Care Management Services:

Practice Administration, Reporting, and Reimbursement Guide

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Care Management Services Practice Administration and Reimbursement Guide

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Introduction

Care management services provide continuous monitoring and support to patients over a calendar month with either a single high-risk condition or multiple conditions. These services have several goals:

Improve care coordination. Patients with multiple conditions may take multiple medications and see different specialists, which often leads to disjointed care. Care management services provide the opportunity for the entire care team to collaborate and appropriately address the patient's condition.

Reduce hospital admissions or services. By providing the patient with 24/7 access to their care team, patients will receive timely responses to concerns or issues without having to go to the emergency room or hospital. If the patient does need to be admitted, it will be with their care team's knowledge and guidance.

Engaging patients and caregivers. Care management services allow for time dedicated to education and dialogue with the patient, family, and/or caregiver. The purpose of these interactions is not only to ensure the patient (or family/caregiver) understands their condition and treatment plan but provide them with the opportunity to take an active role in their care and the decision-making process.

To effectively provide these services to patients and incorporate them into a practice's workflow, it is important to understand:

- Practice requirements to provide care management services.
- Clinician care delivery activities.
- How to appropriately code and report the services to payers.

Medicare Utilization of Care Management Services

Medicare conducted a study of chronic conditions among fee-for-service beneficiaries using 2018 utilization data. The study found that 31% of beneficiaries had at least 1 chronic condition, followed closely by 2-3 chronic conditions at 29%. Though only 18% of beneficiaries had over 6 chronic conditions, their costs of care contributed to 54% of Medicare spending in 2018 and accounted for 82% of hospital readmissions.[1],[2]

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[1] Centers for Medicare and Medicaid Services. N.d. "Chronic Conditions Charts: 2018". https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/cc_charts.zip

[2] Centers for Medicare and Medicaid Services. N.d. "Chronic Conditions among Medicare Beneficiaries: Chronic Conditions Chartbook: 2018"

Figure 13: Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2018
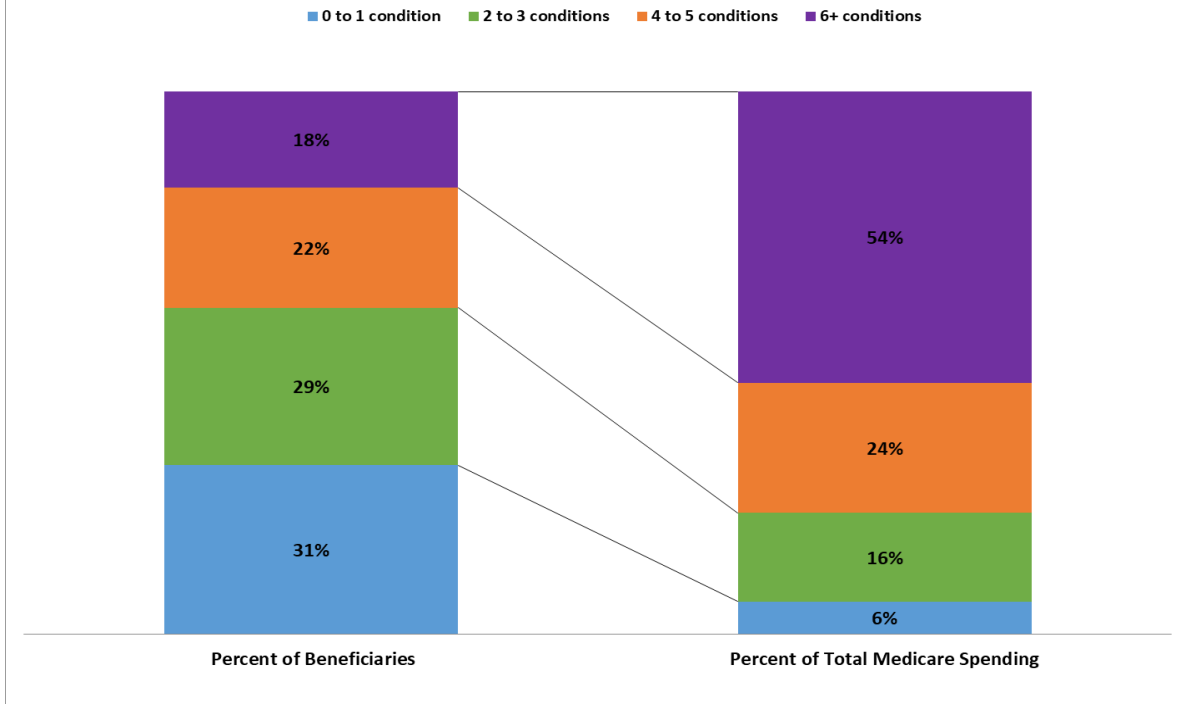
Hematology/Oncology Utilization of Care Management Services

