# CHRONIC CARE MANAGEMENT TIP SHEET

*Information here pertains to Medicare only. Medicaid and private payer guidelines and codes may vary. 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.*

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| **Content** | Comprehensive care plan, 24/7 access to provider, ongoing care management and coordination. For more information, see the Chronic Care Management Services Fact Sheet. |
| **ICD-10 Codes** | Any appropriate billable code. |
| **HCPCS/CPT Codes** | For electronic and/or phone care coordination services furnished to Medicare beneficiaries with two or more chronic conditions. Now there are three codes and payment goes up with increased complexity. 99490 = 20 min, 99487=60 minutes, CCM Add-on 99489 $47 ea additional 30 minutes (add on to 99487). |
| **Eligible Providers** | Physicians, Certified Nurse Midwives, CNSs, NPs, and PAs *whose patients consent* 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, or 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 two or more *significant** 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 minutes is 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 the American College of Physicians' Toolkit below. Payable in RHCs and FQHCs if patient is 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. |

**REFERENCES**:


*Chronic Care Management Changes for 2017*, Medicare Learning Network ICN 909433, December 2016, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.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

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


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