NATIONAL ASSOCIATION OF Community Health Centers®

PAYMENT

Reimbursement Tips:

Chronic Care Management Services

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)

Overview

Medicare's chronic care management services are personalized and supportive services provided to patient with chronic conditions to coordinate care and develop a care plan to achieve health goals.

- **Chronic Care Management (CCM) services support individuals with multiple chronic conditions.**
- **Complex Chronic Care Management (CCCM) services support individuals with multiple chronic conditions who require moderate or high medical decision making.**
- **Principal Care Management (PCM) services support individuals with a single complex chronic condition.**

CCM, CCCM, and PCM services are grouped in with the suite of care management services billable by FQHCs via G0511 (see NACHC resource: Summary of Medicare Care Management Services Billed Using G0511). This Tip Sheet provides FQHCs with simplified, easy-to-understand instructions for providing and billing Medicare for CCM, CCCM and PCM services. Also see NACHC resource: CMS Billing Lingo, Defined! for definitions of terms used throughout this document.

Initiating Visit Requirements

The initiating visit, which is a separately billable and reimbursable service from PIN services, may be any one of the following:

- Evaluation and Management (E/M visit (CPT 99212-99215)
- Initial Preventive Physical Examination (IPPE) (HCPCS G0402)
- Annual Wellness Visit (AWV) (HCPCS G0438, G0439)
- Transitional Care Management (TCM) (CPT 99495-99496)

The initiating visit must:

- Occur within 12 months of the start of chronic care management services.
- Include a discussion about chronic care management services with the patient.
- Be performed by the same billing provider who will also furnish and bill for subsequent chronic care management services, regardless of whether the initiating visit is an E/M, IPPE, AWV, or TCM encounter.
- Establish a patient-centered treatment plan that specifies the benefit of care management support for the patient's chronic condition(s).
- Establish the chronic care management services as incidental to the practitioner's Medicare Part B services and explain to the patient that auxiliary personnel may perform subsequent chronic care management services.

Note: There is an ongoing discrepancy between several CMS Subregulatory documents regarding whether the initiating visit must include a discussion with the patient about chronic care management services, prior to the start of services. (See Chapter 13 of the policy manual 230.2, CMS MLN Chronic Care Management, and CMS Chronic Care Management FAQs.) NACHC recommends for health centers to include a discussion about chronic care management services with the patient during the initiating visit, as this guidance is consistent with new CMS regulations for other CMS care management services. Please contact your MAC for guidance regarding your local policy.

Reimbursement Tips: Chronic Care Management Services CCM, CCCM, and PCM

CCM	CCCM	PCM
Medicare Part B beneficiaries	Medicare Part B beneficiaries	Medicare Part B beneficiaries
Provide consent for services	Provide consent for services	Provide consent for services
Have multiple (two or more) chronic continuous or episodic conditions expected to last at least 12 months or until the patient dies, or that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline; and, for which the authorized billing provider determines that CCM services are medically necessary.	Have multiple (two or more) chronic continuous or episodic conditions expected to last at least 12 months or until the patient dies, or that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline; and, for which the authorized billing provider determines that CCCM services are medically necessary. Moderate or high complexity medical decision making (MDM) required	Have a single, high-risk complex chronic condition that is expected to last at least 3 months and places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death; and, for which the authorized billing provider determines that PCM services are medically necessary.

Note: The definition of a CCM, CCCM, or PCM eligible condition is dependent upon the clinical judgement the practitioner. Examples may include heart disease, cancer, chronic lung disease, stroke, dementia, depression, diabetes, chronic kidney disease, substance abuse disorder, and infectious disease.

Authorized Billing Providers

What they do:

- ✔ Perform an initiating visit for new or established patients not seen by the billing practitioner within 12 months before the start of chronic care management services.
- ✔ Determine medical necessity of chronic care management services and order services.
- ✔ Obtain patient consent for services (verbal or written). If not obtained by billing provider, consent may also be obtained by auxiliary personnel under general supervision.
- ✔ Furnish services personally and/or via general supervision of auxiliary personal as indicated by the service CPT code.
- ✔ For CCCM, perform moderate to high complexity medical decision-making as per CPT© code descriptors.

Note: During the consent process, the patient must be informed of the availability of chronic care management services, that coinsurance applies, that only one practitioner per month can deliver and bill for chronic care management services, and that the patient has the right to end services at any time. Consent must be obtained again if there is a change in the billing provider.

Who they are:

- Physicians (MD,DO)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Certified Nurse Midwife (CNM)

Note: Must be qualified by education, licensure, scope of practice, and training to perform E/M and TCM level services or the specified AWV service.