Though chronic conditions are prevalent among the Medicare beneficiary population, the utilization of care management services is relatively low, especially among hematology/oncology providers. The following data shows total numbers billed for the applicable codes as well as that of hematology/oncology and medical oncology providers. [3]

	2015	2016	2017	2018	2019	2020	2021	2022
Chronic Care Management, Clinical Staff (99490)								
- Oncology	2,465	11,486	23,399	28,611	38,887	60,304	66,361	56,313
- All Specialties	1,051,933	2,530,825	3,514,501	4,313,888	4,480,391	4,956,147	4,687,678	4,975,188
Chronic Care Management, Physician/QHP (99491)								
- Oncology					35	151	918	1,234
- All Specialties					60,551	143,119	172,026	199,453
Complex Chronic Care Management, Clinical Staff (99487)								
- Oncology	0	0	231	147	371	458	220	150
- All Specialties	1,530	1,312	129,192	231,960	302,974	310,091	299,614	352,354
Complex Chronic Care Management, each additional 30 minutes (99489)								
- Oncology	0	0	79	23	111	271	674	43
- All Specialties	319	662	52,028	205,890	267,072	211,498	265,786	494,171

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[3] Centers for Medicare and Medicaid Services. Physician/Supplier Procedure Summary, 2015-2020, data.cms.gov

Challenges Providing Care Management Services

Why are care management services not more widely utilized? Though they can be effective in managing patients with chronic conditions, there are challenges regarding the following:

- Identifying patients needing or may benefit from care management services.
- Having clinical staff available to provide care management services on a regular basis.
- Implementing specific processes and protocols to ensure consistent, quality care.
- Understanding how to report the codes and services to payers.

Care Delivery

Patient Care Plan

At the core of care management services is a comprehensive care plan. A comprehensive care plan may typically include, but is not necessarily limited to, the following items: [4,5]

Care Plan	Problem list
	Expected outcomes and prognosis
	Measurable treatment goals
	Symptom management
	Planned interventions
	Medication management
	Community/social services ordered
	Schedule for review and revisions

The care plan should address all potential challenges and adverse effects that may result from their care and encompass not only oncology related issues, but other conditions such as financial, social, and external issues. The care team may need to collaborate with other teams and professionals to provide the patient with the resources they need. If a patient has multiple specialists, there must be a process for sharing information and coordinating care with other healthcare providers. These care plan requirements align with the Institute of Medicine's (IOM) 13-point care plan that is mandatory as part of the Oncology Care Model (OCM) and as part of the Enhanced Oncology Model's (EOM) care plan requirement.[6,7]

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[4] Centers for Medicare and Medicaid Services. MLN909188 – Chronic Care Management (cms.gov)

[5] *CPT® 2022 Professional Edition*. Chicago, IL: American Medical Association, 2021.

[6] Fargnoli, Brenton, Natasha Jaffe, Nick Bauer-Levey, Keith Cowing, Joanne Schneider, Rohit Parulkar, DJ Lee, et al. "Implementation of the IOM 13 Point Care Plan by Oncology Care Model (OCM) Practices." *Journal of Clinical Oncology* 35, no. 15_suppl (2017). https://doi.org/10.1200/jco.2017.35.15_suppl.e18279.

[7] Centers for Medicare and Medicaid Services. July 2022. Enhancing Oncology Model | CMS Innovation Center

Care Management Services Activities

Care management services consist of these face-to-face AND non-face-to-face activities over a calendar month:[8]

- **Transition management** between and among healthcare providers and settings including referrals, follow up after an emergency department visit, discharge from certain inpatient settings (acute hospital, rehab hospital, partial hospital, long term acute care, skilled nursing facilities), and the exchange of information and/or documents with other providers.
- **Communication with the patient and/or caregiver** through telephone, secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.
- **Assessment and support for the treatment regimen** through the development of measurable treatment goals, symptom management, medication management.
- **Communication, coordination, and collaboration on the care plan** with other healthcare providers.
- **Development and updating of the care plan** by scheduling the plan for periodic review and, when applicable, revision of the care plan and communication of expected outcome and prognosis.
- **Patient and caregiver education** such as discussing medications and symptom management, updates to the care plan.
- **Ongoing review of patient status** by determining intervals for review of the patient's care plan and treatment regimen.

