Summary of Medicare Care Management Services

NATIONAL ASSOCIATION OF Community Health Centers®

See NACHC resource: ***Medicare Billing Lingo, Defined!*** for definitions of terms used throughout this document.

	Chronic Care Management (CCM)	Complex Chronic Care Management (CCCM)	Principal Care Management (PCM)	Advanced Primary Care Management (APCM)
More Information	CCM, CCCM, PCM Reimbursement Tip Sheet			(Coming soon)
Description	Personalized and supportive services provided to patients with multiple chronic conditions to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with multiple chronic conditions, who require moderate or high medical decision making, to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with a single complex chronic condition to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive advanced primary care delivery through streamlined, patient-centered care plans, proactive care coordination, and the integration of digital communication tools.
Eligible Patients	Patients who 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.	Patients who 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. Moderate or high complexity medical decision making (MDM) required.	Patients who 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.	Patients who have: Zero, one, or multiple chronic condition(s). The complexity of the patient determines the APCM level: Level 1: One or no chronic condition expected to last at least 12 months or until death, or posing significant risk of death, acute exacerbation, decompensation, or functional decline. Level 2: Two or more chronic conditions meeting the same criteria as Level 1. Level 3: Meets the same criteria as Level 2 AND the patient is a Qualified Medicare Beneficiary
Billing Providers	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)			• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)
Auxiliary Personnel *(Examples)*	• Nurse (nurse care manager, Clinical Nurse Specialist (CNS), RN, LPN) • Social Worker			• Nurse (nurse care manager, Clinical Nurse Specialist (CNS), RN, LPN) • Social Worker
Service Elements	Billed once per calendar month after: At least **20 minutes** of services provided by auxiliary personnel. Or At least **30 minutes** of services provided by the authorized billing provider.	Billed once per calendar month after: At least **60 minutes** of services provided by auxiliary personnel and/or authorized billing provider per calendar month.	Billed once per calendar month after: At least **30 minutes** of services provided by auxiliary personnel. Or At least **30 minutes** of services provided by the authorized billing provider.	Billed once per calendar month by authorized billing provider (no minimum time). Primary care-focused, incorporating: • CCM for ongoing management of chronic conditions. • TCM to ensure smooth transitions between care settings. • PCM for targeted support of high-risk diseases. Bundles care management services with communication technology-based services (CTBS) such as: • Interprofessional internet consultation for provider collaboration. • Remote evaluation of patient videos/images for virtual assessments. • Virtual check-ins for brief patient-initiated communication. • Online digital E/M (e-Visits) for provider interactions through online platforms. The amount of care is adjusted based on patient needs.
	• 24/7 access to clinical support staff • Continuity of care with designated care team member • Comprehensive assessment of medical, functional, and psychosocial needs • Preventive care • Medication management • 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 • Care coordination			
Billing Codes & Rates	• 99490: $ 60.49 • +99439: $ 45.93 • 99491: $ 82.16 • +99437: $ 57.58 OR continue billing G0511 until July 1, 2025	• 99487: $131.65 • +99489: $ 70.52 OR continue billing G0511 until July 1, 2025	• 99424: $ 80.87 • +99425: $ 58.87 • 99426: $ 61.78 • +99427: $ 50.46 OR continue billing G0511 until July 1, 2025	G0556: $15.20 G0557: $48.84 G0558: $107.07

