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# Frequently Asked Questions about Physician Billing for Chronic Care Management Services

This document answers frequently asked questions about billing chronic care management (CCM) services to the Physician Fee Schedule (PFS) under CPT codes 99487, 99489 and 99490.

**1. The CCM codes describe time spent per calendar month by “clinical staff.” Who qualifies as “clinical staff”? If the billing physician (or other billing practitioner) furnishes services directly, does their time count towards the clinical staff time required to bill CCM?**

Practitioners should consult the CPT definition of the term “clinical staff.” In addition, time spent by clinical staff may only be counted if Medicare’s “incident to” rules are met such as supervision, applicable State law, licensure and scope of practice. Of course, other staff may help facilitate CCM services, but only time spent by clinical staff can be counted. If the billing practitioner provides the clinical staff services themselves, the time of the billing practitioner may be counted as clinical staff time.

**2. Do the times listed for the work of the billing practitioner mean that the billing practitioner must spend that amount of time each month, in addition to the clinical staff time in the code descriptors, in order to bill CCM?**

No, these times should be considered like the typical times for evaluation & management (E/M) office visits. They are assumed times, established through physician survey by the American Medical Association when the codes were created and valued, for how much time the billing practitioner spends himself or herself each month, but are not exact times. The billing practitioner’s time could be spent in activities such as directing clinical staff; personally performing clinical staff activities; or in the case of complex CCM, performing moderate to high complexity medical decision making.

**3. Can CCM services be subcontracted out to a case management company? What if the clinical staff employed by the case management company are located outside of the United States?**

Complex CCM (CPT 99487, 99489) includes moderate to high complexity medical decision-making by the billing practitioner during the service period, an activity that cannot be subcontracted to any other individual. Similarly, regular (“non-complex”) CCM (CPT 99490) assumes 15 minutes of work by the billing practitioner. All CCM service codes are valued to include ongoing oversight, management, collaboration and reassessment by the billing practitioner consistent with the included service elements. This work cannot be delegated or subcontracted to any other individual.

A billing practitioner may arrange to have other aspects of the CCM service provided by clinical staff external to the practice (for example, in a case management company) if all of the “incident to” and other rules for billing CCM to the PFS are met and there is clinical integration among the care team members. If there is little oversight by the billing practitioner or a lack of clinical integration between a third party providing CCM and the billing practitioner, we do not believe CCM could actually be furnished and therefore the practitioner should not bill for CCM. Because there is a regulatory prohibition against payment for non-emergency Medicare services furnished outside of the

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United States (42 CFR 411.9), CCM services cannot be billed if they are provided to patients or by individuals located outside of the United States.

**4. Does the billing practice have to furnish every scope of service element in a given service period, even those that may not apply to an individual patient?**

It is our expectation that all of the scope of service elements will be routinely provided in a given service period, unless a particular service is not medically indicated or necessary (for example, the beneficiary has no hospital admissions that month, so there is no management of a transition after hospital discharge). In order to bill for complex CCM (CPT 99487 or 99489), the comprehensive care plan must be established or substantially revised, and the billing practitioner must personally perform moderate to high complexity medical decision-making during the service period, as the CPT code descriptors include these services.

**5. What date of service should be used on the physician claim and when should the claim be submitted?**

The CCM service period is one calendar month. For non-complex CCM (CPT 99490), CMS expects the billing practitioner to continue furnishing services during a given month as medically necessary after the minimum clinical staff time threshold to bill is met (see #4 above). Practitioners may report CPT 99490 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month.

For complex CCM (CPT 99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

**6. What place of service (POS) should be reported on the physician claim?**

CCM is priced in both facility and non-facility settings. The billing practitioner should report the POS for the location where he or she would ordinarily provide face-to-face care to the beneficiary. Our goal is to pay under the PFS for CCM furnished to beneficiaries in any care setting, but to pay an accurate rate that reflects the resource costs of the practitioner him or herself. We welcome information from stakeholders regarding how often they furnish CCM to beneficiaries who reside or remain in facility settings during part or all of the service period, what kind of facilities, and how often the resources and staff of the billing practitioner are used rather than facility resources and staff in the provision of CCM. We recognize that there could be many different arrangements based on the location(s) of the beneficiary during the month and individual practice patterns.

