Frequently Asked Questions About Practitioner Billing for Chronic Care Management Services

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This document answers frequently asked questions about billing chronic care management (CCM) services to the Physician Fee Schedule (PFS).

What chronic care management codes are currently billable under the PFS?

Under the Physician Fee Schedule, Medicare will pay for:

- CPT codes 99487 – complex CCM, first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
    - CPT code 99489 – add-on code for CPT code 99487; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
- CPT code 99490 – CCM services, at least 20 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month
    - CPT code 99439 – add-on code for CPT code 99490; each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month; note this code, which was adopted in the CY 2021 PFS final rule, replaced HCPCS code G2058
- CPT code 99491 – CCM services provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month
    - CPT code 99437 – add-on code for CPT code 99491; each additional 30 minutes by a physician or other qualified health care professional, per calendar month

Certain CCM codes describe time spent per calendar month by "clinical staff." Who qualifies as "clinical staff?"

Practitioners should consult the CPT definition of the term "clinical staff." In addition, time spent by clinical staff may only be counted if Medicare's "incident to" rules at 42 CFR 410.26 are met for auxiliary staff (which include clinical staff). Of course, other staff may help facilitate CCM services, but only time spent by clinical staff can be counted towards clinical staff time.

How can pharmacists, social workers, registered dieticians, psychologists, and other nonphysician practitioners (NPPs) who aren't able to bill directly for CCM engage in CCM services?

There are a number of NPPs who cannot bill directly for CCM, either because they are limited by their scope of practice or because they cannot bill directly for E/M services (including CCM). Under CMS guidelines, many of these NPPs may participate in CCM delivery as "clinical staff"

who can provide CCM services within their scope of practice under general supervision of a qualified NPP, so long as the requirements for "incident to" are met. As a member of the care team, clinical staff may perform activities such as: collect structured data, maintain/inform updates for the care plan, manage care, provide a 24/7 access to care, document CCM services, and provide support services to facilitate CCM.

Can CCM services billed under CPT code 99491 be furnished "incident to" the billing practitioner's services by other practitioners or clinical staff?

No. As noted in the CY 2019 final rule (83 FR 59577), CPT code 99491 is specifically for use when the billing practitioner personally performs care management services, so this code cannot be furnished incident to a practitioner's professional services.

Can CCM services be completely delegated to clinical staff?

No. The billing practitioner must retain a certain level of involvement in CCM. The CCM service codes for reporting clinical staff time are valued to include a certain amount of ongoing practitioner work, including oversight, management, collaboration, and reassessment by the billing practitioner consistent with the included service elements. This work cannot be delegated or subcontracted to any other individual. Additionally, complex CCM (CPT codes 99487, 99489) includes moderate to high complexity medical decision-making by the billing practitioner during the service period, an activity that cannot be subcontracted to any other individual.

The CCM service codes for reporting services furnished directly by the billing practitioner (CPT code 99491, 99437) cannot be delegated or subcontracted to auxiliary personnel; the work must be personally furnished by the practitioner to be reported.

Can the clinical staff portion of CCM be performed by external third-party companies?

A billing practitioner may arrange to have the clinical staff portion of CCM services provided by clinical staff external to the practice (such as by a case management company) if all of the "incident to" and other rules for billing CCM to the PFS are met. As discussed in the CY 2017 PFS final rule (at 81 FR 80249), if there is little oversight by the billing practitioner or a lack of clinical integration between a third party providing CCM and the billing practitioner, we do not believe CCM could actually be furnished and therefore the practitioner should not bill for CCM.

Can CCM be provided by physicians/NPPs or staff located outside of the United States?

No. Because there is a regulatory prohibition against payment for non-emergency Medicare services furnished outside of the United States (42 CFR 411.9), CCM services cannot be billed if they are provided by individuals located outside of the United States (or provided to beneficiaries who are located outside of the United States).

Does the billing practice have to furnish all of the scope of service elements in a given service period, even those that may not apply to an individual patient?

It is our expectation that all of the scope of service elements will be routinely provided in a given service period, unless a particular service is not medically indicated or necessary (for example, the beneficiary has no hospital admissions that month, so there is no management of a care transition after hospital discharge). Additionally, in order to bill for complex CCM (CPT codes 99487, 99489), it is always necessary that the billing practitioner personally perform moderate to high complexity medical decision-making during the service period, as the CPT code descriptors include these services.

If clinical staff or the practitioner perform CCM activities that will benefit multiple beneficiaries, can a CCM code be billed for each beneficiary?