	Transitional Care Management (TCM)	Chronic Pain Management (CPM)	Behavioral Health Integration (BHI)	Psychiatric Collaborative Care Model (Psych CoCM)
More Information	TCM Reimbursement Tip Sheet	CPM Reimbursement Tip Sheet	BHI Reimbursement Tip Sheet	Psych CoCM Reimbursement Tip Sheet
Description	Personalized and supportive services provided to patients who are being discharged from an inpatient hospital setting to a community setting.	Personalized and supportive services provided to patients with chronic pain to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with behavioral health needs to coordinate care and develop a care plan to achieve health goals.	Personalized and supported behavioral health integration services for patients with complex mental and behavioral health disorders and conditions.
Eligible Patients	Patients who have: Been discharged from an inpatient or partial hospitalization setting and require support to return to a community setting (e.g., home, rest home, assisted living). Moderate or high complexity making (MDM) required.	Patients who have: Persistent or recurrent pain lasting longer than 3 months.	Patients who have: One or more new or pre-existing behavioral health or psychiatric conditions, including substance use disorder.	Patients who have: One or more new or pre-existing complex behavioral or mental health conditions, substance abuse disorder. Require an integrated plan of care management for primary care, behavioral health, and psychiatric inter-specialty consultation.
Billing Providers	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM) • Clinical Psychologist (CP) • Clinical Social Worker (CSW) • Mental Health Counselor (MHC) • Marriage and Family Therapist (MFT)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)
Auxiliary Personnel *(Examples)*	• Nurses (nurse care manager, CNS, RN, LPN) • Social Workers • Mental Health Counselors	*No billable auxiliary personnel services.*	• Nurse (nurse care manager, CNS, RN, LPN) • Social Worker	CoCM services use an interdisciplinary team model: 1. Primary Care provider (MD, DO, NP, PA, CNM) 2. Psychiatric Consultant 3. Behavioral Health Care Manager • Nurse (CNS, RN, LPN) • Clinical Psychologist • Mental Health Counselor • Marriage & Family Therapist • Social Worker
Service Elements	Within a 30-day period, all three (3) components of TCM service must be provided in order to bill. 1. Interactive contact with the patient within 2 business days of discharge to assess post-discharge service needs, confirm medication instructions, and schedule a face-to-face visit with the authorized billing provider. 2. A face-to-face visit to assess the patient and develop a plan to aid the patient's return to the community, including any adjustments to treatments or medication. This visit must occur within the required time frame associated with either a moderate (14 days) or a high (7 days) MDM. 3. Ongoing non-face-to-face care coordination to make sure the post-discharge care elements are aligned and that the patient has access to necessary resources and support.	Billed once per calendar month after at least **30 minutes** of services provided by the authorized billing provider, including: • Administration of a validated pain rating scale or tool • Patient-centered care plan • Patient assessment and monitoring of their diagnosis and treatment • Medication management • Pain and health literacy counseling • Facilitation, coordination, and on-going communication with other necessary providers (e.g., behavioral health, physical and/or occupational therapy, home care) • Facilitation for crisis care for chronic pain	Billed once per calendar month after at least **20 minutes** of services provided by the authorized billing provider or auxiliary personnel (CPT 99484) or by CP, CSW, MHC, or MFT (G0323), including: • Initial assessment and ongoing monitoring using validated clinical rating scales • Behavioral health care planning in relation to behavioral/psychiatric health problems, including time spent modifying plans for patients who are not progressing or whose status changes • Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation • Continuity of care with a designated member of the care team • Coordination with and/or referral to qualified providers for medication, E/M services, counseling and/or psychiatric consultation (G0323)	Initial CoCM Visit: Billed once in the initial calendar month after at least **70 minutes** to establish services delivered by a behavioral health care manager, in consultation with the psychiatric consultant, under the direction of the treating (and billing) primary care provider: • Comprehensive initial assessment to develop a patient-centered care plan • Initiate treatment with care team and provide brief interventions using various evidence-based techniques • Educate patient about the CoCM model and set expectations for care • Identify and connect patient with community resources and with other providers, as needed • Enter and track patient follow-up in registry Subsequent CoCM Services: Billed once per calendar month after at least **60 minutes** of continuing CoCM services performed by a behavioral health manager, in consultation with the psychiatric consultant, under the direction of the treating (and billing) primary care provider. The focus is on monitoring, maintaining, and refining the established plan.
Billing Codes & Rates	• 99495 - Qualifying PPS service • 99496 – Qualifying PPS service Billed via PPS G0467: $ 202.65	• G3002: $80.22 • +G3003: $29.44 OR continue billing G0511 until July 1, 2025	• 99484: $53.05 • G0323: $53.70 OR continue billing G0511 until July 1, 2025	• 99492: FQHC bills G0512 • 99493: FQHC bills G0512 • G2214: $54.34 or +99494: $55.96 Billed via G0512: $139.41

