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# Providing and Billing Medicare for Chronic Care Management and Related Services

Updated February 2022

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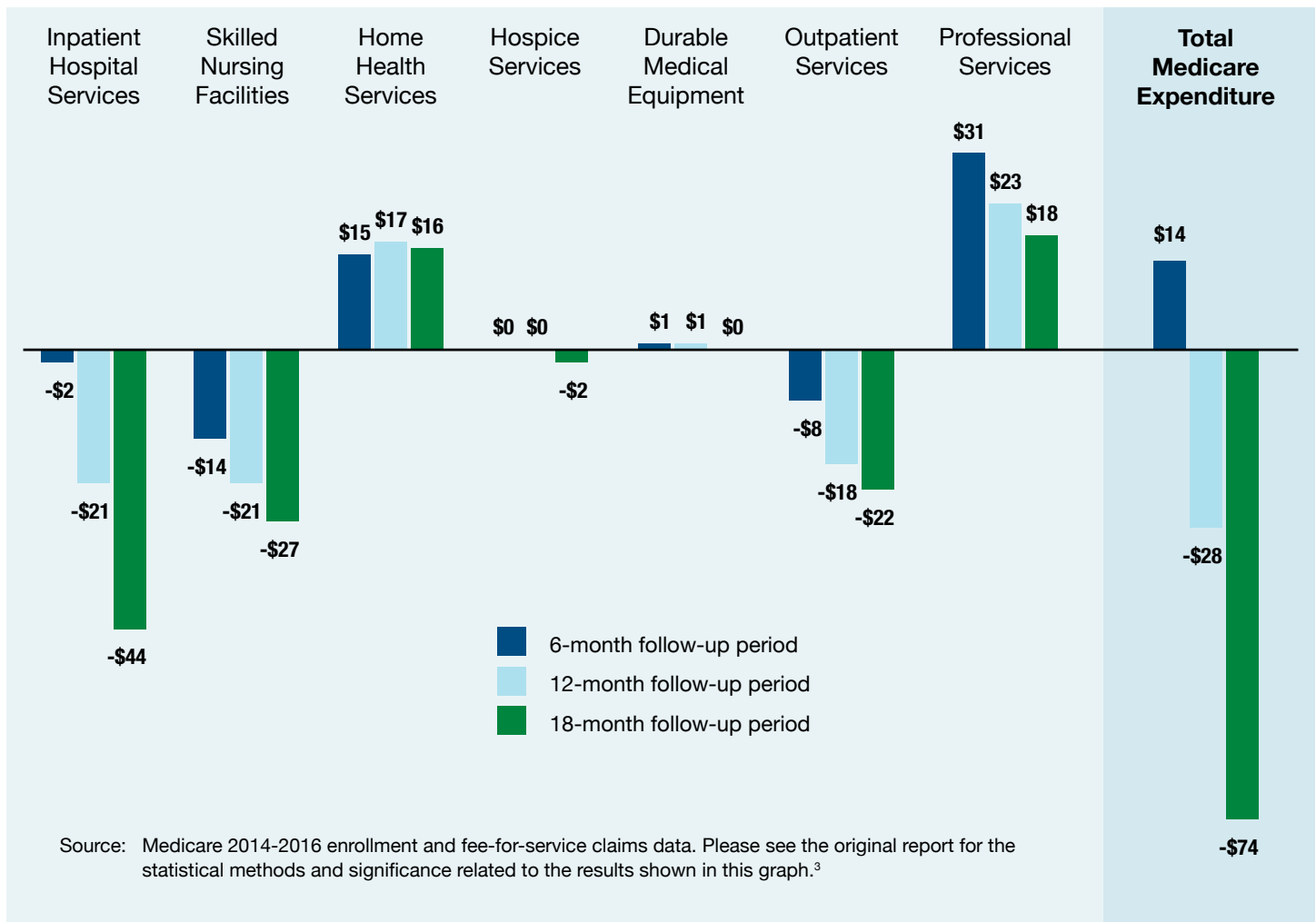


# February 2022 Update

Medicare began reimbursing physicians for chronic care management (CCM) services in January 2015 under CPT® 99490<sup>1</sup> in response to anecdotal evidence that care management services reduce the total costs of care and improve patient outcomes.

In November 2017, the Centers for Medicare & Medicaid Services' (CMS) evaluation contractor, Mathematica, published its analysis<sup>2</sup> of CCM's impact on Medicare spending from 2014 to 2016. The results were impressive: per-beneficiary-per-month (PBPM) expenditures **decreased by \$74** for CCM beneficiaries after 18 months. Most of these savings were realized in inpatient and post-acute care, while Medicare payments to physicians actually increased.

Estimated PBPM impact of CCM on total expenditures and by expenditure category: follow-up periods of 6, 12, and 18 months



1 Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association.

2 Schurrer, J. et al. *Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report*. November 2, 2017. Mathematica Policy Research.