The ASCO Cancer Treatment Plan organizes basic information about cancer care history, treatments received, medication doses, surgeries, and any additional treatment that was provided. This template may be helpful in developing the care plan or to facilitate conversations with the patient, family, or caregiver.[9]

Role of the Practitioner vs. Clinical Staff

The care team is led by the practitioner, which may include physicians in addition to non-physician providers such as physician assistants, clinical nurse specialists, and nurse practitioners. Clinical staff are employees or working under contract with the billing provider and receive general supervision and guidance from the billing practitioner.[10]

There is a certain division of labor between the clinicians and clinical staff. Practitioners are responsible for developing the care plan and assessment of the patient. Under the direction of the physician, clinical staff may be responsible for education, responding to patient inquiries, reconciling medications, managing care transitions, and sharing information with other healthcare providers.

The collaboration between clinicians and clinical staff is not a one-way or one-time process. The physician and the clinical staff team should continuously work together to ensure the patient is receiving appropriate care.[11]

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[8] *CPT® 2022 Professional Edition*. Chicago, IL: American Medical Association, 2021.
[9] American Society of Clinical Oncology. "ASCO Resources for Patients and Providers". https://society.asco.org/practice-patients/patient-resources/asco-resources-patients-providers
[10] Centers for Medicare and Medicaid Services. "Chronic Care Management." MLN909188 – Chronic Care Management (cms.gov)
[11] *CPT® 2022 Professional Edition*. Chicago, IL: American Medical Association, 2021.

Physician

- Develop a comprehensive care plan and assessment.
- Address all health issues (medical and psychosocial).
- Focus on patient's chronic condition(s).
- Provide guidance and direction to clinical staff.

Clinical Staff

- Educate patient and/or caregiver.
- Respond to patient inquiries.
- Reconcile medications list (including those prescribed by other providers).
- Manage care transitions.
- Share information with other health care providers.

Quality Programs and Initiatives

Oncology Medical Home (OMH) Standards

Care management services are directly integrated into quality initiatives established in the ASCO / Community Oncology Alliance Medical Home (OMH) Standards.[12] Requirements for care management services feed into patient engagement, availability, access to care, and equitable and comprehensive team-based care standards of the model.

- **Patient engagement:** All patients are provided with an initial orientation to the OMH model and ongoing reinforcement of policies related to this model.
- **Availability and access to care**: The OMH practice institutes expanded access and an evidence-based symptom triage system to ensure patients can easily access the practice and their providers.
- **Equitable and comprehensive team-based care:** In most instances, a medical oncologist directs the patient's care team within the OMH practice, as well as the care coordination with the patient's primary care physician and/or other pertinent physicians and services, including ongoing collaboration with the inpatient team.
- **Goals of care and palliative and end-of-life care discussions:** The practice routinely offers an advance care planning discussion and completes a goals of care discussion with all patients that recognizes the individual patient's needs and preferences. For patients who choose to participate in this discussion, advance care planning would include advance directives and consideration or selection of an agent for medical decision making.

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[12]Woofter, Kim, Erin B. Kennedy, Kerin Adelson, Ronda Bowman, Rachel Brodie, Natalie Dickson, Rose Gerber, et al. "Oncology Medical Home: Asco and COA Standards." *JCO Oncology Practice* 17, no. 8 (2021): 475–92. https://doi.org/10.1200/op.21.00167.

Enhanced Oncology Model

Care management services activities are integral to the requirements outlined in the Centers for Medicare and Medicaid Services (CMS) Enhanced Oncology Model (EOM). This model necessitates 24/7 access to care, patient navigation, care planning, and screening for health-related needs which are part of care management activities. In addition, the model requires use of electronic patient reported outcomes, use of data for quality improvement, use of evidence-based guidelines, and use of certified electronic health record technology.[13]

	EOM	Chronic Care	Complex Chronic Care	Principal Care
Conditions	▪ Breast cancer, chronic leukemia, small intestine/ colorectal cancer, lung cancer, lymphoma, multiple myeloma, or prostate cancer	▪ Two or more chronic conditions.	▪ Two or more chronic conditions, moderate or high complexity.	▪ One single, high-risk condition.
Service Time Period	▪ Episode of 6 months.	▪ Time over a calendar month.	▪ Time over a calendar month.	▪ Time over a calendar month.
Practice Administration Requirements	▪ 24/7 access to a clinician with real-time access to the EOM participant's medical records. ▪ Patient navigation services. ▪ Documentation of a care plan. ▪ Therapies consistent with nationally recognized clinical guidelines. ▪ Identify health-related social needs (HRSN) using a health-related social needs screening tool. ▪ Gradual implementation of electronic Patient Reported Outcomes (ePROs) ▪ Utilization of data for continuous quality improvement (CQI). ▪ Use of Certified EHR Technology (CEHRT).	▪ 24/7 access to physicians/QHP or clinical staff. ▪ A designated member of the care team to provide continuous care. ▪ Timely access and management for follow-ups. ▪ Access to information through an EHR. ▪ Coordination and integration of care among all service professionals (within and outside the practice). ▪ A physician/QHP overseeing activities of the care team.	▪ 24/7 access to physicians/QHP or clinical staff. ▪ A designated member of the care team to provide continuous care. ▪ Timely access and management for follow-ups. ▪ Access to information through an EHR. ▪ Coordination and integration of care among all service professionals (within and outside the practice). ▪ A physician/QHP overseeing activities of the care team.	▪ 24/7 access to physicians/QHP or clinical staff. ▪ A designated member of the care team to provide continuous care. ▪ Timely access and management for follow-ups. ▪ Access to information through an EHR. ▪ Coordination and integration of care among all service professionals (within and outside the practice). ▪ A physician/ QHP overseeing activities of the care team.