**7. Can I bill for CCM services furnished to beneficiaries in skilled nursing facilities, nursing facilities, assisted living or other facility settings?**

Yes. CCM is priced in both facility and non-facility settings. The POS on the claim should be the location where the billing practitioner would ordinarily provide face-to-face care to the beneficiary, see #6 above.

**8. Is a new patient consent form required each calendar month or annually?**

No, as provided in the CY 2014 PFS final rule (78 FR 74424), a new consent is only required if the patient changes billing practitioners, in which case a new consent must be obtained and documented by the new billing practitioner prior to furnishing the service.

**9. Is Medicare now paying separately under the PFS for remote patient monitoring services described by CPT code 99091 or similar CPT codes?**

CPT 99091 continues to be bundled with other services for payment under the PFS. As per CPT guidance, CPT codes 99090, 99091 and other codes cannot be billed during the same service period as CPT 99490. However as discussed in the CY 2015 PFS final rule (79 FR 67727), analysis of patient-generated health data and other activities described by CPT 99091 or similar codes may be within the scope of CCM services, in which case these activities would count towards the minimum minutes of qualifying care per month that are required to bill CCM services. But in order to bill CCM services, such activity cannot be the only work that is done—all other requirements for billing CCM must be met in order to bill the appropriate code, and time counted towards billing CCM services cannot also be counted towards billing other codes.

**10. If a practitioner arranges to furnish CCM services to his/her patients “incident to” using a case management entity outside the billing practice, does the billing practitioner need to ever see the patient face-to-face?**

Yes, for new patients or patients not seen within a year prior to the commencement of CCM services, CCM must be initiated by the billing practitioner during a “comprehensive” E/M visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the CCM service and can be separately billed to the PFS, but is required for the specified patients before CCM services can be provided directly or under other arrangements. The billing practitioner must discuss CCM with the patient at this visit. While informed patient consent does not have to be obtained during this visit, it is an opportunity to obtain the required consent. The face-to-face visit included in transitional care management (TCM) services (CPT 99495 and 99496) qualifies as a “comprehensive” visit for CCM initiation. Levels 2 through 5 E/M visits (CPT 99212 through 99215) also qualify; CMS is not requiring the practice to initiate CCM during a level 4 or 5 E/M visit. However CPT codes that do not involve a face-to-face visit by the billing practitioner or are not separately payable by Medicare (such as CPT 99211, anticoagulant management, online services, telephone and other E/M services) do not meet the requirement for the visit that must occur before CCM services are furnished. If the practitioner furnishes a “comprehensive” E/M, AWV, or IPPE and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.

**11. Do face-to-face activities count as billable time?**

CCM includes, in large part, activities that are not typically or ordinarily furnished face-to-face with the beneficiary and others, such as telephone communication, review of medical records and test results, and coordination and exchange of health information with other practitioners and providers. Prior to separate payment for CCM, these activities were primarily included in the payment for face-to-face visits (though they usually occurred before or after), and we tend to refer to them as “non-face-to-face” activities because generally, they are such. If these activities are occasionally provided face-to-face for convenience or other reasons, the time may be counted towards a CCM service code(s). CCM also includes activities such as patient education or motivational counseling,

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that are frequently provided to patients either in person or non-face-to-face (such as by phone). If the practitioner believes a given beneficiary would benefit or engage more in person, or for similar reasons recommends a given beneficiary receive certain CCM services in person, they may still count the activity as billable time. In all cases, the time and effort cannot count towards any other code if it is counted towards CCM.

**12. Medicare and CPT allow billing of E/M visits during the same service period as CCM. If an E/M visit or other E/M service is furnished the same day as CCM services, how do I allocate the total time between CCM and the other E/M code(s)?**

CCM services are E/M services. Time or effort that is spent providing services within the scope of the CCM service, on the same day as an E/M visit or other E/M service that Medicare and CPT allow to be reported during the CCM service period, can be counted towards CCM codes, as long as it is not counted towards other reported E/M code(s). We note that time and effort cannot be counted twice, whether face-to-face or non-face-to-face, and Medicare and CPT provisions specify certain codes that can never be billed during the CCM service period (see below).