First, we note that all time counted towards CCM codes must be spent performing activities that are part of the CCM scope of service, as described in the PFS rules. Additionally, Section 1862(a)(1)(A) of the Social Security Act prohibits Medicare payment for services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve function. CCM services are largely designed to be person-centered and focused on individual patient needs.

However, there may be limited circumstances when clinical staff or practitioners provide CCM services to multiple beneficiaries at the same time, or perform a single activity that will benefit multiple beneficiaries. In these instances, the time spent by the clinical staff or practitioner must be split among the beneficiaries. For instance, if a clinical staff person spends 30 minutes on an activity that will benefit three CCM patients (and the activity is reasonable and necessary for all three), the 30-minute time interval would be split among the three beneficiaries. Ten minutes would be counted towards each beneficiary's CCM service time.

What elements are required to be included in the CCM care plan?

As discussed in the CY 2020 final rule (84 FR 62691), CMS updated the typical care plan elements. Note that these are "typical" care plan elements, and do not comprise a set of strict requirements that must be included in a care plan for purposes of billing for CCM services. The elements are intended to reflect those that are typically, but perhaps not always, included in a care plan as medically appropriate for a particular beneficiary.

As revised, the comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals

- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers

What date of service should be used on the practitioner claim and when should the claim be submitted?

The CCM service period is one calendar month.

For complex CCM (CPT codes 99487, 99489), billing practitioners should report the service code(s) at the conclusion of the service period. In addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making; medical decision-making is determined by the problems addressed by the practitioner throughout the service period.

For CCM provided by clinical staff (CPT codes 99490, 99439) and CCM furnished directly by practitioners (CPT codes 99491, 99437), the billing practitioner may report the appropriate claim(s) at the conclusion of the service period. Practitioners may also choose to report the appropriate claim(s) after completion of the service time for the code. When the time threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month. Note that for these CCM services, CMS expects the billing practitioner to continue furnishing services during a given month as medically necessary, even after the billing threshold for the billed code(s) has been met.

What place of service (POS) should be reported on the practitioner claim?

CCM is priced in both facility and non-facility settings. The billing practitioner should report the POS for the location where they would ordinarily provide face-to-face care to the beneficiary. Our goal is to pay an accurate rate that reflects the resource costs of the practitioner.

We welcome information from impacted parties who provide CCM services on the following: how often they furnish CCM to beneficiaries who reside or remain in facility settings during part or all of the service period; the kind of facilities; and how often the resources and staff of the billing practitioner are used rather than facility resources and staff. We recognize that there could be many different arrangements based on the location(s) of the beneficiary during the month and individual practice patterns.

Can I bill for CCM services furnished to beneficiaries I provide care to in skilled nursing facilities, nursing facilities, assisted living or other facility settings?

Yes. CCM is priced in both facility and non-facility settings. The POS on the claim should be the location where the billing practitioner would ordinarily provide face-to-face care to the beneficiary.

Is a new patient consent required each calendar month or annually?

There is not a requirement to obtain patient consent either monthly or annually. Consent must be obtained from the patient once prior to the start of CCM. Patient consent must be obtained again if the patient changes billing practitioners - in which case, consent must be obtained and documented by the new billing practitioner prior to furnishing the service. We also note that in the CY 2017 PFS final rule (81 FR 80250), we updated consent requirements to allow for verbal (rather than written) consent from the patient.

Do the billing practitioners need to ever see their CCM patients face-to-face?

Yes. For new patients or patients not seen by the billing practitioner within a year prior to the commencement of CCM services, CCM must be initiated by the billing practitioner during a "comprehensive" E/M visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE).

What types of visits may serve as CCM initiating visits?

If an initiating visit is required (see prior question), CCM must be initiated by the billing practitioner during a "comprehensive" E/M visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the CCM service and can be separately billed to the PFS

Levels 2 through 5 E/M visits (CPT codes 99212 through 99215) qualify as a "comprehensive" E/M visit for CCM purposes. The face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) also qualifies as a "comprehensive" visit for CCM initiation. CPT codes that do not involve a face-to-face visit by the billing practitioner or are not separately payable by Medicare cannot be used as the "comprehensive" E/M visit for CCM initiation.

Note that if the practitioner furnishes a "comprehensive" E/M, AWV, or IPPE, and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.

Can the initiating visit for CCM be conducted using telehealth?

As part of the COVID-19 Public Health Emergency, CMS expanded a number of flexibilities for telehealth services. If an E/M visit that can otherwise qualify as an initiating visit for CCM is allowed to be furnished via telehealth under these flexibilities, this telehealth visit can be used

for the CCM initiating visit. Please visit https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth for a list of services that may be delivered via telehealth as well as additional resources regarding telehealth services.