3 *Ibid.*



In February 2019, Mathematica published its qualitative study of Medicare beneficiaries' experience with chronic care management, finding that “[p]atients reported multiple benefits of participating in CCM services, including better access to their primary care team, improved continuity of care, and improved care coordination.”<sup>4</sup>

These findings make a compelling case for CCM for providers participating or preparing to participate in risk-based contracts. As CMS noted in the 2020 Medicare Physician Fee Schedule Final Rule, CCM is “increasing patient and practitioner satisfaction, saving costs, and enabling solo practitioners to remain in independent practice.”<sup>5</sup>

Despite this, CCM remains underutilized. Although two-thirds of traditional Medicare beneficiaries—about 35-million individuals—suffer from multiple chronic conditions, less than 10% have received these services.<sup>6</sup> In the year CCM was introduced (2015), approximately 8,000 physicians and non-physician practitioners billed around 1 million CCM services (CPT 99490) for about 320,000 Medicare beneficiaries. By 2019 (the most recent year for which Medicare utilization data is available), those numbers had grown to 24,000 physicians and non-physician practitioners, 4.3 million CCM services, and 1 million Medicare beneficiaries.<sup>7</sup>

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4 C. Wilson, et al., *Patient Experiences with Chronic Care Management Services and Fees: a Qualitative Study*, *Gen Intern Med.* 2019 Feb;34(2):250-255.

5 84 Fed. Reg. 62,698 (Nov. 15, 2019).

6 See 84 Fed. Reg. 40,549 (Aug. 14, 2019).

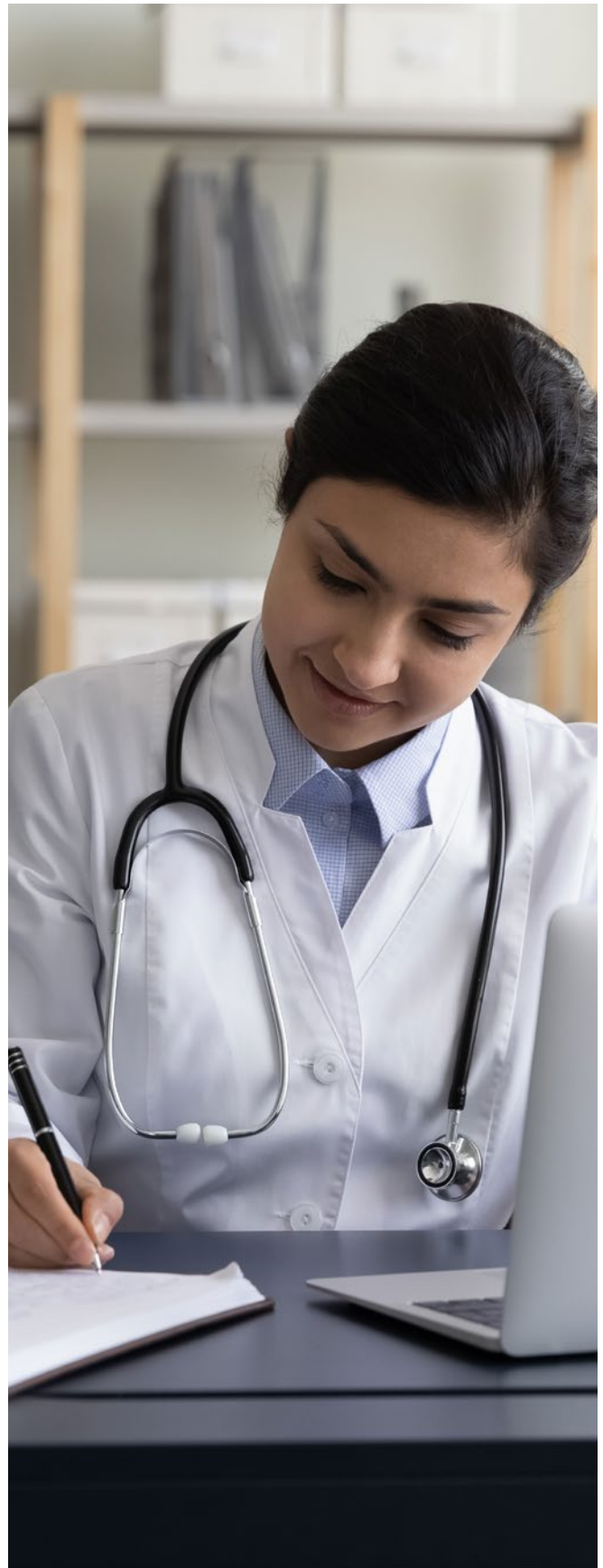
7 <https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners/medicare-physician-other-practitioners-by-geography-and-service>.

Since 2015, CMS has made multiple revisions to the CCM billing rules and expanded coverage for related services, all for the purpose of expanding beneficiary access to care management services. In 2022, CMS adjusted the relative value units (RVUs) assigned to CCM and related services, resulting in a significant increase in Medicare reimbursement for most of these services.

Also, CMS has published extensive guidance on providing and billing for these services. In fact, the agency maintains a website devoted exclusively to CCM resources.<sup>8</sup>

To help providers understand the rules for billing care management services, we have condensed the regulations and related agency guidance (i.e., webinar presentations, FAQs, and Medicare Learning Network fact sheets) into the following summary.

This summary includes CCM, complex CCM, principal care management, care management for rural health clinics and federally qualified health centers, and care plan development. The billing rules for remote physiologic and therapeutic monitoring (including their relationship with the CCM billing rules) are the subject of a separate PYA white paper, [Providing and Billing Medicare for Remote Patient Monitoring](#).



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<sup>8</sup> <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management>.