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[13] Centers for Medicare and Medicaid Services. July 2022. Enhancing Oncology Model | CMS Innovation Center

	EOM	Chronic Care	Complex Chronic Care	Principal Care
Reimbursement[14]	▪ Monthly Enhanced Oncology Services (MEOS) payment. ▪ Six payments for each 6-month episode. ▪ $110 per EOM beneficiary per month. ▪ Additional $30 per dual eligible beneficiary per month.	▪ 99490 $60.49 ▪ 99439 $45.93 ▪ 99491 $82.16 ▪ 99437 $57.58 *National payment amounts.	▪ 99487 $131.65 ▪ 99489 $70.52 *National payment amounts.	▪ 99426 $61.78 ▪ 99427 $50.46 ▪ 99424 $80.87 ▪ 99425 $58.87 *National payment amounts.
Payers	▪ Medicare FFS; other plans may elect to recognize code.	▪ Medicare, Medicaid, private payers subject to policy.	▪ Medicare, Medicaid, private payers subject to policy.	▪ Medicare, Medicaid, private payers subject to policy.

Social Determinants of Health

The Centers for Medicare and Medicaid Services (CMS) is encouraging providers to use care management services as a means of addressing a patient's social determinants of health (SDOH). The time spent on patient care over a calendar month can be attributed to home and community-based care coordination such as:[15]

- Coordination with home and community based clinical services providers.
- Communication with home/community providers regarding psychosocial needs and other deficits.
- Enhanced communication opportunities for patients and caregivers.

The ASCO Social Determinants of Health podcast series provides insights and education from experts on how to address SDOH and incorporation into patient care.[16]

The Centers for Medicare and Medicaid Services has a Connected Care Campaign highlighting how chronic care management (CCM) services fit into the equity plan framework outlined by the organization as well as tools for integrating the services into care.[17]

More information regarding coding, reporting and SDOH can be found on [ASCO's Coding and Reimbursement page](#).

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[14] Centers for Medicare and Medicaid Services, CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. [CY 2025 Medicare Physician Fee Schedule Final Rule](#)

[15] Centers for Medicare and Medicaid Services. "Chronic Care Management". https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

[16] American Society of Clinic Oncology. Social Determinants of Health podcast series. [ASCO's Social Determinants of Health in Cancer Care Podcast](#)

[17] Centers for Medicare and Medicaid Services. "Chronic Care Management." [WHAT IS CHRONIC CARE MANAGEMENT? (cms.gov)](#)

Practice Administration and Workflow

Practice Requirements

To successfully execute care management services, practices must be able to provide the following:[18]

- 24/7 access to physicians/QHP or clinical staff
- A designated member of the care team to provide continuous care
- Timely access and management for follow-ups
- Timely access to information through an EHR
- Coordination and integration of care among all service professionals (within and outside the practice)
- A physician or QHP who oversees the activities of the care team.

Many practices may have these processes already in place as part of OCM and EOM.[19, 20] It will be important to conduct a self- audit to see what the practice currently has, what needs to be implemented, and which processes require improvements.

Required Actions

Once the practice administration requirements have been established, there are four required actions:[21]

1. **Obtaining patient consent**
   Consent should be obtained after a patient's eligibility is determined during a required initiating E/M visit. The patient's consent is only needed once and must be done before furnishing or billing care management services. However, it is imperative the patient be aware of their right to terminate the services at any time, any applicable cost sharing, and that only one practitioner (for chronic and complex chronic care) can bill for these services in a calendar month.
2. **Assigning a designated care team lead**
   The designated team lead serves as a point of contact and ensures continuity of care for the patient, which is central to the care management service.
3. **Establishing, implementing, revising, and monitoring the care plan**
   Establishing the care plan and periodic review is not only integral to the care plan itself, but also care management services. The plan, as well as any changes, should be shared with the patient and/or caregiver along with other healthcare providers.
4. **Recording data in the electronic health record**
   Demographics, medications, allergies, and medical problems must be recorded using a certified electronic health record (EHR).

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[18]*CPT® 2022* Professional Edition. Chicago, IL: American Medical Association, 2021.