Auxiliary Personnel

What they may do (under general supervision, and after the initiating visit has taken place):

- ✔ Obtain patient consent for services (verbal or written)
- ✔ Provide chronic care management services
- ✔ Collect data relative to patient demographics, assessments, interviews, and outcomes
- ✔ Maintain and update, within scope of practice, the patient-centered care plan
- ✔ Provide 24/7 access to care

Who they are (examples):

- ✔ Nurses (nurse care manager, clinical nurse specialist (CNS), RN, LPN)
- ✔ Social Worker

Service Elements, Coding & Billing: CCM, CCCM, PCM

CODE	*Service Elements*	*Service Provider*	*FQHC Medicare Billing Code & Rate*
CCM			
CPT® 9949	CCM services may be billed once per calendar month after at least 20 minutes of services performed by auxiliary personnel under the direction of an authorized billing provider and include the following elements: • Multiple chronic conditions expected to last at least 12 months, or until patient's death, and place the patient at significant risk of death or acute exacerbation/ decompensation or functional decline • Comprehensive care plan developed, implemented, modified, or monitored	Auxiliary personnel under general supervision, or the billing provider may choose to personally delivery these services.	G0511: $72.90 Along with the CPT© service codes, FQHCs must submit HCPCS G0511 on the claim to be reimbursed. Since this service is reported by calendar month, the date of service may be set for the date when billing requirements have been met, or any date after that, as long as it is on or before the last day of the calendar month.
CPT® +99439*	CCM services, each addtl' 20 minutes per calendar month		
CPT® 99491	CCM services may be billed once per calendar month after at least 30 minutes of services performed personally by the authorized billing provider and include the elements listed above under CPT© 99490.	Authorized billing provider only	
CPT® +99437*	CCM services, each addtl' 30 minutes per calendar month		
CCCM			
CPT© 99487	CCCM services may be billed once per calendar month after at least 30 minutes of services performed by auxiliary personnel under the direction of an authorized billing provider and include the following elements: • Multiple chronic conditions expected to last at least 12 months, or until patient's death, and places the patient at significant risk of death or acute exacerbation/ decompensation or functional decline • Comprehensive care plan developed, implemented, modified, or monitored • Moderate or high complexity medical decision making	Auxiliary personnel under general supervision, or the billing provider may choose to personally delivery these services.	
CPT© +99489*	CCCM services, each addtl' 30 minutes per calendar month		

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CODE	*Service Elements*	*Service Provider*	*FQHC Medicare Billing Code & Rate*
PCM			
CPT© 99424	PCM services may be billed once per calendar month after at least 30 minutes of services performed personally by the authorized billing provider and include the following elements: • One complex chronic condition expected to last at least 3 months, or until patient's death, and places the patient at significant risk of death or acute exacerbation/ decompensation or functional decline • Comprehensive disease-specific care plan developed, implemented, modified, or monitored • Frequent adjustments in medication and/or unusually complex management of condition due to comorbidities • Ongoing communication and care coordination between various practitioners providing other care.	Authorized billing provider only	G0511: $71.70 Along with the CPT© service codes, FQHCs must submit HCPCS G0511 on the claim to be reimbursed. Since this service is reported by calendar month, the date of service may be set for the date when billing requirements have been met, or any date after that, as long as it is on or before the last day of the calendar month.
CPT® +99425*	PCM services, each addtl' 30 minutes per calendar month		
CPT 99426	PCM services may be billed once per calendar month after at least 30 minutes of services performed by auxiliary personnel under the direction of an authorized billing provider and include the elements listed above under CPT© 99424.	Auxiliary personnel under general supervision, or the billing provider may choose to personally delivery these services.	
CPT® +99427*	PCM services, each addtl' 30 minutes per calendar month		

Activities of CCM, CCCM, and PCM

Chronic care management activities of CCM, CCCM, and PCM performed by qualified auxiliary personnel or performed personally by the authorized billing provider, after an initiating visit, typically include:

- 24/7 access to clinical support staff
- Continuity of care with designated care team member, including communication and engagement with the patient, all caretakers, and the care team
- Comprehensive assessment of medical, functional, and psychosocial needs
- Preventive care services
- Medication management and support for treatment compliance;
- A comprehensive care plan created, monitored, revised, and shared with the patient/caregiver and other internal/external members of the patient's care team.
- Patient education and resources to support self-management and independent functional living needs.
- Care coordination through communication, and facilitation of care access and services, with identified home health agencies and community support services.