# Chronic Care Management (CPT 99490 and 99439)

## Potential Revenue

### What is the Medicare reimbursement for CCM?

As of January 1, 2021, the national payment rates for the CCM codes are as follows:

	Non-Facility	Facility
CPT 99490	\$64.02	\$51.56
CPT 99439	\$48.45	\$36.34

CPT 99490 is the primary CCM code. The differences between this code and CPT 99439 are outlined in a later section.

As noted above, Medicare reimbursement for CCM and related services increased significantly in 2022. For example, the non-facility national payment rate for CPT 99490 increased by more than 50%, from \$41.17 to \$64.02.

For CCM services billed as hospital outpatient department services (see discussion that follows regarding appropriate place of service for billing CCM services), CMS has assigned CPT 99490 to APC 5822, with a 2022 payment rate of \$76.42 (not adjusted for labor costs). CPT 99490 has been assigned to status indicator “S,” which means it is a procedure or service paid under the Medicare Outpatient Prospective Payment System (OPPS) with a separate APC payment and that no multiple procedure discount is applied. CMS has not assigned CPT 99439 to any APC.

### Does CCM qualify as a preventive service exempt from beneficiary cost-sharing?

No. CMS determined it does not have the statutory authority to exempt CCM from cost-sharing requirements. A beneficiary will be responsible for any co-payments or deductible amounts. If a beneficiary has coverage under Medicaid, a Medicare Supplemental Insurance (Medigap) policy, or employer- or union-sponsored plan, these amounts will be covered in the same manner as co-payments and deductibles for regular office visits and other Part B services.

While no exceptions exist today, the impact of beneficiary cost-sharing on CCM utilization is on the radar. In late 2019, the Office of Inspector General (OIG) published proposed changes to the Anti-Kickback Statute and Civil Monetary Penalties Law.<sup>9</sup> As part of this proposed rule, the OIG sought public comment regarding a limited waiver of beneficiary cost-sharing requirements for CCM and other care management services.

In March 2020, the OIG announced that for the duration of the COVID-19 public health emergency, it will not pursue enforcement action against any provider that waives the amount owed by a beneficiary for telehealth or virtual services (including CCM).<sup>10</sup>

<sup>9</sup> <https://www.federalregister.gov/documents/2019/10/17/2019-22027/medicare-and-state-healthcare-programs-fraud-and-abuse-revisions-to-safe-harbors-under-the>.

<sup>10</sup> The OIG's Policy Statement is available at <https://oig.hhs.gov/documents/special-advisory-bulletins/960/policy-telehealth-2020.pdf>. The related Frequently Asked Questions are available at <https://oig.hhs.gov/documents/special-advisory-bulletins/962/telehealth-waiver-faq-2020.pdf>.



## Potential Revenue continued

### **Will Medicare Advantage (MA) plans reimburse for CCM? Commercial payers?**

An MA plan must offer its enrollees at least traditional Medicare benefits, which include CCM. Many MA plans are paying for CCM in the same manner as they now pay for other physician services. Some MA plans, however, are not paying for CCM, claiming the plan itself is providing care management services directly to beneficiaries. Commercial plan coverage and payment for CCM varies.

### **Are there other financial benefits associated with developing a CCM program?**

In addition to direct revenue, CCM offers practitioners a bridge over the chasm between fee-for-service and risk-based contracting. By developing and implementing a CCM program, a practitioner will grow skill sets and internal processes critical to population health management, all the while receiving fee-for-service payment to support those activities.

## Eligible Practitioners

### **Which practitioners are eligible to bill Medicare for CCM?**

Physicians (regardless of specialty), advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse-midwives (or the provider to which such individual has reassigned his/her billing rights) are eligible to bill Medicare for CCM. Other non-physician practitioners and limited-license practitioners (e.g., clinical psychologists, social workers) and providers not eligible for reimbursement under the Medicare Physician Fee Schedule (e.g., pharmacists) cannot bill for CCM.

### **Can more than one practitioner bill for CCM for the same beneficiary for the same calendar month?**

No. CMS will pay only one claim for CCM per beneficiary, per calendar month. CMS has not stated how competing claims will be resolved.