Does informed consent for CCM have to be obtained at the initiating visit?

The initiating visit for CCM and informed consent are two separate requirements for CCM services. The billing practitioner must discuss CCM with the patient at the initiating visit. While the initiating visit presents an opportunity to obtain the required informed consent, informed consent does not have to be obtained during the initiating visit.

Do face-to-face activities count as billable time?

CCM includes, in large part, activities that are not typically or ordinarily furnished face-to-face with the beneficiary and others, such as telephone communication, review of medical records and test results, and coordination and exchange of health information with other practitioners and providers.

Prior to separate payment for CCM, these activities were primarily included in the payment for face-to-face visits (though they usually occurred before or after), and we tend to refer to them as "non-face-to-face" activities because generally, they are such. If these activities are occasionally provided face-to-face for convenience or other reasons, the time may be counted towards a CCM service code(s). CCM also includes activities such as patient education or motivational counseling, that are frequently provided to patients either in person or non-face-to-face (such as by phone). 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.

Medicare and CPT allow billing of E/M visits during the same service period as CCM. If an E/M visit or other E/M service is furnished the same day as CCM services, how do I allocate the total time between CCM and the other E/M code(s)?

CCM services are E/M services. Time or effort that is spent providing services within the scope of the CCM service, on the same day as an E/M visit or other E/M service that Medicare and CPT allow to be reported during the CCM service period, can be counted towards CCM codes, as long as the time is not counted towards other reported E/M code(s). We note that time and effort cannot be counted twice, whether face-to-face or non-face-to-face, and Medicare and CPT provisions specify certain codes that can never be billed during the CCM service period.

Are there services that cannot be billed under the PFS during the same calendar month as CCM?

Yes, Medicare does not allow the CCM service codes to be billed during the same service period as home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182), or certain ESRD services (CPT 90951-90970) because the comprehensive care management included in CCM could significantly overlap with these services. Please refer to CPT coding guidance for a list of additional codes that cannot be billed during the same month as the CCM service codes.

Note that CPT codes for CCM provided by clinical staff (CPT codes 99490, 99439) cannot be reported in the same calendar month as CPT codes for CCM services furnished directly by physicians/NPPs (CPT codes 99491, 99437) or for complex CCM (CPT codes 99487, 99489). CPT codes for CCM furnished directly by physicians/NPPs (CPT codes 99490, 99437) cannot be reported in the same calendar month as complex CCM (CPT codes 99487, 99489).

There may be additional restrictions on billing for practitioners participating in a CMS model or demonstration program; if you participate in one of these separate initiatives, please consult the CMS staff responsible for these initiatives with any questions on potentially duplicative billing.

Can TCM and CCM codes be billed concurrently?

In the CY 2020 PFS final rule (84 FR 62685) and CY 2021 PFS final rule (85 FR 84547), CMS indicated that TCM may be billed concurrently with CCM codes when relevant and medically necessary. Note that the minutes counted for TCM services cannot also be counted towards other services (including CCM).

Can CCM and principal care management (PCM) be billed concurrently? Can they be billed for the same practice in a multispecialty group that has a PCP and a specialist?

Yes. As discussed in the CY 2020 PFS final rule (84 FR 62697), CCM and PCM cannot be billed by the same practitioner for the same patient in the same month. However, it is allowable, for instance, for a primary care practitioner to offer CCM and a specialist to offer PCM (or vice versa, as appropriate). The conditions being addressed by CCM and PCM must be different.

If CCM and PCM are provided concurrently, two care plans would be required. Note, however, that for PCM, the care plan needs only to be "disease-specific." Refer to the CY 2020 PFS final rule (84 FR 62695-62696) for a comparison of the CCM and PCM scope of service requirements, including the care plan.

Can I bill for CCM if the beneficiary dies during the service period?

The CCM service code(s) can be billed if the beneficiary dies during the service period, as long as the required service time for the code(s) was met that calendar month and all other billing requirements are met.

If a beneficiary declines to receive CCM services or does not provide consent, or if other conditions of payment for CCM are not met, can the practitioner bill the beneficiary for CCM services?

No. The beneficiary must provide the required consent and all other Medicare conditions of payment must be met in order to bill Medicare or the beneficiary for CCM. If the beneficiary does not provide consent or if other conditions for payment are not met, the practitioner cannot bill Medicare or the beneficiary for CCM. Medicare would consider any CCM services furnished to the beneficiary (but not separately billable under a CCM CPT code) as included in payment for the face-to-face E/M visit(s) furnished to the beneficiary. As we noted in the CY 2014 PFS final rule with comment period (78 FR 74414-74415), payment for non-face-to-face care management services was previously bundled into payment for face-to-face visits; we did not revalue these E/M visits under the PFS to account for separate payment of CCM services. We also note that CCM would be considered a reasonable and necessary covered Medicare service, so it would not be appropriate to issue the beneficiary an Advance Beneficiary Notice of Noncoverage (ABN).

