Billing for Chronic Care Management

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Chronic Care Management (CCM) Services offer an opportunity to be paid for services you perform outside of the face-to-face patient encounter. Billing for CCM services may seem daunting, but the Centers for Medicare & Medicaid Services (CMS) offers extensive guidance about reimbursement protocols for Medicare.

Before we dig into the details, CCM is defined as: “the care coordination that is outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline.” CCM requires a minimum of 20 minutes during a calendar month; services include non-face-to-face clinical staff time, directed by the billing provider. Only one provider may bill for CCM for a patient during a calendar month.

The FAQs presented herein are extracted from CMS guidance about CCM. However, other payers may have different guidelines, so it’s always wise to review the CPT® code descriptions, as well as the provider manual and/or any documentation from the payer.

If you perform them, you deserve to be paid for these services. Start by reviewing these responses to common queries – and then set up a time to discuss this opportunity internally with your team.

Q. When should a chronic care management claim be submitted?

A. The given service period comprises one calendar month. The claim can be held until the end of the month, but that is not necessary. The service can be billed “…after completion of the minimum required service time.” The date of service is the day on which the minimum requirement (i.e., 20 minutes) is met – or any day thereafter during that calendar month.

Q. Who qualifies as “clinical staff” when it comes to time spent during a calendar month?

A. CMS defers to the American Medical Association’s definition of clinical staff, which is "persons who work under the supervision of a physician or other qualified health care professions and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service." While other staff can support chronic care management services, only the time dedicated by clinical staff can be counted towards CCM billing. Any

and all time spent by the billing provider – which includes physicians, as well as physician assistants, clinical nurse specialists, nurse practitioners, and certified nurse midwives - counts as well.

Q. A vendor has approached our practice about providing CCM services. Our practice would pay the vendor, and we would bill for the CCM codes. Is this possible?

Contracting is possible, but caution is warranted. CMS reveals: “A billing practitioner may arrange for clinical staff activities to be provided by an individual(s) external to the practice…if all of the applicable “incident to” and other rules for the [Medicare] Physician Fee Schedule are met and there is clinical integration among the care team members.” In other guidance, CMS reveals that “general supervision” is adequate. CMS espouses that the medical decision-making components, or the “ongoing oversight, management, collaboration and reassessment by the billing practitioner… cannot be delegated or subcontracted to any other individual.” Finally, CCM must be initiated by the billing provider during a face-to-face visit “…before CCM services can be provided directly or under other arrangements.”

Q. Can CPT codes 99487, 99489, 99490 and 99491 be billed together for the same patient?

A. No, even if it is just one patient in a given service period. Only one type of chronic care management can be billed at a time. In addition, complex CCM – codes 99487 and 99489 – cannot be reported during the same month as any other chronic care management code.

Q. What place of service (POS) should be reported on the claim?

A. The billing practitioner should report the POS for the location the billing practitioner would ordinarily provide face-to-face care to the patient. CCM can be billed for services provided in nursing and skilled nursing facilities as well as assisted living and other similar settings.

Q. Are we required to update the consent each month?

A. There is no need, according to CMS, to update the consent each month or even annually. The consent can be utilized in perpetuity, although it is important to note that it is required to be in place prior to rendering the service. Consent may be obtained verbally, but it must be documented in the patient’s record.

Q. Can face-to-face services count as billing time in terms of CCM?

A. Many CCM services are not typically face-to-face services – for example, communicating via phone, coordinating health information with other provides, providing referrals, coordinating with home-based services, patient education, reviewing test results and medical records, and so on. However, if there is an occasional face-to-face component, then the time associated with these services can be counted towards CCM if it

is not an element of another service.

Q. Can our practice bill for CCM services if the patient dies during the given service period?

A. Yes, the CCM service can be billed if the required service time is met for that calendar month (as well as any other billing requirements for that time period). The date of service must precede the date of death.

Q. Can specialists also bill CCM?

A. While CCM codes were created for primary care practitioners, any specialist who meets the requirements can bill CCM. For example, cardiologists, rheumatologists, and nephrologists may manage the overall care for a patient and therefore qualify due to their comprehensive patient management and services.

Visit the CMS website for more information about billing CCM services for Medicare

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