of care document(s) promptly with other practitioners.

Home- and Community-Based Care Coordination

- ☐ Coordinate care with home- and community-based clinical service practitioners.
- ☐ Communicate with home- and community-based practitioners about the patient's psychosocial needs and functional decline and document it in the patient's medical record.

Enhanced Communication Opportunities

- ☐ Provide patients and caregivers enhanced opportunities 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 secure electronic patient portal).

Patient Consent

- ☐ Inform patient that:
  - ☐ CCM services are available
  - ☐ They may have cost sharing responsibilities
  - ☐ Only 1 practitioner can furnish and bill CCM services during a calendar month
  - ☐ They can stop the CCM services at any time (effective the end of calendar month)
- ☐ Document in patient's medical record that you explained the required information and whether they accepted or declined services.

Medical Decision-Making

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

Resources

- CCM Materials for FQHCs
- CCM Materials for RHCs
- CCM Materials for Hospital Outpatient Departments
- CCM Materials for Physicians
- Chronic Conditions Data Warehouse
- Connected Care: CCM
- Find Your Medicare Administrative Contractor (MAC's) Website
- Health Disparities & CCM