- *The payment rate is based on the 2024 Medicare Physician Fee Schedule (PFS). The most up-to-date 2024 payment rates, reflecting the changes effective March 9th, can be confirmed here. The payment rate is based upon the date of service as opposed to the billing date. No Geographical Adjustment Factor (GAF) or Geographic Practice Cost Index (GPCI) has been applied; FQHCs can expect the payment to be slightly higher or lower depending on the GAF/GPCI.*
- *Code descriptions taken from the AMA's CPT 2024 Manual, Professional Edition.*
- **Not permitted to be billed by FQHCs. Once a minimum CPT service time threshold is reached, FQHCs are expected to continue furnishing services, as applicable, during the calendar month and are not permitted to bill for any additional time via add-on service codes.*

Be sure to capture the following documentation elements when billing for chronic care management services:

- ✔ Single or multiple chronic condition(s) and other criteria used (i.e., complexity, risk) to determine which chronic care management program (i.e., CCM, CCCM, PCM) supports the patient's needs.
- ✔ The medical necessity of the chronic care management services
- ✔ The date and practitioner who furnished the initiating visit

Reimbursement Tips: Chronic Care Management Services CCM, CCCM, and PCM

- ✔ Patient consent
- ✔ Comprehensive patient-focused care plan which may include, but is not limited to, the following elements:
  - Problem list
  - Outcome expected
  - Prognosis of condition
  - Comprehensive assessment of medical, functional, and psychosocial needs and methods used to address them, as needed (CCM and CCCM)
  - Disease-specific care plan (PCM)
  - Preventive care services provided
  - Symptom management methods and effectiveness
  - Medication management and adherence
  - Continuity of care, including environmental evaluation, planned interventions, and caregiver assessment
  - Coordination with home- and community-based providers
  - Advance directives summary

Note: Certified Electronic Health Record (EHR) technology must be used to record chronic care management services and patient health information (i.e., demographics, problems, medications, and medication allergies) which can be used by the care team and shared with the patient/caregiver and to providers outside the primary care team as appropriate.

The billing practitioner is ultimately responsible for documentation, including that of any contracted community-based organizations (CBOs) or other contracted personnel who furnish chronic care management services under the clinical care and treatment of this same billing practitioner.

As chronic care management activities do not include a face-to-face service (see CMS Billing Lingo, Defined!), CMS does not include the services in the Medicare telehealth services list. Chronic care management services may be provided in person or virtually (i.e., audio-visual or two-way audio technology), or a combination of both. Additionally, some activities may not directly involve the patient (for example, creating connections with local community-based resources on behalf of the patient).

Capturing the time spent on care chronic management activities can be challenging. Here are some helpful guidelines:

- Chronic care management services may spread across the entire calendar month, so be sure to capture and count time by each auxiliary personnel and/or authorized billing provider to best determine which service to bill.
- Only count the billing provider's time in addition to the auxiliary staff time when the provider is not otherwise reporting the time for a separately reported code.
- Count only the time of one auxiliary staff member or authorized billing provider when multiple care team members meet together about a patient.
- Auxiliary personnel and authorized billing provider time cannot be reported separately in the same calendar month for CCM or PCM service activities.

Any additional service time above the base service code minutes is typically billed for through the submission of the add-on codes indicated in the table; however CMS does not reimburse FQHCs for additional service time for any G0511 services. Once a minimum time threshold is reached, FQHCs are expected to continue furnishing services, as applicable, during the calendar month even after the minimum time threshold to bill the service has been reached.

Patients pay 20% coinsurance based upon the lesser of the submitted charges or the local payment rate for G0511. Coinsurance may be covered in part or in full by secondary coverage (Medigap, private, or Medicaid). Coinsurance may be "slid" commensurate with the sliding fee discount program (SFDP) policy of the health center Sliding Coinsurance for CMS/Medicare Care Management for more information).

Co-Occurring Care Management Services

CCM and CCCM may not be billed for during the same period for the same patient. CCM and PCM may not be billed by the same billing provider for the same patient in the same calendar month. However, there is an exception to this rule: CCM or CCCM and PCM may be billed for the same patient during the same calendar month by different providers if the conditions being addressed are different, there are two separate care plans, and there is no overlap with auxiliary personnel or activities. CMS also allows separately identifiable care management services to be delivered and billed during the same calendar month as chronic care management services, including TCM, Psych CoCM (G0512), BHI, CHI, RPM, and RTM for CCM and CCCM; and, TCM, PIN, RPM, RTM for PCM. PCM may not be billed in the same calendar month as Psych CoCM, or BHI, or CHI for the same patient during the same calendar month by different providers if the conditions being addressed are the same.

See NACHC resource: Summary of Medicare Care Management Services Billed Using G0511 for more information on Medicare Care Management Services.

References

- AMA. 2024 CPT 2024 Codebook
- AAPC. 2024 HCPCS Level II Codebook
- CMS. CY 2015 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Medicare Part B https://www.govinfo.gov/content/pkg/FR-2014-11-13/pdf/2014-26183.pdf
- CMS. CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Medicare Part B (introduction of PCM and comparison with other CCM services) https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other
- CMS. CY 2024 Physician Fee Schedule Final Rule https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other

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