

Patients with multiple chronic conditions can easily get off track in their care. Disruptions in routines, decreased access to care, or delays in medication refills can quickly escalate to acute exacerbations in previously stable conditions. Managing care between office visits helps patients get the care they need in the most appropriate setting. Ambulatory providers and their clinic teams can now receive reimbursement for these care management services. And because CMS recognizes that this care can take time, new codes were added in 2020 to help reflect the value of this work.

Eligibility Requirements

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored each month of service

Performing & Documenting Chronic Care Management (CCM)

- Consent must be obtained and documented before providing services; verbal consent is sufficient to meet the requirements. Consent must include:
 - Notification of cost-sharing obligations
 - Only one practitioner may bill CCM per month
 - Patients may stop services at any time
- New patients, or patients not seen within the past year, must have an initiating visit; initiating visits include
 - Face to face clinic visit
 - Initial Preventive Physical Exam (IPPE)
 - Annual Wellness Visit (AWV)
 - Transitional Care Management
- CCM services can be delivered by the clinical team, under the general supervision of the billing provider.
- CCM requires 20 minutes of care management each month of service
- Comprehensive care management may include systematic needs assessments, planning and provision of preventive services, medication reconciliation and management, oversight of patient self-management, and coordinating care across home, community, and clinical services

99490 - CCM, 20 min/month

G2058 - CCM, extra 20 min/month

99487 - Complex CCM, 60 min/month

99489 - Complex CCM, extra 30 min

99491 - Provider-Only CCM, 30 min/month

G0506 - Chronic Care Management Planning

G0511 - General Care Management in RHC/FQHC

20 minutes of provider or clinical team care management time can include time spent:

- Medication management and monitoring the patient's self-management of medication treatment
- Ensure the patient receives all preventive care services
- Monitor the patient's overall condition including physical health, social determinates of health and mental health
- Provide education
- Answer any questions from the patient or caregiver
- Communicating and organizing with home health agencies, or other community services on behalf of the patient

- An electronic comprehensive care plan is required to be created and shared within and outside of the practice, including a copy shared with the patient/caregiver. Practices may share the care plan electronically including via fax
- Certified EHR Technology, 24/7 “On call” service, a designated care team member who serves as the patient’s main point of contact, home and community care coordination, management of care transitions/referrals, and enhanced communication options.
- Details of these and other requirements can be found in the [CCM MLN](#).

Complex Chronic Care Management

Some patients have significantly more complex needs, requiring moderate to high medical decision making in their care management. When these patients also require 60 minutes or more of care team time per month, Complex CCM (**99487**) will be a better choice for managing between visit care. Complex CCM must meet the same care provision requirements, such as the comprehensive care plan, as CCM in addition to the moderate to high medical decision-making criteria.

When care teams provide more than 60 minutes of Complex CCM, 30 minute add-on blocks of time may be added to the monthly claim using code **99489**. Unlimited add-on blocks of time can be billed each month to reflect the full amount of time the care team spends managing the patient.

Tracking and Documenting Time

The time spent by the clinical team can be combined to reach the 20-minute time threshold for CCM and 60-minute threshold for Complex CCM

- If two members of the care team are providing care management services at the same time, only the time spent by one staff member may be counted towards the cumulative time total
- Creating a centralized method of tracking time from care team contributors is necessary to adequately document time spent and select appropriate time-based codes
- Time cannot be carried over from a previous month
- Total time spent during the month should be documented in the medical record each month

Care management services are often provided over the telephone, but interactions with patients or other members of the care team may also be face-to-face or via other secure methods, such as the patient portal.

Comprehensive Care Plans should include the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions including all preventive care services
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers
- Periodic review

Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Considerations

- **G0511**, general care management services, can be used to bill for multiple care management services, including CCM, Complex CCM, and Behavioral Health Integration (BHI).
- All patient eligibility criteria must be met, and care management time must meet 20-minute minimums.
- **G0511** may be billed alone or on a claim with an RHC/FQHC visit, but only the All-Inclusive Rate (AIR) or Perspective Payment System (PPS) rate will be paid.
- **G0511** may be billed in the same month as Transitional Care Management (TCM) (**99495, 99496**)
- Consent for CCM must be obtained under direct supervision, however, **during the PHE**, consent may be obtained by auxiliary personnel under general supervision.

Billing Tips

- CCM may *not* be billed in the same month as
 - **G0181** - Home Health Supervision
 - **G0182** - Hospice Care Supervision
 - **90951-90970** - End Stage Renal Disease (ESRD) Services
- Transitional Care Management (TCM) and CCM may be billed by the same practitioner in the same calendar month
- **99490** - CCM, 20 minutes, can be billed once per month; **G2058** - 20 minute add-on time for CCM can be billed up to twice per month.
- **99487** - Complex CCM, 60 minutes, can be billed once per month; **99489** - 30 minute add-on time for Complex CCM can be billed an unlimited number of times per month, but only in months when 99487 is billed
- **99491** - Provider-Only CCM, 30 minutes, does not have any add-on time codes available. This service requires the provider to spend 30 minutes or more providing care management services
- **G0511** - General Care Management in RHC/FQHC does not have additional add-on time codes available
- **G0506** - Chronic Care Management Planning may be billed once, at the initiation of CCM or Complex CCM, when extensive assessment and care planning (outside of that in the initiating visit) is personally performed by the billing practitioner
- During the National Public Health Emergency, providers **may waive cost sharing** for this service

Medicare does not have specific documentation requirements for CCM, but best practice is to document the following each month:

- Date of services
- Total time spent providing care management
- Name of care team member(s) providing services
- Type of services provided during the calendar month
- Billing provider oversight

Suggested Citation:

Showalter, G. (2020, April 20). Chronic Care Management: Between Visit Care. Loengard, A., Findley, J. (Eds.). <https://caravanhealth.com/>
