Understanding Chronic Care Management

Chronic Care Management (CCM) is all about supporting patients beyond the patient encounter, especially those juggling two or more long-term health conditions that are expected to persist for a year or more, or potentially for the rest of their lives. These individuals often face serious risks, including sudden health flare-ups, loss of independence, or even death. CCM services are designed to help manage a wide range of conditions like Alzheimer's, diabetes, arthritis, and others that require ongoing attention.

Since 2015, Medicare has recognized the value of this kind of care by offering separate reimbursement for CCM under the Physician Fee Schedule. Providers can bill for at least 20 minutes each month of behind-the-scenes care coordination, led by a qualified healthcare professional and carried out by clinical staff, to help keep these patients on track and supported between visits.

Why Is CCM Important?

CCM is important, not only for the benefits it provides to the patient, but also for the practice itself.

Patients benefit from having a dedicated care team and monthly check-ins, comprehensive, person-centered care plans, and support between visits for better adherence. Practices benefit from improved patient care coordination and outcomes, increased patient satisfaction and compliance, and sustainable, billable services.

With two-thirds of Medicare beneficiaries reportedly having two or more chronic conditions, CCM is a vital service for many patients.

Implementation of CCM in Practices

Successful CCM implementation requires coordinated efforts across the care team. A workflow that is easy to achieve is key in the implementation process. This includes the development and maintenance of a comprehensive person-centered care plan to address medical and psychosocial needs, engaging and educating patients and caregivers, coordination with home- and community-based service providers when appropriate, routine medication reconciliation and access after inpatient care transitions, and having a way to provide 24/7 access and enhanced communication methods.

Implementation of CCM in Practices cont.

- Communication Modalities
  - Acceptable methods include telephone, patient portal, secure email, and asynchronous messaging.
  - Document the mode of communication for each encounter.

Eligibility & Billing for CCM

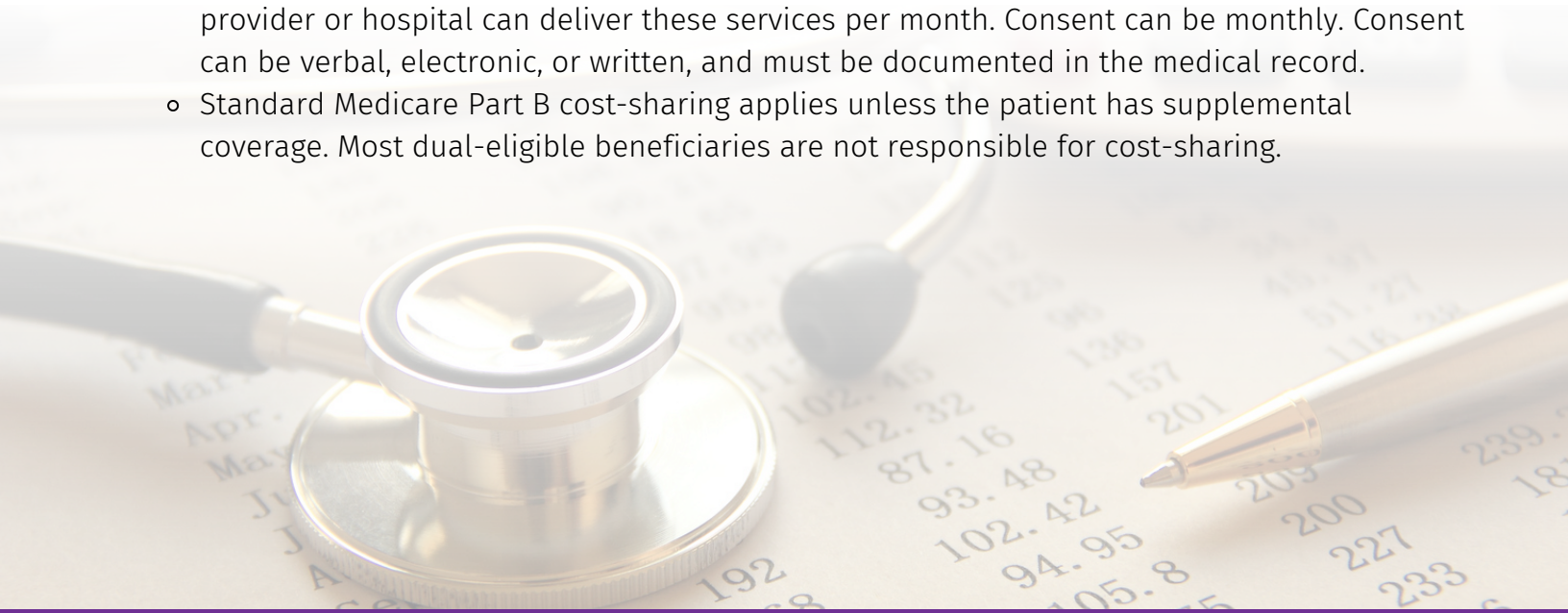
- **Eligible patients:** Medicare fee-for-service and dual eligible beneficiaries with two or more chronic conditions expected to last at least 12 months, placing them at significant risk.