[19] Centers for Medicare and Medicaid Services. "Oncology Care Model Fact Sheet". June 2019.

[20] Centers for Medicare and Medicaid Services. July 2022. Enhancing Oncology Model | CMS Innovation Center

[21] Centers for Medicare and Medicaid Services. N.d. "MLN Booklet 909188: Chronic Care Management". MLN909188 – Chronic Care Management (cms.gov)

Steps for Practice Administration

The timeframe for implementation of care management services in a practice will vary depending on what the practice currently has available. The Chronic Care Management (CCM) Toolkit developed by the Centers for Medicare and Medicaid Services provides guidance on "Implementation Strategies for a Successful CCM Program." Those steps include:[22]

1. **Establishing a workflow**. Outline what the practice workflow may look like initially based on program requirements, practice/organization capacities and resources, and estimated revenue from the services.
2. **Define your care management process**. Identify the population of patients appropriate for care management services, the triggers for beginning care management, who will provide the services, and what should be included in your patient's care management service. It is recommended to start with a small population to test the program, and then incorporate more patients over time.
3. **Prepare for reimbursement**. Review coding, billing, and reporting guidelines and be sure they are integrated into the EHR or practice management system for timely and successful reimbursement.
4. **Establish ongoing monitoring and quality improvement**. A practice's care management services program must regularly be monitored and measured to ensure quality care is being provided to patients.
5. **Identify opportunities with commercial payers**. Check commercial payer policies to determine if care management services are covered and their guidelines for reporting. Commercial payer policies may differ from Medicare's.
6. **Leverage digital tools**. Using online or virtual platforms can be helpful tools to monitor patients, respond to questions, and reduce the number of face-to-face visits for routine condition management.

In addition to the "Chronic Care Management (CCM) Toolkit", there are other publicly available resources regarding the implementation of care management services, such as the "Value Transformation Framework Guide"[23] by the National Association of Community Health Centers or the "Care Management issue brief"[24] from the Agency for Healthcare Research and quality.

Coding, Reporting, and Reimbursement

Coding Guidance

There are three sets of CPT ® codes used to describe care management services:[25]

- Chronic care management (CCM): 99490, 99439, 99491, 99437
- Complex chronic care management (CCCM): 99487, 99489
- Principal care management (PCM): 99426, 99427, 99424, 99425

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[22] Health Quality Innovation Network. "Chronic Care Management Toolkit." https://www.khconline.org/files/CCM-Toolkit.pdf

[23] National Association of Community Health Centers. "Value Transformation Framework Guide". NACHC-VTF-Care-Management-AG_November-2019.pdf

[24] Agency for Healthcare Research and Quality. "Care Management: Implications for Medical Practice, Health Policy, and Health Services Research." https://www.ahrq.gov/ncepcr/care/coordination/mgmt.html#vehicle

[25] *CPT® 2022 Professional Edition*. Chicago, IL: American Medical Association, 2021.

These services have several similar concepts, but may differ in terms of the time, the practitioner performing the service, and the level of complexity.

Chronic Care Management	Complex Chronic Care Management	Principal Care Management
Two or more chronic conditions expected to last **at least 12 months** (or until the death of the patient).		**One** complex chronic condition expected to last **at least 3 months**.
Significant risk of death, acute exacerbation/decompensation or functional decline.		
A care plan is established, implemented, revised, or monitored.		
	Moderate or high complexity medical decision making.	Management of the condition is **complex** due to comorbidities.

CPT® Codes

Applicable CPT® codes are separated into services reported by clinical staff (under the guidance and oversight of a physician) and services performed by a physician/QHP. The time associated with the codes account for work performed *over a calendar month*. For a full set of the guidelines and code descriptions, refer to the latest version of the AMA CPT® Professional Edition.

Chronic Care Management

99490: First 20 minutes of clinical staff time directed by a physician or qualified healthcare professional
     99439: Each additional 20 minutes (limited to 2x per month)
99491: First 30 minutes, personally provided by a physician or qualified healthcare professional
     99437: Each additional 30 minutes

Complex Chronic care Management*

99487: First 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional
     99489: Each additional 30 minutes

Principal Care Management

99426: First 30 minutes of clinical staff time directed by a physician or qualified healthcare professional
     99427: Each additional 30 minutes (limited to 2x per month)
99424: First 30 minutes, personally provided by a physician or qualified healthcare professional
     99425: Each additional 30 minutes
* While there is no CPT code to describe a complex chronic care management service personally provided by a physician or qualified healthcare professional, they must still provide direction to clinical staff. In addition, If

the physician personally performs the clinical staff activities, the time may be counted toward the required clinical staff time to meet the elements of the code.[26]

Time Requirements

For each set of services, there are time requirements to report the primary code (99490, 99491, 99487, 99426, 99424) and add-on code (99439, 99437, 99489, 99427, 99425). The primary codes may only be reported <u>once</u> per calendar month with the add on services covering additional time during the same month.