## Eligible Practitioners continued

<b>Must a practice be recognized as a patient-centered medical home (PCMH) to provide CCM?</b>	<p>At one point, CMS proposed PCMH recognition as a condition to provide CCM, but the agency did not finalize that proposal. Instead, CMS requires a practice to have five specific capabilities to bill for CCM. Each of these capabilities is covered in detail later.</p>
<b>Are there specific services the billing practitioner must furnish to a beneficiary as a prerequisite to providing CCM for that beneficiary?</b>	<p>If the billing practitioner has not seen the beneficiary in the last 12 months (or if the beneficiary is a new patient), the practitioner must discuss CCM with the beneficiary as part of a regular office visit, annual wellness visit, or initial preventive physical exam prior to billing for CCM for that beneficiary. The face-to-face visit is not a component of the CCM service, and thus may be billed separately.</p> <p>An initiating visit is not required for the practitioner to bill for CCM services as long as the practitioner has had a similar visit with the beneficiary in the last 12 months.</p>
<b>Are there services for which the same practitioner cannot bill for the same beneficiary during the same calendar month as CCM?</b>	<p>The same practitioner cannot bill Medicare for CCM and any of the following four services for the same beneficiary in the same calendar month (with one exception noted below): (1) transitional care management (TCM) (CPT 99495 and 99496), (2) home healthcare supervision (HCPCS G0181), (3) hospice care supervision (HCPCS G0182), and (4) certain end-stage renal disease (ESRD) services (CPT 90951-90970).</p> <p>In the case of TCM, that service and CCM may be billed by the same practitioner in the same calendar month for the same beneficiary if the 30-day post-discharge service period for TCM concludes prior to the end of that calendar month, and at least 20 minutes of CCM services are furnished between that time and the end of that month.</p>
<b>Is CCM recognized as a rural health clinic (RHC) service and/or a federally qualified health center (FQHC) service?</b>	<p>Yes, but the RHC or FQHC will not receive its all-inclusive rate for CCM. Instead, the RHC or FQHC will be paid under a separate care management code specifically for RHCs and FQHCs, as explained later.</p>
<b>Can Medicare Shared Savings Program (MSSP) participants bill for CCM?</b>	<p>Physician practices participating in CMS' Primary Care First program cannot bill CCM for their attributed beneficiaries. Otherwise, participation in other CMS initiatives—including the MSSP—does not disqualify a practitioner from billing CCM for any beneficiary. All CCM payments will be included in CMS' calculations of total costs of care for purposes of shared savings and bundled payment programs.</p>

## Eligible Beneficiaries

<b>Who is an eligible beneficiary?</b>	<p>A beneficiary is eligible to receive CCM if he or she has been diagnosed with two or more chronic conditions, expected to persist at least 12 months (or until death), that place the individual at significant risk of death, acute exacerbation/decompensation, or functional decline.</p> <p>CMS has not provided a definition or definitive list of “chronic conditions” for the purposes of CCM. Nor has the agency offered guidance for determining or documenting the specified acuity level. However, CMS has stated it intends for CCM services to be broadly available.</p>
<b>Is there a list of chronic conditions on which a practitioner can rely?</b>	<p>CMS maintains a <a href="#">Chronic Condition Warehouse</a> (CCW), which organizes data for 67 specified chronic and potentially disabling conditions. However, the CCW list is not an exclusive list of chronic conditions, and CMS may recognize other conditions for the purposes of providing CCM.</p>

## Beneficiary Consent

<b>What type of consent is required?</b>	<p>A signed consent form is not required as a condition of payment. Instead, the practitioner must inform the beneficiary of: (1) the availability of CCM services, (2) that only one physician can furnish and be paid for CCM during a calendar month, and (3) that the beneficiary has the right to stop CCM services at any time, effective at the end of the calendar month.</p> <p>The practitioner must document in the beneficiary’s medical record that the required information was provided and that the beneficiary explicitly accepted the services.</p>
<b>When and how must the consent be obtained from the beneficiary?</b>	<p>A practitioner should follow his or her practice’s existing policies and procedures for obtaining consent for treatment. If the beneficiary is not competent to give his or her consent to receive CCM, the required information should be provided to an individual with legal authority under applicable state law to consent to treatment on behalf of the beneficiary.</p>
<b>What happens if a beneficiary revokes his or her consent?</b>	<p>If a beneficiary revokes his or her consent to receive CCM from a specific practitioner, that practitioner cannot bill for CCM after the then-current calendar month. The practitioner may bill for CCM for the month in which the revocation is made if the practitioner has furnished the minimum number of minutes of non-face-to-face care management services for the beneficiary.</p>



## Beneficiary Consent continued

### How does a beneficiary revoke consent?

CMS does not specify the manner in which a beneficiary must revoke consent. Presumably, if a beneficiary gives written or verbal consent to a second practitioner to furnish CCM, that action will revoke the consent given to the first practitioner. However, this can create confusion (and billing issues) if the first practitioner is unaware of the consent given to the second practitioner. CMS will presumably make payment on the first claim it receives, and deny a claim subsequently received from another provider. It would be up to this provider to appeal the denial and raise the issue of beneficiary consent.

## Five Specified Capabilities

### What are the five specified capabilities a practitioner must possess to bill for CCM?

The five specified capabilities include: (1) using a certified electronic health record (EHR) for specified purposes, (2) maintaining an electronic care plan, (3) ensuring beneficiary access to care, (4) facilitating transitions of care, and (5) coordinating care.

When a practitioner submits a claim for CCM, the practitioner is, in effect, attesting to possessing each of these capabilities for providing CCM. Each is addressed in the following sections.

### For what purposes must a practitioner use a certified EHR in furnishing CCM (1st capability)?

A practitioner is not required to be a meaningful user of a certified EHR technology, but is required to use “CCM certified technology” to meet the following core technology capabilities:

1. Structured recording of demographics, problems, medications, and medication allergies, all consistent with 45 CFR 170.314(a) (3)-(7)
2. Creation of summary care record consistent with 45 CFR 170.314(e)(2)

The practitioner must be able to transmit the summary care record electronically for purposes of care coordination. CMS does not specify acceptable methods of transmission.

Additionally, the following must be documented in the beneficiary's medical record, but effective January 1, 2017, the regulations no longer require the use of a qualifying certified EHR to record this information:

1. Beneficiary consent
2. Communication to, and from, home- and community-based practitioners regarding beneficiary's psychosocial needs and functional deficits (care coordination)



## Five Specified Capabilities continued

### What is the requirement for an electronic care plan (2nd capability)?

The practitioner must develop and regularly update (at least annually) an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment of the beneficiary's needs.

