

How to Bill Chronic Care Management



Chronic Care Management CPT 99490

As of January 1, 2015, Medicare began reimbursing for Chronic Care Management (CCM) services using CPT Code 99490. This service is for Medicare patients with multiple chronic conditions and is non-face-to-face.

The new reimbursements are in line with CMS' move to focus on higher quality primary care in an effort to reduce spending and improve outcomes.

And while more money for physicians is definitely a plus, there are a lot of ins and outs to actually getting paid for this service. Below, I'll cover the basics.

Who is Eligible?

Not all patients qualify for CCM services. Those who do must meet the following three criteria:

1. Patient must have two or more chronic conditions.
2. Conditions are expected to last at least 12 months or until death of the patient.
3. Conditions place the patient at significant risk of death, acute exacerbation (i.e. worsening of condition), decompensation (i.e. organ failure), or functional decline.

While CMS does not have a set list of chronic conditions, they do provide a brief summary of conditions that may apply (see below). They also have a [databank of chronic conditions](#) that may be a helpful resource for physicians, although this is not an all-inclusive list by any means. Otherwise, the decision of what classifies as chronic is left up to the treating physician, along with the responsibility of providing detailed supporting chart documentation and an appropriate care plan.

Which Healthcare Practitioners are Eligible?

Physicians as well as non-physicians may bill for CCM services:

1. Physician Assistants
2. Nurse Practitioners
3. Certified Nurse Midwives
4. Clinical Nurse Specialists

Clinical staff, working under the general supervision of an eligible practitioner, may also provide the CCM service.

It's important to note that if two practitioners within a practice – say a physician assistant and a nurse practitioner – both provide CCM for the same patient, only one may bill for the code in any given month.

Patient Agreement and Consent

Medicare wants to make sure patients understand prospective medical services as well as the financial implications, prior to receiving treatment. With CCM, this is no different, and is carried out via specific patient agreement requirements.

The patient agreement is similar to an advanced beneficiary notice, or ABN, and must be completed prior to the start of services.

CMS does not provide a standard form for this. Instead, each physician creates their own agreement, but at a minimum, it should:

- 1. Inform the patient of CCM availability, and obtain written authorization for services.** Authorization for the electronic communication of medical information should also be obtained.
- 2. Explain the services as well as possible cost-sharing expenses.** This discussion should be documented in the patient's medical record, along with their decision to accept or decline the service.
- 3. Explain how to revoke services.** Generally, patients have the right to discontinue CCM services at any time by revoking the agreement, effective at the end of the current calendar month.
- 4. Inform the patient of CCM billing limitations.** The patient should understand that only one practitioner per calendar month may be reimbursed for the service.

The key here is to have everything clearly documented in the patient's medical record, and ideally, within the patient agreement. Consents, revocations, and any changes in CCM services must be documented.

Download our sample agreement below:



Scope of Services

The scope of services for CCM is quite detailed, but in general, there are eight elements that must be satisfied:

1. Access to care management services 24/7.
2. Continuity of care.
3. Care management for chronic conditions, including medication management and assessment of the patient's medical, functional, and psychosocial needs.
4. Creation of a patient-centered care plan, with a written or electronic copy provided to patient.
5. Management of care transitions, such as referrals or follow-up care after hospital or SNF discharge. This includes the transitional care management code. Clinical summaries must be transmitted electronically, not faxed, to other providers. A PDF via secured email should be sufficient.
6. Coordination with home- and community-based clinical service providers, such as hospice.
7. Multiple ways for patient and/or caregivers to contact providers, including via phone, the patient portal, or by email.
8. Electronic capture and sharing of care plan information. Providers must use a certified EHR, and the patient's records are to be available 24/7 to all providers within the practice who may provide CCM services. Providers outside the practice should be sent pertinent medical information electronically as well.

How do I get paid? What is the coding & billing process?

Detailed documentation has always been important for coding and billing, but it's critical if you want to obtain CCM reimbursement.

You must:

1. Document that clinical staff spent 20 minutes of non-face-to-face time in a given month.
2. Record the date, time spent, name of provider, and the services provided.
3. Bill Medicare using CPT code 99490. This should be billed only once per month per participating patient.
4. In addition to billing 99490, the CPT codes for the chronic conditions should also be included.

The non-face-to-face time should never be rounded up. Documentation should note the time spent in total minutes. For example, clinical staff would document four minutes and not 10:04 to 10:08.

Also be mindful of not falling into recording the same number of minutes every time. While it may be easier to document in 5-minute intervals, precision and accuracy is crucial. Every service recorded as 5 minutes is not realistic. In the event of an audit, this type of documentation would not be favorable. Record the actual time spent.

CPT Code 99490 is subject to cost-sharing, including the patient's deductible, co-pay, and co-insurance. That should be clearly explained in the patient consent as well.

Some medical practices have found that creation of an internal log may be helpful in tracking the time spent with CCM patients.

Download our sample log below:



How much does Medicare pay for 99490 Chronic Care Management?

The average expected reimbursement for code 99490 is \$42, depending on locality. While that number may initially seem small given the amount of documentation needed, it can have a dramatic impact on a practice's revenues.

If just 50 patients utilize the CCM services, that will generate an additional \$2,000+ per month. Or better yet, \$24,000+ over the course of the year.

Resources

[Medicare Learning Network](#) – Chronic Care Management Services

Q&A

What date of service should be used?

Some carriers want just the last day of the month noted. Others want the entire date range of the month included. Example: September 1st through September 30th.

Be sure to check with each carrier regarding their preference.

Can 99490 be billed for inpatients?

Possibly. The place of residence could be an assisted living or nursing home facility. You will need to find out how the patient is registered. If Part A is being received by the facility, then you cannot bill CCM services. You should instead use codes such as 99307, 99308, and other home health certification codes.

Will commercial carriers pay for this code?

Check with your local carriers. They may or may not. It's possible they may pay in the future too as CCM gains traction.

Do Medicare Advantage plans pay for 99490?

At a minimum, provide them with what is required by Medicare. They should pay unless they are a capitated Advantage plan. Although, some Advantage plans do offer and go beyond the minimum requirements of Medicare.

Does patient consent have to be obtained each month?

Informed patient consent only needs to be obtained once, prior to providing the first CCM service. However, if the patient changes providers and the new provider will bill for CCM, then the patient must sign a new consent with that provider.

Is an annual wellness visit (AWV) or “Welcome to Medicare Visit” required before CCM services can be billed?

No. CMS requires an AWV, welcome visit, OR comprehensive E/M before CCM services can be billed.

Are there any codes that cannot be billed in the same month as 99490?

Yes. Those codes include:

1. Transition Care Management – 99495, 99496
2. Home Healthcare Supervision – HCPCS G0181
3. Hospice Care Supervision – HCPCS G9182
4. Certain ESRD Services – CPT 90951-90970

Do you understand CCM now?

Hopefully this information helps you understand the basics of billing Chronic Care Management. As always, make sure to check with your local Medicare carrier and other insurance companies on their rules and policies on how to bill for CCM.

About the Author



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Manny Oliverrez, CPC, is a 20-year healthcare veteran and the CEO and co-founder of Capture Billing, a medical billing services company located outside of Washington, D.C. He teaches the nation's physicians, administrators, and medical practices how to maximize billing and revenue cycle management processes. Manny also frequently posts articles and videos on his [award-winning healthcare blog](#). For more information on Manny and his company, please visit [his website](#), or call (703)327-1800. And if you're on [LinkedIn](#), please look for him there too. **READ MORE**

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