Unlike many other time-based codes, the "mid-point rule" does not apply (a unit of time is attained when the midpoint has passed). The practitioner must perform <u>at least</u> the number of minutes indicated in the code description to report the service. For example, to report 99487, the clinical staff must conduct, at a minimum, a 60-minute service. If they performed 31 minutes, 99487 may not be reported.

Medicare guidance states the date of service for chronic care management services and principal care management services is the date the minimum time requirement is reached; however, practices should check with their local MAC to confirm. Private payers may have different policies from CMS.[27,28]

Clinical Staff and Physician Work

Clinical staff and the physician/QHP cannot both report a care management service in the same calendar month (ex. 99490 and 99491). However, if the physician personally performs any of the care management services and those activities are not used to meet the criteria for a separately reported code (99424, 99491), then their time may be counted toward the clinical staff time of the applicable service. If a physician personally performs the clinical staff activities but does not bill for that time, his or her time can be counted towards the clinical staff time.

Activities That Do Not Count Towards Time

The time of the following services do not count towards the time of the care management service as they may be separately reported with other CPT® codes (and therefore would be considered overlapping services): [29]

- Telephone E/M services
- Medication therapy management-Pharmacist
- Online digital E/M services
- Prolonged E/M Services (different day than E/M)
- Patient/caregiver training INR monitoring
- ESRD services

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[26] *CPT® 2022 Professional Edition*. Chicago, IL: American Medical Association, 2021.

[28] Centers for Medicare and Medicaid Services. "Frequently Asked Questions about Billing Medicare for Chronic Care Management Services." March 2016. Frequently Asked Questions About Billing Medicare for CCM Services

[28] NGS Medicare. "Care Management: Principal Care Management." https://www.ngsmedicare.com/documents/20124/121705/2330_0222_princ_care_final_508.pdf/ce5d4dab-52df-bea2-3291-0dc981ff4222?t=1644859745549

[29] *CPT® 2022 Professional Edition*. Chicago, IL: American Medical Association, 2021.

Code Selection

To determine which care management service is appropriate to report, consider the following:

1. How many conditions are being managed?
2. How long is the condition expected to last?
3. Who provided the service?
4. Were the time requirements for the code(s) met?

The decision trees on the following pages may aid in determining if the service provided fulfills the requirements for the corresponding code.

Principal Care Management Services

Single, high-risk condition requiring moderate or high complexity medical decision making.

Single Condition
Is the condition expected to last at least 3 months?

Yes. Who provided the service?

No. A PCM service may not be reported.

Physician or QHP. Did the service add up to 30 minutes or more?

Clinical staff. Did the service add up to 30 minutes or more?

Yes. Report CPT code 99424 and if appropriate, 99425.

No. Did the staff have any reportable time?

Yes. Report CPT code 99426 and if appropriate, 99427.

Yes. Combine the time of the physician/QHP and staff. Report 99426 and 99427, if appropriate.

No. A PCM service may not be reported.

Chronic Care Management Services
Two or more chronic conditions.

Two or more
Is the condition expected to last at least 12 months?

Yes. Who provided the service?

No. A CCM service may not be reported.

Physician or QHP. Did the service add up to 30 minutes or more per calendar month?

Clinical staff. Did activities add up to 20 minutes or more per calendar month?

Yes. Report codes 99491 and, if appropriate, 99437.

No. Did staff have any reportable time?

Yes. Report 99490 and, if appropriate, 99439.

Yes. Combine the time of the physician/QHP and staff. Report 99426 and 99427, if appropriate.

No. A CCM service may not be reported.

Complex Chronic Care Management Services

Two or more chronic conditions requiring **moderate or high-level MDM**.

Two or more
Are the patient's conditions expected to last **at least 12 months**?

Yes. Did the service (physician and/or staff) add up to 60 minutes or more?

No. A CCCM service may not be reported.

Yes. Report 99487 and, if appropriate, 99489.