The plan should include a list of current practitioners and suppliers who are regularly involved in providing medical care to the beneficiary, the assessment of the beneficiary's functional status related to chronic health conditions, the assessment of whether the beneficiary suffers from any cognitive limitations or mental health conditions that could impair self-management, and an assessment of the beneficiary's preventive healthcare needs.

The plan should address all health issues (not just chronic conditions) and be congruent with the beneficiary's choices and values.

### What items are typically included in a care plan?

According to CMS, a care plan should include the following:

- Problem list, expected outcome and prognosis, and measurable treatment goals
- Symptom management and planned interventions (including all recommended preventive care services)
- Interaction and coordination with outside resources and practitioners and providers
- Medication management (including a list of current medications and allergies, reconciliation with review of adherence and potential interactions, and oversight of patient self-management)
- Responsible individual for each intervention
- Requirements for periodic review/revision

### Does the care plan have to be created, maintained, and updated using a certified EHR?

CMS requires a practitioner to “use some form of electronic technology tool or services in fulfilling the care plan element,” but acknowledges that “certified EHR technology is limited in its ability to support electronic care planning at this time.” Accordingly, practitioners “must have flexibility to use a wide range of tools and services beyond EHR technology now available in the market to support electronic care planning.”

## Five Specified Capabilities continued

<b>Who must have access to the electronic care plan?</b>	<p>The regulations impose two requirements with respect to access to the beneficiary’s care plan:</p> <ol style="list-style-type: none"><li>1. The practitioner should timely share the care plan electronically with individuals involved in the beneficiary’s care, both within and outside the billing practice.</li><li>2. The practitioner must provide a copy of the care plan to the beneficiary and/or caregiver in a format consistent with patient/caregiver preference (e.g., hard copy, electronic, or verbal).</li></ol>
<b>What is required with respect to beneficiary access to care (3rd capability)?</b>	<p>A practitioner furnishing CCM must:</p> <ol style="list-style-type: none"><li>1. Provide a means for the beneficiary to access a member of the care team (who qualifies as a “member of the care team” is explained in a later section) on a 24/7 basis to address acute/urgent needs in a timely manner.</li><li>2. Ensure the beneficiary can receive successive routine appointments with a designated practitioner or member of the care team.</li><li>3. Provide enhanced opportunities for beneficiary-provider (or caregiver-provider) communication by telephone and asynchronous consultation methods (e.g., secure messaging).</li></ol>
<b>What is required with respect to transitions of care (4th capability)?</b>	<p>A practitioner must have the capability to do the following:</p> <ol style="list-style-type: none"><li>1. Follow up with the beneficiary after an ER visit.</li><li>2. Provide post-discharge TCM services as necessary (although the practitioner cannot bill for TCM and CCM during the same month except as previously noted).</li><li>3. Coordinate referrals to other clinicians.</li><li>4. Create and exchange timely continuity-of-care documents with other practitioners and providers (see previous information on summary care record and electronic care plan).</li></ol>
<b>What is required with respect to coordination of care (5th capability)?</b>	<p>The practitioner must have the capability to coordinate with home- and community-based clinical service providers (including providers of home health and hospice, outpatient therapies, durable medical equipment, transportation services, and nutrition services) to meet the beneficiary’s psychosocial needs and functional deficits.</p> <p>The practitioner’s communication with these service providers must be documented in the beneficiary’s medical record.</p>



## 20 Minutes of Care Management Services

### What level of service must be furnished to bill for CCM?

At least 20 minutes of care management services must be performed on a beneficiary's behalf during a calendar month for a practitioner to bill CPT 99490 for that month.

Prior to January 1, 2020, a practitioner would receive the same reimbursement regardless of whether 20 or 40 minutes of care management services were provided in a given month. Effective January 1, 2020, a practitioner can bill CPT 99490 for the first 20 minutes of clinical staff time spent performing CCM activities in a given calendar month and can bill CPT 99439 for the second and third 20-minute increments. We understand that some Medicare Administrative Contractors have denied claims for more than one unit of CPT 99439 in a given month for the same beneficiary, despite CMS having stated that up to two units of CPT 99439 is permitted.

### What types of services constitute care management services?

In the context of CCM, CMS identifies the following types of services performed on a beneficiary's behalf as counting toward the 20-minute time requirement: (1) performing medication reconciliation and overseeing the beneficiary's self-management of medications, (2) ensuring receipt of all recommended preventive services, and (3) monitoring the beneficiary's condition (physical, mental, and social).

This list, however, is not exclusive; other types of services may count toward the 20-minute requirement. In the context of TCM, for example, CMS identified the following additional services as non-face-to-face care management services: (1) providing education and addressing questions from the patient, family, guardian, and/or caregiver; (2) identifying and arranging for needed community resources; and (3) communicating with home health agencies and other community service providers utilized by the beneficiary.