- **Who can bill:** Physicians, certain non-physician practitioners, Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and hospitals (including CAHs). Only one provider or facility can bill for CCM per patient per month.
  - ***Note** – Codes for RHC/FQHC billing may vary.

- **Billable activities:** Non-face-to-face care coordination, sharing health information, managing care transitions, and coordinating with community services.
  - To adhere to compliant documentation standards, it is important to:
    - Record date, time spent, and specific activities each month.
    - Ensure documentation is complete and tied to the care plan.
    - Update care plan regularly and note revisions.
    - Additionally, CCM supports MIPS quality measures and other value-based programs. Be sure to tie CCM documentation to patient outcomes and quality reporting.

Key Requirements for CCM Billing

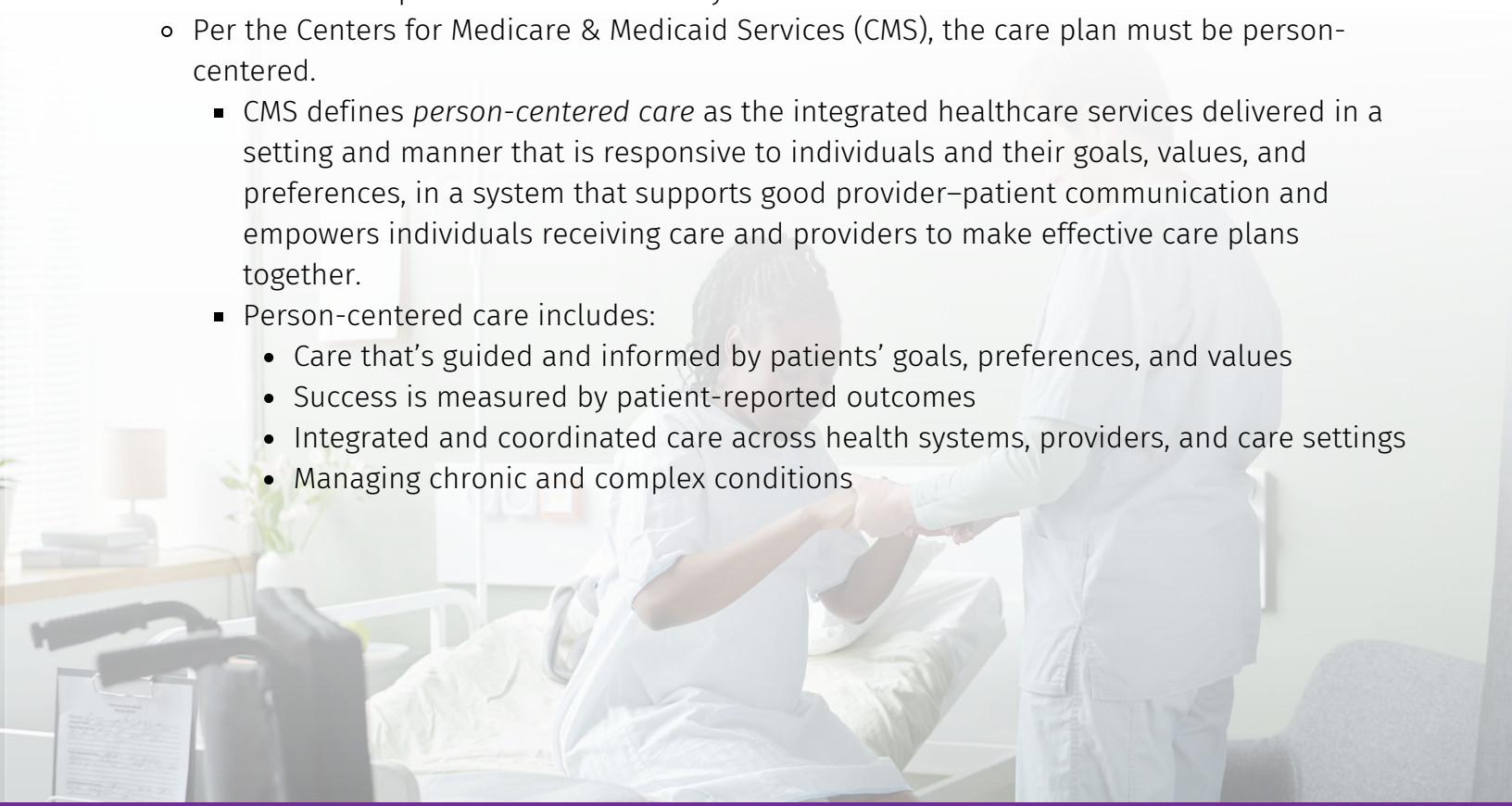
- **Patient Consent** - Obtain and document verbal or written consent, inform about cost sharing, and clarify that only one provider can bill per month, and the patient can disenroll at any time.
  - Patients must provide advance consent to participate in CCM, understanding that only one provider or hospital can deliver these services per month. Consent can be monthly. Consent can be verbal, electronic, or written, and must be documented in the medical record.
  - Standard Medicare Part B cost-sharing applies unless the patient has supplemental coverage. Most dual-eligible beneficiaries are not responsible for cost-sharing.