No. A CCCM service may not be reported.
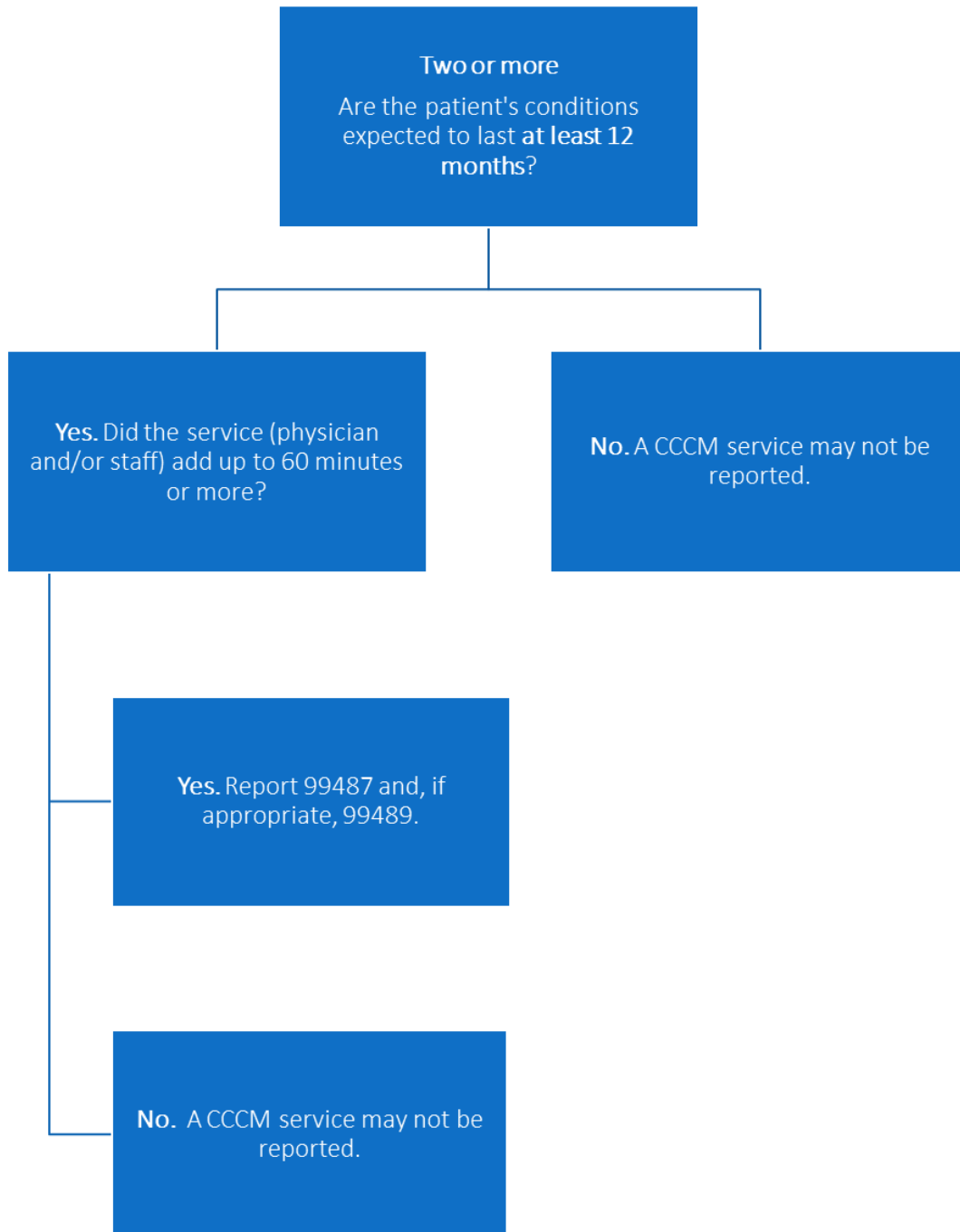
Other Reporting Requirements and Guidelines

Initiation of Care Management

To initiate the process of providing a chronic care management service for a new patient or patient not seen within 1 year, CMS requires that one of these three services must be performed:[30]

- Annual Wellness Visit (AWV).
- Initial Preventive Physical Exam (IPPE).
- E/M visit.

Multiple Care Management Services for One Beneficiary

Chronic and Complex Care Management services only allow for <u>one clinician per beneficiary</u> to report the services <u>per calendar month</u>. For example, a patient's primary care physician and oncology provider cannot both report chronic care management services during the same month. If two care management services are reported for the same beneficiary during a calendar month, one provider will receive a claim denial for their service. Principal care management services may allow for more than one clinician per beneficiary to report the service if the patient experiences an exacerbation of more than one complex chronic condition simultaneously.

Documentation

To support the reporting of care management services, documentation should include the following information:[31]

- ☑ Narrative detailing need for care management services
- ☑ Beneficiary eligibility for service.
- ☑ Comprehensive care plan (with measurable goals) established, implemented, revised or significantly monitored.
- ☑ Patient or caregiver must be given a copy of the care plan. Medicare does not specify a certain format for care plan.
- ☑ Discussion narrative with beneficiary and his/her prior permission acceptance (verbally for patients who have been seen in the practice within past 12 months or written for those who have not).
- ☑ Documentation of verbal acceptance and explanation to the patient.
- ☑ Note regarding beneficiary may terminate consent at any time
- ☑ Support services rendered.
- ☑ Time spent on services.

