

# Chronic Care Management (CCM) Services FAQs

## Q. What is the difference between chronic care management (99490) and complex chronic care management services (99487, 99489)?

A. Complex chronic care management services include the same criteria as the chronic care management service, plus an additional requirement of the establishment or substantial revision of a comprehensive care plan, medical decision-making of moderate to high complexity, and at least 60 minutes of clinical staff time...

## Q. Can all physicians, including specialists, bill CCM services, or are they just for primary care physicians?

A. Yes. Any physician who meets the reporting requirements is able to bill for CCM. Physicians treating patients with at least two or more chronic conditions could be eligible to bill the codes. Only one physician per month may report these services.

## Q. Are there only certain diagnoses for which the CCM code can be reported?

A. There is not a defined list of diagnosis codes that meet the requirements of. What is required is that the chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline and that management requires a care plan. The AAN recognizes patients with two or more of the following conditions may be appropriate for the use of chronic care management services\*:

- Neurocognitive disorders including Alzheimer's disease, Dementia, and Parkinson's disease
- Stroke with late effects that place the patient at risk for falls, fractures, and aspiration pneumonia
- Poorly controlled diabetes mellitus

## Q. Can Advance Practice Providers (APPs) bill for CCM services?

A. APPs with a unique Tax ID can separately report the services, as can APPS in states that allow incident to billing. APP time under the general supervision of a physician can be counted towards the total time used to report a CCM code.

## Q. Does a neurologist have to be managing all of the chronic conditions of the patient in order to utilize the CCM code? Or is it sufficient if the neurologist manages one condition along with the subsequent conditions that impact the management of the neurologic condition?

A. The neurologist has to manage all of the patient's chronic conditions to report CCM. Of note, only one physician is allowed to bill and be paid for the service during any one calendar month.

1. The term "physician" throughout refers to a physician or other qualified health care professional.

\* Please note that this is not an all-inclusive list.

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**Q. Can an E/M visit be billed at the same time as the CCM code?**

A. Yes. But any clinical staff time on a day when the physician reports an E/M service may not be counted toward the care management service code. E/M services may be reported separately by the same physician during the same calendar month.

**Q. Will the patient be required to provide a copay when the CCM service is reported?**

A. Yes. The patient indicate to the physician that he/she wants chronic care management services. It is the responsibility of the health care provider to notify the patient of the co-insurance and document patient consent in the medical record.

**Q. Can CCM services be reported if the patient/caregiver has not given consent?**

A. No. One of the requirements for billing CCM services is "knowledge and recognition by the patient that the physician will perform care management services on the patient's behalf." In the event of an audit, documentation of patient consent in the patient record is crucial.

**Q. Is a new consent form required for each calendar month the service is provided? Or is it preferred the potential length of care be established with the care plan?**

A. Absent Medicare guidance, we believe a reasonable assumption is that the consent would apply for the period of time established for the care plan. We hope to obtain further guidance from CMS as to whether once annually is reasonable or request CMS define in future guidance a time period that would be sufficient and reduce the administrative burden.

**Q. Must all of the required elements be met in order to report CCM services?**

A. Yes. All of the required elements as listed in the CPT book must be met in order to report the service.

**Q. Can CCM services be reported if the total time spent on care management for a patient is less than 20 minutes in a calendar month?**

A. No. One requirement of CPT code 99490 is at least 20 minutes of clinical staff time directed by a physician or physician time, if the physician performs the clinical staff function. This language deviates from previous CPT standards around time-based coding, which allows a service to be reported once the mid-point is reached.

**Q. Can care management time within the emergency department (ED) be reported using the CCM code?**

A. Yes. Time within the ED is reportable using 99490, but time while the patient is inpatient or admitted as observation is not.

**Q. Can CCM services be reported by more than one physician within a calendar month?**

A. No. Only one physician can report CCM services for a patient in a calendar month.

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**Q. If more than 20 minutes are spent on care management services within a given calendar month, can multiple units of 99490 be reported?**

- A. No. One unit of the CCM code should be reported per calendar month, however it is important to document the time spent on care management services in the medical record in its entirety.

**Q. What date of service should be used when reporting CCM services?**

- A. Medicare has not yet specified the date of service to bill as they did with the Transitional Care Management services. In general, when the code elements are met the provider should choose that date as the date of service. We would not see any reason to hold the claim unless CMS or third party payers provide further guidance. Consecutive month billing need not use dates 30 more days apart, but the months must be different.

**Q. Can other care management services be reported in addition to the CCM?**

- A. No. Additional care management services may not be reported separately during the month for which chronic care management services are reported. This includes care plan oversight services, prolonged services without patient contact, anticoagulant management, medical team conferences, education and training, telephone services, online medical evaluation, preparation of special reports, analysis of data, transitional care management services, and medication therapy management services. These services may have higher payments than CCM in some cases (e.g. care plan oversight), so it is useful to be aware of this when deciding what services to report.

**Q. Can CCM services be provided for patients in the hospital in-patient setting?**

- A. No. The introductory language in the 2018 CPT book states, "Care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient residing at home or in a domiciliary, rest home, or assisted living facility."

**Q. For the purposes of a potential future audit, how should the required 20 minutes or more of clinical staff time be documented?**

- A. At this time, specific requirements have not been established however it is in the healthcare professional's best interest to document the clock start and stop time of each of the services.

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