**13. Medicare and CPT specify that CCM and TCM cannot be billed during the same month. Does this mean that if the 30-day TCM service period ends during a given calendar month and a qualifying amount of time is spent furnishing CCM services on the remaining days of that calendar month, CCM service codes cannot be billed that month to the PFS?**

The CCM service code(s) could be billed to the PFS during the same calendar month as TCM, if the TCM service period ends before the end of a given calendar month and a qualifying amount of time is spent furnishing CCM services subsequently during that month. (Also for complex CCM, there must be moderate or high complexity medical decision-making by the billing practitioner during the remainder of the month).

**14. Are there any other services that cannot be billed under the PFS during the same calendar month as CCM?**

Yes, Medicare does not allow the CCM service codes to be billed during the same service period as home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182) or certain ESRD services (CPT 90951-90970) because the comprehensive care management included in CCM could significantly overlap with these services. Complex and non-complex CCM cannot be billed for a given beneficiary the same service period (the practitioner would bill one or the other, depending what services were furnished). Also see CPT coding guidance for a list of additional codes that cannot be billed during the same month as the CCM service codes. There may be additional restrictions on billing for practitioners participating in a CMS model or demonstration program; if you participate in one of these separate initiatives, please consult the CMS staff responsible for these initiatives with any questions on potentially duplicative billing.

**15. Can I bill for CCM if the beneficiary dies during the service period?**

The CCM service code(s) can be billed if the beneficiary dies during the service period, as long as the required service time for the code(s) was met that calendar month and all other billing requirements are met.

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**16. Will practitioners be able to use an acceptably certified electronic health record (EHR) technology for which certification expires mid-year in order to bill for CCM? For example, can they use technology certified to the 2011 Edition to fulfill the scope of services required to bill CCM in 2015 once this technology no longer bears a “2011 Edition certified” mark?**

Yes. Under the CCM scope of services, practitioners must record certain patient health information in a structured format, using technology certified to the Edition(s) of certification criteria that is acceptable for the EHR Incentive Programs as of December 31st of the year preceding each CCM payment year. In certain years, this may mean that practitioners can fulfill the scope of services requirement using multiple Editions of certification criteria. For instance, for payment in 2015, practitioners may use technology certified to either the 2011 or 2014 Edition of certification criteria to meet the EHR scope of service requirements, as both Editions could be used to meet the requirements of the EHR Incentive Programs as of December 31, 2014. This remains true for a given PFS payment year even after ONC-Authorized Certification Bodies (ONC-ACBs) have removed the certifications issued to technology certified to a given acceptable edition (e.g., the 2011 Edition for CCM payment in 2015) as a result of the relevant criteria being removed from the Code of Federal Regulations. Thus, practitioners using an acceptable EHR technology that loses its certification mid-year may still use that technology to fulfill the certified EHR criteria for billing CCM during the applicable payment year.

**17. Does the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10) affect the billing rules for CCM services?**

No, Section 103 of the MACRA codifies payment broadly for chronic care management services under the PFS, authorizing PFS payment after January 1, 2015, for CCM services furnished by physicians and the non-physician practitioners that Medicare generally recognizes to furnish and bill for E/M services (physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives). It does not impact the current billing and payment rules for CCM. It provides that provision of an AWW or IPPE in advance shall not be a condition of payment for CCM services, which is consistent with our current policy. It also provides that payment shall not be duplicative of other Medicare payments, consistent with the rules we have implemented to date regarding duplicative payment for CCM.