Common Reasons for Claim Denials

Claim payment denials can be frustrating and disrupt a practice's revenue cycle. Therefore, it is important to understand not only the coding guidelines, but payer requirements as well. Private payers may have different policies than CMS.

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[30] CMS VMCG, CMS/CM/PCG/DPIPD, and CMS. 2016. "Chronic Care Management Services." https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf.

[31] Noridian Healthcare Services. "Chronic Care Management." June 2019. Chronic Care Management (CCM) - JE Part B - Noridian (noridianmedicare.com)

Common reasons for claim denials include:

- Multiple claims for the same beneficiary:
  - two or more providers submitting claims for either a complex/non-complex CCM service
  - one provider submitting multiple initial care management services for the same patient in a calendar month
  - services reported by both clinical staff and the physician or qualified health provider
- Not meeting the service's time requirements.
- Reporting complex chronic care management services, complex chronic care management services, or principal care management services during the same calendar month.
- Reporting care management services with other overlapping services that are reportable with a separate code.

Coding Scenarios

Below are a variety of scenarios which demonstrate how care management services may be reported:

1. Clinical staff performs a complex chronic care management service of 20 minutes on the 18th. Clinical staff then performs a complex chronic care management service of 40 minutes on the 25th. The total time of 60 minutes was reached for the month of January.

   Report CPT code 99487 on the 25th of the month, as this is when the total time was reached.

2. Clinical staff performs a chronic care management service of 30 minutes on the 13th. The physician performs a chronic care management service of 20 minutes on the 20th and an additional 30 minutes on the 28th. The physician, however, does not use these services for criteria. Therefore, a total of 80 minutes was reach for the month of January.

   Report CPT code 99490 on the 13th of the month, as this is when the initial time was reached. Report CPT code 99439 on the 20th and an additional 99439 on the 28th. 99439 may only be reported <u>twice</u> in a calendar month, so the maximum number of units would be reported.

3. The patient's primary care physician performed a complex chronic care management service on the 8th of this month. His oncologist performed a chronic care management service on the 10th.

   Because the primary care physician has already billed a chronic or complex chronic care management service in the calendar month, the oncologist is unable to bill for the CCM service performed on the 10th.

Reimbursement

The following non-facility payments reflect 2025 estimated national rates prior to geographic adjustment and the conversion factor.[32]

Chronic Care Management				
CPT	Provider	Time	Non-Facility RVU	Non-facility Payment
99490	Staff	First 20 min	1.87	$60.49
99439	Staff	Add'l 20 min	1.42	$45.93
99491	Physician	First 20 min	2.54	$82.16
99437	Physician	Add'l 30 min	1.78	$57.58

Complex Chronic Care Management				
CPT	Provider	Time	Non-Facility RVU	Non-facility Payment
99487	Staff	First 60 min	4.07	$131.65
99489	Staff	Add'l 30 min	2.18	$70.52

Principal Care Management				
CPT	Provider	Time	Non-Facility RVU	Non-facility Payment
99426	Staff	First 30 min	1.91	$61.78
99427	Staff	Add'l 30 min	1.56	$50.46
99424	Physician	First 30 min	2.50	$80.87
99425	Physician	Add'l 30 min	1.82	$58.87

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[32] Centers for Medicare and Medicaid Services, CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies. CY 2025 Medicare Physician Fee Schedule Final Rule

Resources

ASCO

Changchuan Jiang, Haowei Wang, Qian Wang, Binbin Zheng, and Charles L. Shapiro. "Cancer survivors with multiple chronic conditions: A rising challenge—Trend analysis from National Health Interview Survey." Journal of Clinical Oncology 2020 38:15_suppl, e24089-e24089

Dana Ketcher, Amy Otto, and Maija Reblin. "Chronic conditions among advanced cancer patients and their spouse caregivers." Journal of Clinical Oncology 2019 37:31_suppl, 20-20

ASCO Fact Sheet: Enhancing Oncology Care Model (EOM)

ASCO Cancer Treatment Plans

Centers for Medicare and Medicaid Services

Connected Care Toolkit

MLN Booklet: Chronic Care Management Services

Chronic Conditions Prevalence, State/County 2018

Chronic Conditions among Medicare Beneficiaries: Chronic Conditions Chartbook: 2018

CMS's Care Management Landing Page

American Medical Association

"Get paid for the care management your physician practice delivers"

"Physician-led team-based care"

Other Resources

Chronic Care Management (CCM) Toolkit: Your implementation guide for patients with chronic conditions

Provider Experiences with Chronic Care Management (CCM) Services and Fees: A Qualitative Research Study

Noridian Part B: Chronic Care Management (CCM)