Will Medigap cover the beneficiary cost sharing for CCM?

Yes. If services are covered under Medicare Part B, Medigap insurers do not have authority to deny the coinsurance, copayments or other benefits that are payable on behalf of the beneficiary under the provisions of the Medigap insurance contract. Private insurers providing standardized Medigap plans agree to accept a notice of Medicare payment as a claim for the payment of benefits under the Medigap plan, unless the Medigap policy itself has a deductible that has not yet been met.

Will Medicaid cover the beneficiary cost sharing for CCM for dually eligible beneficiaries?

We wish to ensure that Medicare-Medicaid dually eligible beneficiaries have access to CCM services. The majority of dually eligible beneficiaries (approximately 8 million of the 11.9 million dually eligible beneficiaries) are Qualified Medicare Beneficiaries who will not be responsible for CCM cost sharing. For Qualified Medicare Beneficiaries, Medicaid is responsible for deductibles/coinsurance for Medicare services, including CCM, even if the services are not covered in the State Plan.

However, as permitted by federal statute, most states limit payment of Medicare cost sharing to the "lesser-of" Medicaid or Medicare rates. If the service is not covered in the State plan, states can set other reasonable payment limits, approved by CMS, for the service. The net effect of these policies is that many states pay little to none of the Medicare deductible/coinsurance,

leaving practitioners to absorb the costs for Qualified Medicare Beneficiaries. In states where there would be coverage of some or all of the beneficiary cost sharing, practitioners need to be enrolled as Medicaid providers to be paid for the Medicare cost sharing; however, Medicare automatically "crosses over" claims to states for dual eligible beneficiaries, so practitioners need not submit their own bill.

Will practitioners be able to use acceptably certified electronic health record (EHR) technology for which certification expires mid-year in order to bill for CCM?

Yes. Under the CCM scope of services, practitioners must record certain patient health information in a structured format, using technology certified to the edition(s) of certification criteria that is acceptable for the EHR Incentive Programs as of December 31st of the year preceding each CCM payment year. In certain years, this may mean that practitioners can fulfill the scope of services requirement using multiple versions of certification criteria that are valid during that year. This remains true for a given PFS payment year even after ONC-Authorized Certification Bodies (ONC-ACBs) have removed the certifications issued to certified technology as a result of the relevant version of the criteria being removed from the Code of Federal Regulations. Thus, practitioners using an acceptable EHR technology that loses its certification mid-year may still use that technology to fulfill the certified EHR criteria for billing CCM during the applicable payment year.

Where can I find more guidance on CCM billing requirements?

Fact Sheets and other materials on CCM are available on the CMS website on the Physician Fee Schedule (PFS) page under the "Care Management" hyperlink at (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/). CCM materials are also available on the Office of Minority Health web page (http://go.cms.gov/omh). Materials for CCM in federally qualified health centers (FQHCs) and rural health centers (RHCs) are available on the FQHC web page (https://www.cms.gov/Center/Provider-Type/Federally-Qualified- Health-Centers-FQHC-Center.html).

CCM policy guidance and discussions can be found in the following Physician Fee Schedule rules:

- CY 2022 (86 FR 65117), https://www.federalregister.gov/d/2021-23972/p-1094
- CY 2021 (85 FR 84639(, https://www.federalregister.gov/d/2020-26815/p-1578
- CY 2020 (84 FR 62684), https://www.federalregister.gov/d/2019-24086/p-1160
- CY 2019 (83 FR 59577), https://www.federalregister.gov/d/2018-24170/p-1500
- CY 2018 (82 FR 53166), https://www.federalregister.gov/d/2017-23953/p-1529
- CY 2017 (81 FR 80225), https://www.federalregister.gov/d/2016-26668/p-862
- CY 2016 (80 FR 70918), https://www.federalregister.gov/d/2015-28005/p-584
- CY 2015 (79 FR 67715), https://www.federalregister.gov/d/2014-26183/p-1226
- CY 2014 (78 FR 74414), https://www.federalregister.gov/d/2013-28696/p-1713

Note that all Physician Fee Schedule proposed and final rules are on the CMS Physician Fee Schedule web page, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.

You may direct questions to the Division of Practitioner Services or your Medicare Administrative Contractor.