Key Requirements for CCM Billing cont.

- Initiating Visit
  - Within 12 months prior to the start of CCM services.
    - Annual Wellness, IPPE, or a comprehensive E/M visit.
    - During the initial visit, providers can use code **G0506** if they personally carry out detailed care planning. While not required, this option can be especially helpful for patients with complicated medical needs.

- **Comprehensive Person-Centered Care Plan** - Establish, implement, and share an electronic care plan with the patient and other providers as appropriate.
  - The electronic care plan typically includes:
    - Problem list
    - Expected outcome and prognosis
    - Measurable treatment goals
    - Symptom management
    - Medication management
    - Community/social services ordered (if applicable) and how services will be directed/coordinated
    - Planned interventions and the individual responsible for each intervention.
    - Schedule for reviews/revision of the care plan
  - The patient and/or caregiver should be provided with a copy of the care plan.
  - The care plan should be available and shared within and outside the practice to individuals involved in the patient's care in a timely manner.
  - Per the Centers for Medicare & Medicaid Services (CMS), the care plan must be person-centered.
    - CMS defines *person-centered care* as the integrated healthcare services delivered in a setting and manner that is responsive to individuals and their goals, values, and preferences, in a system that supports good provider–patient communication and empowers individuals receiving care and providers to make effective care plans together.
    - Person-centered care includes:
      - Care that's guided and informed by patients' goals, preferences, and values
      - Success is measured by patient-reported outcomes
      - Integrated and coordinated care across health systems, providers, and care settings
      - Managing chronic and complex conditions



Key Requirements for CCM Billing cont.

- **Continuity & Access** - Assign a care team member for ongoing support and ensure 24/7 access for urgent needs.

- **Certified EHR Use** - Record patient demographics, problems, medications, and allergies using allergies using certified Electronic Health Records.

To report CCM services, you will use the following CPT® codes:

G0506 - Comprehensive assessment of and care planning for patients requiring chronic care management services, when performed (list separately in addition to primary monthly care management service).

99490 - Chronic care management services; first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.

- **+99439** - each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month (List separately in addition to code for primary procedure) (Use 99439 in conjunction with 99490).
  - Supervision rules apply for clinical staff; they must work under general supervision of a physician or qualified healthcare professional.
  - The care team can be made up of clinical staff, which may include RNs, LPNs, MAs, or other staff permitted by state law. It is important to clarify roles to avoid billing errors.