	Community Health Integration (CHI)	Principal Illness Navigation (PIN)	Remote Physiologic Monitoring (RPM)	Remote Therapeutic Monitoring (RTM)
More Information	CHI Reimbursement Tip Sheet	PIN Reimbursement Tip Sheet	RPM, RTM Reimbursement Tip Sheet	
Description	Personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.	Personalized and supportive services provided to patients with a high-risk condition and healthcare navigation needs.	A patient's use of devices to remotely assess and record physiologic data (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate) outside of the clinical setting, usually in the home.	A patient's use of devices to remotely monitor adherence and response to therapeutic treatment (e.g., respiratory, musculoskeletal) using non-physiologic data outside of the clinical setting, usually in the home.
Eligible Patients	Patients who have: Unmet SDOH need(s) interfering with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.	Patients who have: One or more high-risk condition(s) expected to last at least 3 months, which place(s) the patient at significant risk of hospitalization or nursing home placement, acute exacerbation/decompensation, function decline, or death. May or may not have unmet SDOH needs.	Established patients who have: Acute or chronic condition(s) for which the authorized billing provider determines that RPM services are medically necessary.	Patients with an established treatment plan who have: Acute or chronic respiratory, musculoskeletal, or other condition(s) for which the authorized billing provider determines that RTM services are medically necessary.
Billing Providers	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM) • Clinical Psychologist (CP)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM)	• Physician (MD, DO) • Nurse Practitioner (NP) • Physician Assistant (PA) • Certified Nurse Midwife (CNM) • Clinical Psychologist (CP) • Clinical Social Worker (CSW) • Mental Health Counselor (MHC) • Marriage and Family Therapist (MFT)
Auxiliary Personnel *(Examples)*	Certified or trained: • Community Health Worker • Nurse (nurse care manager, CNS, RN, LPN) • Social Worker	Certified or trained: • Community Health Worker • Nurse (nurse care manager, CNS, RN, LPN) • Social Worker • Peer support specialists *(use CPT code for PIN-PS (peer support), PIN-PS activities are limited to behavioral health conditions, and do not include clinical care coordination)*	• Nurse (nurse care manager, CNS, RN, LPN) • Medical Assistant • Clinical Pharmacist • Community Health Workers	
Service Elements	Billed once per calendar month after at least **60 minutes** of services provided by certified or trained auxiliary personnel, including: • Patient-centered assessment • Coordination with home- and community-based resources • Health education • Developing self-advocacy skills • Health care access and navigation • Patient behavioral change facilitation • Facilitate and provide social and emotional patient support	Billed once per calendar month after at least **60 minutes** of services provided by certified or trained auxiliary personnel, including: • Patient-centered assessment (PIN) or interview (PIN-PS) • Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services. • Health education • Developing self-advocacy skills • Health care access/health system navigation • Facilitating behavioral change as necessary for meeting diagnosis and treatment goals (PIN only) • Facilitating and providing social and emotional support	Billed once per calendar month after at least **16 days of data** have been collected in a 30-day period. • Initial device set-up and patient education on the use of equipment. • Device supply with scheduled recording(s) and transmissions • The collection, analysis, and interpretation of digitally collected physiologic data. • Management of a patient-centered treatment plan. • CPT services 99457 and 99458 require at least one interactive communication with the patient during the calendar month, 20 minutes of authorized billing provider time. *Note: This is a summary of RPM service elements. Each RPM CPT code includes a unique set of service elements to be provided.*	Billed once per calendar month after at least **16 days of data** have been collected in a 30-day period. • Initial device set-up and patient education on the use of equipment. • Device supply with scheduled recording(s) and transmissions • Review and monitoring of data related to signs, symptoms, and functions of respiratory or musculoskeletal system therapeutic response. • Non-physiologic and therapeutic data can be patient self-reported and/or digitally uploaded • Management of a patient-centered treatment plan. • CPT services 98980 and 98981 require at least one interactive communication with the patient during the calendar month, 20 minutes of authorized billing provider time. *Note: This is a summary of RTM service elements. Each RTM CPT code includes a unique set of service elements to be provided.*
Billing Codes & Rates	• G0019: $77.95 • +G0022: $48.52 OR continue billing G0511 until July 1, 2025	• G0023: $77.95 • +G0024: $48.52 • G0140 PIN-PS: $77.95 • +G0146 PIN-PS: $48.52 OR continue billing G0511 until July 1, 2025	• 99453: $19.73 • 99454: $43.02 • 99457: $47.87 • +99458: $38.49 • 99091: $51.57 OR continue billing G0511 until July 1, 2025	• 98975: $19.73 • 98976: $43.02 • 98977: $43.02 • 98980: $50.14 • +98981: $39.14 OR continue billing G0511 until July 1, 2025

Payment rate is based on the 2025 Medicare Physician Fee Schedule (PFS). 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.

Patients pay 20% coinsurance based upon the lesser of the submitted charges or the local payment rate for care management & PPS services. 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 (see Sliding Coinsurance for CMS/Medicare Care Management for more information).

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