**18. If a beneficiary declines to receive CCM services or does not provide consent, or if other conditions of payment for CCM are not met, can the practitioner bill the beneficiary?**

No, the beneficiary must provide the required consent and all other Medicare conditions of payment must be met in order to bill Medicare or the beneficiary for CCM. If the beneficiary does not provide consent or if other conditions for payment are not met, the practitioner cannot bill Medicare or the beneficiary for CCM. Medicare would consider any CCM services furnished to the beneficiary as included in payment for the face-to-face visit(s) furnished to the beneficiary. As we noted in the CY 2014 PFS final rule with comment period (78 FR 74414-74415), payment for non-face-to-face care management services was previously bundled into payment for face-to-face visits, and we did not revalue these visits under the PFS to account for separate payment of CCM services. We also note that CCM would be considered a reasonable and necessary covered Medicare service, so it would not be appropriate to issue the beneficiary an Advance Beneficiary Notice of Noncoverage (ABN).

**19. If I provided more than 20 minutes of CCM services, can I bill more than one unit or more than one line item of CPT 99490 in the service period to account for this time?**

CPT code 99490 (non-complex CCM) describes a minimum number of minutes of service (there is no maximum). Therefore, the practitioner may only bill one unit and one line item of CPT 99490 per calendar month. Also only one practitioner can bill CCM per service period, and must report either complex or non-complex CCM (not both). Practitioners should report complex CCM (under CPT 99487, 99489) if the higher service times for complex CCM are met, the problems addressed by the billing practitioner during the month require moderate to high complexity medical decision-making, and the comprehensive care plan is established or substantially revised.

**20. Will Medigap cover the beneficiary cost sharing for CCM?**

Yes. If services are covered under Medicare Part B, Medigap insurers do not have authority to deny the coinsurance, copayments or other benefits that are payable on behalf of the beneficiary under the provisions of the Medigap insurance contract. Private insurers providing standardized Medigap plans agree to accept a notice of Medicare payment as a claim for the payment of benefits under the Medigap plan, unless the Medigap policy itself has a deductible that has not yet been met (e.g., high deductible Plan F).

**21. Will Medicaid cover the beneficiary cost sharing for CCM for dually eligible beneficiaries?**

The Centers for Medicare & Medicaid Services (CMS) wishes to ensure that Medicare-Medicaid dually eligible beneficiaries have access to CCM services. The majority of dually eligible beneficiaries (approximately 64%, or 7 of the 11.4 million dually eligible beneficiaries) are Qualified Medicare Beneficiaries who will not be responsible for CCM cost sharing. For Qualified Medicare Beneficiaries, Medicaid is responsible for deductibles/coinsurance for Medicare services, including CCM, even if the services are not covered in the State Plan. However, as permitted by federal statute, most states limit payment of Medicare cost sharing to the “lesser-of” Medicaid or Medicare rates. If the service is not covered in the State plan, states can set other reasonable payment limits, approved by CMS, for the service. The net effect of these policies is that many states pay little to none of the Medicare deductible/coinsurance, leaving practitioners to absorb the costs for Qualified Medicare Beneficiaries. In states where there would be coverage of some or all of the beneficiary cost sharing, practitioners need to be enrolled as Medicaid providers to be paid for the Medicare cost sharing; however, Medicare automatically “crosses over” claims to states for dual eligible beneficiaries, so practitioners need not submit their own bill.

**22. Where can I find more guidance on CCM billing requirements?**

Fact Sheets and other materials on CCM are available on the CMS website on the Physician Fee Schedule (PFS) page under the “Care Management” hyperlink at (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/>). CCM materials are also available on the Office of Minority Health web page (<http://go.cms.gov/omh>). Materials for CCM in federally qualified health centers (FQHCs) and rural health centers (RHCs) are available on the FQHC web page (<https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>). The governing regulations for CCM are the CY 2014, CY 2015 and CY 2017 PFS final rules, which are also available on the CMS Physician Fee Schedule web

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page. CCM payment rules were initially finalized in the CY 2014 and CY 2015 PFS final rules, and were significantly revised to reduce administrative burden and improve payment accuracy in the CY 2017 PFS final rule. Regarding intersection with CMS' care coordination models and demonstrations, please consult the CMS staff responsible for those projects. You may also direct questions to your Medicare Administrative Contractor.