### Can face-to-face services be included in CCM time?

According to CMS, CCM involves activities not typically or ordinarily furnished face-to-face. CMS has cautioned against including face-to-face time for CCM due to concerns about double-counting—i.e., the time counted for CCM should, in fact, be considered a component of an office visit. However, CMS has recognized there are some circumstances in which face-to-face CCM services are appropriate: "If the practitioner believes a given beneficiary would benefit or engage more in person, or for similar reasons recommends a given beneficiary receive certain CCM services in person, they may still count the activity as billable time. In all cases, the time and effort cannot count towards any other code if it is counted towards CCM."<sup>11</sup>

<sup>11</sup> See <https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/payment-chronic-care-management-services-faqs.pdf> (FAQ #11).



## 20 Minutes of Care Management Services continued

### Who may perform care management services?

CMS anticipates “clinical staff will provide CCM services incident to the services of the billing physician” or non-physician practitioner. However, if the billing practitioner provides some services directly, his or her time also may count toward the 20-minute minimum, assuming those services are not content of another service billed by the practitioner.

The agency references the CPT definition of “clinical staff”: “a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.”

CMS clarifies that “time spent by clinical staff may only be counted if Medicare’s ‘incident to’ rules are met such as supervision, applicable state law, licensure and scope of practice.” It is the responsibility of the billing practitioner to determine if a clinical staff member is competent and capable of performing a specific service under appropriate supervision. CMS also notes that “other staff may help facilitate CCM services, but only time spent by clinical staff may be counted towards the 20-minute minimum time.”

The agency also explains that a billing practitioner may arrange to have clinical staff external to the practice (e.g., a case management company) provide care management services for his or her patients, but only if all requirements for “incident to” billing are satisfied, including general supervision (see following section). However, Medicare rules prohibit billing for services furnished by individuals located outside the U.S.



## 20 Minutes of Care Management Services continued

### What level of supervision is required for clinical staff providing care management services?

Initially, CMS proposed requiring direct supervision of clinical staff (i.e., physician or other practitioner present in the same suite of offices and immediately available to provide assistance while non-face-to-face care management services were being provided), with a limited exception for services furnished outside normal business hours.

However, the regulations now require only general supervision (i.e., physician or other practitioner available by telephone to provide assistance as required). To comply with the “incident to” rule, however, the physician or other practitioner billing for the service must be the same individual who provides general supervision of the clinical staff.

Effective January 1, 2017, CCM services furnished by an RHC or FQHC may be performed by clinical staff under general supervision; prior to that date, the relevant regulation required direct supervision.

### What documentation is required?

CMS does not list explicit documentation requirements for care management services. In the event of an audit, a practitioner would be well-served to have the following documentation available in the beneficiary’s record:

1. Date and amount of time spent providing non-face-to-face services (preferably start/stop time, although this is not explicitly required)
2. Clinical staff furnishing services (with credentials)
3. Brief description of services

Because CCM is furnished under general supervision, it is unnecessary for the billing practitioner to review each note regarding care management services furnished by clinical staff.

In our experience, auditors are looking for variation in the care plan and the care management notes based on the patient’s specific needs and circumstances. Documentation that is highly templated, and that appears to lack customization, is likely suspect.

### What time counts toward the 20-minute minimum requirement?

Time spent providing services on different days, or by different clinical staff members in the same calendar month, may be aggregated to total 20 minutes, depending on the CCM code. However, if two staff members are furnishing services at the same time, only the time spent by one individual may be counted. Time of fewer than 20 minutes during a calendar month cannot be rounded up to meet this requirement, nor may time be carried over from a prior month.

## 20 Minutes of Care Management Services continued

<p><b>Can CCM services furnished on the same day as an office visit be counted toward the 20-minute minimum requirement?</b></p>	<p>CMS has stated that “[f]ace-to-face time that would otherwise be considered part of the E/M [evaluation and management] service that was furnished cannot be counted toward [CCM]. Time spent by clinical staff providing non-face-to-face services within the scope of the CCM service can be counted. . . . If both an E/M and the CCM code are billed on the same day, modifier -25 must be reported on the CCM claim.”</p>
<p><b>Can CCM services furnished while the beneficiary is an inpatient be counted toward the 20-minute minimum requirement?</b></p>	<p>CCM cannot be billed for services furnished to an inpatient at a hospital or skilled nursing facility, or a resident at a facility that receives Medicare payment for that individual. However, if the beneficiary is not an inpatient or resident for the entire month, time spent furnishing CCM services while he or she is not an inpatient or resident can be counted toward the 20-minute minimum requirement for that month.</p>
<p><b>Can a practitioner practicing in a hospital outpatient department bill for CCM? Can the hospital bill for CCM?</b></p>	<p>CCM is billed with the site of service at which the supervising practitioner primarily practices. If that site is a hospital outpatient department, CMS will pay for the service at the facility rate, which is less than the non-facility rate (i.e., the payment made to a practitioner practicing in an outpatient office setting). This payment compensates the practitioner for providing direction to hospital staff furnishing non-face-to-face care management services for the beneficiary (who is considered a hospital outpatient for this purpose).</p> <p>CMS also has clarified a hospital outpatient department is eligible to bill under the OPSS in these circumstances. This payment compensates the hospital for the costs associated with the clinical staff furnishing the non-face-to-face care management services and related expenses.</p>
<p><b>Can remote monitoring be counted as part of the 20-minute time requirement?</b></p>	<p>According to CMS, “[p]ractitioners who engage in remote monitoring of patient physiological data of eligible beneficiaries may count the time they spend reviewing the reported data towards the monthly minimum time for billing the CCM code, but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device.”</p> <p>CMS has clarified that “in order to bill CPT 99490, such activity cannot be the only work that is done—all other requirements for billing CPT 99490 must be met in order to bill the code.”</p> <p>As of January 1, 2019, CMS provides separate reimbursement for remote physiologic monitoring (RPM) under CPT 99453, 99454, 99091, 99457, and 99458, and for remote therapeutic monitoring (RTM) under CPT 98976, 98977, 98980, and 98981. For a complete description of the Medicare RPM and RTM billing rules, please see our white paper, <a href="#">“Providing and Billing Medicare for Remote Patient Monitoring.”</a></p> <p>CMS describes remote monitoring as “complementary to CCM,” and therefore, can be billed once per patient during the same service period as CCM, as long as requirements for both codes are met independently.</p> <p>Remember, time spent furnishing these services cannot be counted toward both codes for a single month.</p>

