

CHRONIC CARE MANAGEMENT

1. Information here pertains to Medicare only. Medicaid and private payer guidelines and codes may vary.
2. Beneficiaries who have Medicare Advantage Plans are entitled to the same preventive service. For maximum coverage, however, MAPs may require member beneficiaries to obtain the preventive services from providers enrolled in the MAP network. If the service is obtained from an out-of-network provider, the member beneficiary may have a higher copayment.

Content	Comprehensive Care Plan, 24/7 Access to Provider, Ongoing Care Management and Coordination. For more info see Chronic Care Management Services Fact Sheet, May 2015.
ICD-10 Codes	Any appropriate billable code.
HCPCS/CPT Codes	99490 (non-face-to-face care coordination services furnished to Medicare beneficiaries with multiple chronic conditions), 20 min, electronic and/or phone (not fax).
Eligible Providers	Physicians, Certified Nurse Midwives, CNS, NP, and PA <i>whose patients consent</i> to CCM. Clinical staff can furnish "incident to" under 24/7 general supervision. Staff can be RPh, CNS, NP, PA, RN, LPN, LCSW, RD, CMA, MA. Staff can be external. Billing stays under provider on record.
Acceptable Locations	Outpatient, Home, Domiciliary, Rest Home, or Assisted Living not already receiving Medicare funds.
Who is Covered	Medicare Part A or B recipients with 2 or more <i>significant</i> * chronic conditions on which provider/staff spends at least 20 minutes of non-face-to-face time managing, coordinating care or care transition.
Frequency	Billed up to once a month per patient, by one PCP or specialist physician, not both. Date on claim can be the date 20 min reached or the last day of that month.
Restrictions or Exceptions	Care plan already in EHR. CCM initiated by physician or beneficiary and written agreement formed between them before CCM counts toward billing. To end the CCM services, the beneficiary's signature on a CCM termination form is required. For sample forms, see pages 7-9 in American College of Physicians' Toolkit below. For more info see References and Resources below. Payable in RHCs & FQHCs if patient not already captured in RHC AIR or FQHC PPS.
Beneficiary Pays	Part B deductible, 20% copay, and monthly cost-sharing applies. Provider must explain cost during agreement process.

REFERENCE:

*Chronic Care Management Services, (Fact Sheet) Medicare Learning Network ICN 909188, May 2015, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

Frequently Asked Questions about Billing Medicare for Chronic Care Management Services

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/Payment-Chronic-Care-Management-Services-FAQs.pdf>

RESOURCES:

American Academy of Family Physicians, *Chronic Care Management in the Real World*, Oct 2015, accessed Nov 11, 2015 at <http://www.aafp.org/fpm/2015/0900/p35.html> (includes tools to use in Related Resources at bottom)

American College of Physicians, *Chronic Care Management Tool Kit*, 2015 accessed Nov 11, 2015 at https://www.acponline.org/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf

Chronic Care Management Services for Rural Health Clinics and Federally Qualified Health Centers, MLN Matters MM9234, Released Nov 18, 2015, Effective 1-1-16, Implementation 1-4-2016