99491 - Chronic care management services; first 30 minutes provided personally by a physician or other qualified healthcare professional, per calendar month.

- **+99437** - each additional 30 minutes by a physician or other qualified healthcare professional, per calendar month (List separately in addition to code for primary procedure) (Use 99437 in conjunction with 99491).

Important note: only one care management service can be billed per patient per month.

- CCM cannot overlap with:
  - Transitional Care Management (TCM)
  - Home healthcare Supervision
  - Hospice Care Supervision

Be mindful of and watch for these common compliance pitfalls:

- Missing or vague care plans.
- Lack of documented patient consent.
- Insufficient time tracking.
- Overlapping services billed in the same month.
- Care plan not shared with patient/caregiver.

CCM

DOCUMENTATION CHECKLIST

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CCM SERVICES

Consent

- ○ Patient must consent to receiving CCM Services (verbal or written (preferred)).
- ○ Documentation of the discussion and the patient's decision to accept/decline CCM services.
- ○ Patient understands the availability of CCM services and is informed that there may be cost-sharing.
- ○ Patient understands how to revoke CCM services.
- ○ Patient understands only one practitioner can furnish & be paid for CCM services during a calendar month.

Documentation

- ○ Documentation of two or more chronic conditions expected to last at least 12 month or until the death of the patient
- ○ Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- ○ Detailed accounting of time furnished (start and stop or total time)
- ○ 24 hour a day 7 day a week patient access for urgent needs
- ○ Enhanced opportunities for patient or caregiver to communicate with practitioner (i.e. Telephone, email, secure messaging, secure internet)
- ○ Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments
- ○ Time reported under or counted towards the reporting of the CCM service is not counted towards any other billed service code

Patient centered electronic care plan based on physical, mental, cognitive, psychosocial, functional and environmental (re) assessment, and inventory of resources that typically includes the following elements:

- ○ Problem list
- ○ Expected outcome and prognosis
- ○ Measurable treatment goals
- ○ Symptom management
- ○ Planned interventions and identification of the individuals responsible for each intervention
- ○ Medication management
- ○ Community/social services ordered (if applicable) and a description of how services of agencies and specialists outside the practice will be directed/coordinated (if applicable)
- ○ Schedule for period review and, when applicable, revision of the care plan
- ○ Provide patient/caregiver a copy of the care plan
- ○ Ensure the electronic care plan is available and shared timely within and outside the practice to individuals involved in the patient's care.

CPT FOR CCM SERVICES

99490 - Chronic care management services; first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month

99439 - each add'l 20 minutes

99491 - Chronic care management services; first 30 minutes provided personally by a physician or QHP per calendar month

99437 - each add'l 30 minutes

Total Duration Care Management Services	Chronic Care Management	Staff Type
Less than 20 minutes	Not reported separately	Clinical Staff
20-39 minutes	99490 X 1	Clinical Staff
40-59 minutes	99490 X 1 and 99349 X 1	Clinical Staff
60 minutes or more	99490 X 1 and 99349 X 2	Clinical Staff
Less than 30 minutes	Not reported separately	Physician/QHP
30-59 minutes	99491 X 1	Physician/QHP
60-89 minutes	99491 X 1 and 99437 X 1	Physician/QHP
90 minutes or more	99491 X 1 and 99437 X 2	Physician/QHP

Sources
Person-centered care. CMS.gov. (n.d.). https://www.cms.gov/priorities/innovation/key-concepts/person-centered-care#:~:text=Person%2Dcentered%20care%20includes:,Managing%20chronic%20and%20complex%20conditions

About LW Consulting, Inc.

For two decades, LWCI has delivered operational and compliance improvements to acute, post-acute, and sub-acute healthcare providers and government entities. This expertise is also applied to compliance actions and legal proceedings, with a specialty in serving as an independent review organization (IRO).

Whether the goal is proactive compliance, improved clinical and financial outcomes, or navigating regulatory changes, LWCI brings deep industry expertise to support strategic decision-making and operational success.

Our experienced team delivers actionable insights that help healthcare organizations, including hospitals, long-term care, physician practices, rehabilitation and senior living providers, government programs, and payers, maintain compliance, enhance performance, and minimize risk.

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