## Billing for CCM

**When filing a claim for CCM, what should be listed as the date of service?**

The billing practitioner may list the date of service as the day on which the 20-minute minimum requirement is satisfied, or any day thereafter through the end of the calendar month. If the beneficiary dies during the month, the claim for CCM will be paid only if the date of service is prior to the date of death.

**What should be listed as the place of service?**

The billing practitioner must list the place of service as the location at which he or she would furnish a face-to-face office visit with the beneficiary. Thus, a practitioner who practices in a hospital outpatient department must list “22” as the place of service on the CCM claim form, triggering payment at the facility rate.

**Under whose provider number should the service be billed?**

Effective January 1, 2016, services billed “incident to”—including CCM—must be billed under the provider number of the practitioner who supervises the person(s) who actually provide(s) the service.

## Chronic Care Management (CPT 99491 and 99437)

**How does one bill for care management services furnished by a practitioner directly (as opposed to services furnished by clinical staff under the general supervision of a practitioner)?**

Effective January 1, 2019, CMS reimburses for CCM services personally performed by a practitioner (as opposed to services furnished by clinical staff under a practitioner’s supervision) under CPT 99491. To bill for this service in a given month, a practitioner must perform a minimum of 30 minutes of CCM services (as opposed to 20 minutes for CPT 99490). For the second and third 30-minute increments, the practitioner may bill CPT 99437. The entire 30 minutes must be personally performed by the practitioner. If, for example, in a given month, clinical staff performs 10 minutes of service and the practitioner performs 20 minutes, the practitioner could only bill CPT 99490. Otherwise, the billing rules for CPT 99491 and 99437 are the same as the rules that apply to 99490 and 99439.

**What is the Medicare reimbursement for CCM for which the practitioner personally performs the care management services?**

As of January 1, 2022, the national payment rates are as follows:

	Non-Facility	Facility
CPT 99491	\$86.17	\$77.52
CPT 99437	\$61.25	\$52.26

For CCM services billed as hospital outpatient department services, CMS has not assigned CPT 99491 or 99437 to any APC.





**What payment is available for time spent by a physician or non-physician practitioner outside usual office visits addressing an individual patient's needs?**

In addition to CPT 99491 and 99437, CMS also reimburses physicians and non-physician practitioners under the following codes:

Code	Description	2022 National Payment (facility and non-facility)
99358	Prolonged E/M service before and/or after direct patient care, first 60 minutes	\$110.74
99359	Prolonged E/M service before and/or after direct patient care, each additional 30 minutes (listed separately with 99358)	\$53.39

Rather than developing its own billing rules (as it did for CCM), CMS adopted the CPT rules for these two codes, which include the following: (1) these codes do not have to be billed on the same day as a face-to-face visit; (2) different periods of time during the same day may be aggregated to meet the time requirements, but time from different days cannot; (3) these services cannot be reported during the same month as complex CCM or TCM; and (4) because a unit of time is attained when the mid-point is passed, CPT 99358 may be reported when 31 minutes have been spent, and CPT 99359 may be reported at 76 minutes. (The mid-point rule does not apply to CCM because CMS specifically requires 20 minutes of services per month.)

In explaining these services, CMS warns the time counted toward these codes must be separate and distinct from time spent providing any other service reimbursable under the Medicare Physician Fee Schedule, including, but not limited to, new and established patient office visits, transitional or CCM services, or care plan development.

RHCs and FQHCs cannot bill for CPT 99358 or 99359.

## Complex CCM (CPT 99487 and 99489)

### What is the difference between CCM and complex CCM?

Effective January 1, 2017, practitioners can bill CPT 99487 for complex CCM. The billing rules for CCM and complex CCM are the same, except: (1) complex CCM requires 60 minutes of non-face-to-face care management services per month, as compared to 20 minutes for CCM, and (2) the beneficiary's condition must be such as to require medical decision-making of moderate-to-high complexity on the part of the billing physician.

### Is there additional reimbursement available if more than 60 minutes of care management services are provided?

CMS will pay for an add-on code, CPT 99489, with complex CCM (CPT 99487), for each 30-minute increment that goes beyond the initial 60 minutes of non-face-to-face care management services in a given month.

Neither CPT 99487 nor CPT 99489 may be billed in the same month as CPT 99490 or 99491.

Note there is no CPT code (and no separate Medicare reimbursement) for complex CCM for which a practitioner personally performs the care management services.

### What is the reimbursement for complex CCM?

As of January 1, 2022, the national payment rates are as follows:

Code	2022 National Payment Rate (Non-Facility)	2022 National Payment Rate (Facility)
99487	\$134.27	\$92.75
99489	\$70.66	\$51.22

In 2022, the increase in reimbursement for complex CCM was not as dramatic as the increases for CPT 99490 and 99439. As a result, the non-facility reimbursement for one unit of CPT 99490 and two units of 99439 (a total of 60 minutes) is \$160.92, \$26.65 more than the non-facility reimbursement for 60 minutes of complex CCM.

For CCM services billed as hospital outpatient department services, CMS has assigned CPT 99487 to APC 5823 with a 2022 payment rate of \$136.65 (not adjusted for labor costs). CPT 99487 has been assigned to status indicator "S," which means it is a procedure or service paid under the Medicare OPPS with a separate APC payment and that no multiple procedure discount is applied. CMS has not assigned CPT 99489 to any APC.

### What guidance is available to providers regarding complex CCM?

All the billing rules for CCM (CPT 99490) apply to complex CCM, except the time and medical decision-making requirements.

# Principal Care Management (CPT 99424, 99425, 99426, and 99427)

## Does CMS reimburse for care management services for beneficiaries who have only one chronic condition?

Effective January 1, 2020, CMS reimburses for principal care management (PCM) furnished to beneficiaries with a single chronic condition to stabilize that condition following exacerbation or hospitalization. Unlike CCM, which requires management of total patient care, PCM focuses on disease-specific care. While CCM typically is furnished by primary care physicians, PCM typically is furnished by specialists.

## How do the billing rules for PCM differ from CCM?

*First*, PCM requires 30 minutes of care management services per month, as opposed to 20 minutes. Effective January 1, 2022, CMS now reimburses for additional 30-minute increments of PCM services.

*Second*, a practitioner billing for PCM must document in the patient's record ongoing communication and care coordination between all practitioners furnishing care to the beneficiary.

*Third*, a practitioner cannot bill for interprofessional consultations or other care management services (excluding RPM) for the same beneficiary for the same period as PCM. Otherwise, the same requirements apply to CCM and PCM.

## What is the reimbursement for PCM?

PCM services involving care management services furnished by clinical staff under general supervision are billed under CPT 99426 and 99427, while services personally performed by a practitioner are billed under CPT 99424 and 99425. Here are the 2022 national payment amounts for these codes:

	Non-Facility	Facility
99424	\$83.40	\$75.44
99425	\$60.22	\$52.60
99426	\$63.33	\$50.53
99427	\$48.45	\$35.64

For PCM services billed as hospital outpatient department services, CMS has assigned CPT 99426 to APC 5822, with a 2022 payment rate of \$76.42 (not adjusted for labor costs). CPT 99426 has been assigned to status indicator "S," which means it is a procedure or service paid under the Medicare OPPS with a separate APC payment and that no multiple procedure discount is applied. CMS has not assigned CPT 99424, 99425, or 99427 to any APC.



## Care Management for RHCs and FQHCs (HCPCS G0511)

<b>Can RHCs and FQHCs bill for CCM?</b>	RHCs and FQHCs bill for CCM services furnished by clinical staff under HCPCS G0511. They will not receive payment under any of the aforementioned CPT codes. An RHC or FQHC should report care management services with revenue code 052x. Effective January 1, 2022, RHCs and FQHCs may now bill for transitional care management and other care management services furnished for the same beneficiary during the same service period, provided all requirements for billing each code are met.
<b>Can RHCs and FQHCs bill for multiple units of G0511 in a given month?</b>	No. An RHC or FQHC may bill for only one unit of G0511 per beneficiary per month, regardless of the number of minutes of care management services furnished during that month.
<b>What requirements must be met for RHCs and FQHCs to bill for G0511?</b>	An RHC or FQHC must meet the same requirements as other providers to bill for CCM, complex CCM, or PCM, including those requirements regarding the use of a certified EHR.
<b>What is the payment for G0511?</b>	For 2022, the national payment rate for G0511 is \$79.26, an increase of \$14.02 over the 2021 payment rate.



# Care Plan Development

## How are practitioners reimbursed for their time and effort in developing a patient's care plan?

Prior to January 1, 2017, CMS considered the reimbursement for E/M services to include care plan development. Now, CMS will pay practitioners for care plan development under a new code, HCPCS G0506. This add-on code is to be listed separately, in addition to the CCM-initiating visit, and billed separately from monthly care management services.

There is no specific time requirement associated with G0506. However, CMS cautions providers that this code should be billed only if the time and effort involved in care plan development are beyond the usual time and effort involved in the underlying E/M service. Also, the code may be billed only one time, at the outset of CCM services. Time and effort involved in revising a beneficiary's care plan still are not separately reimbursed.

CMS has clarified that the date of service for G0506 should be the same as the base initiating-visit code. The face-to-face assessment should be performed the same day as the initiating visit, although CMS recognizes that some, or all, care planning could be completed on a subsequent day.

RHCs and FQHCs cannot bill for G0506.

## What is the reimbursement for care plan development?

The 2022 national payment amounts for G0506 are \$62.64 (non-facility) and \$45.33 (facility).

For more information about providing and billing Medicare for chronic care management and related services, contact:

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