Chronic Care Management Frequently Asked Questions

The National Council on Aging (NCOA) has compiled this list of Frequently Asked Questions (FAQs) to support community-based organizations in implementing and receiving reimbursement for chronic care management (CCM) services to help sustain chronic disease-self-management education (CDSME) programs.

Chronic care management (CCM) is a Medicare Part B benefit delivered under the supervision of a physician or non-physician provider (nurse practitioner or physician assistant) for individuals with two or more chronic conditions. The CCM benefit allows eligible providers to offer services outside of doctor’s office visits to help Medicare beneficiaries with multiple chronic conditions follow their medical care plan, practice preventive health care, and more effectively manage their chronic conditions and overall health. Assistance in accessing needed resources to optimize self-care is a primary goal of CCM services.

Questions have been grouped under the headings below. The FAQs will be updated as additional questions are posed.

- **General**
- **Personnel**
- **CCM and Complex CCM**
- **Documentation and Billing**
- **CCM and DSMT**

**General:**

1. **What types of services can be provided under CCM?**

   There are a wide range of services that can be provided under CCM for Medicare beneficiaries with multiple chronic conditions. While the list below is not exhaustive, it provides examples of the types of services that can be provided:

   - Care management and transitional care management services
   - Communicating with the Medicare beneficiary in person, by phone, or electronically for care coordination
   - Community resource referral and linkage
   - Coordinating community and social support services
   - Disease self-management education and support
   - Health coaching
   - Health education, including health literacy
• Interventions to reduce falls or risk factors for falls
• Medication management
• Preventive health counseling
• Symptom management

2. Outside the doctor’s office, in what settings can CCM be provided?

Under general supervision, CCM services can be delivered in a variety of locations outside the provider’s office, including community and in-home settings, by telephone, and online. Services may also include contacts with other providers to coordinate care, as well as direct contacts with the Medicare beneficiary.

3. Please explain what is meant by the initiating visit?

Before CCM services can be offered, there must be an initiating face-to-face visit with a Medicare qualified provider for new patients or patients who have not been seen within one year prior to the commencement of CCM services. The initiating visit can be an annual wellness visit, an initial preventive physical exam, transitional care visit, or other qualifying evaluation and management visit. This visit is not part of CCM services and is billed separately.

Once the initiating visit has been provided (for new patients or those not seen within a year of the commencement of CCM services), a comprehensive person-centered plan for CCM is developed. An add-on face-to-face visit may be provided to complete the person-centered plan.

4. Does the Medicare provider or the CBO complete the comprehensive care plan?

The clinical team, including staff from the CBO, should provide input into development of the person-centered plan under the direction of the qualified physician or non-physician provider (nurse practitioner or physician assistant). If the comprehensive care plan is billed using the add on-code, the provider must be actively involved in the care planning process.

5. Does telehealth apply to CCM?

Telehealth regulations do not apply to CCM, but CCM services can be provided by telephone or online.

Personnel:

1. Who can provide CCM?

There are no specific credentialing requirements for personnel who deliver CCM services, as long as they operate under the general supervision of a qualified physician.
or non-physician provider (nurse practitioner or physician assistant) provider. However, personnel should be part of the clinical team, not administrative staff. Each organization should ensure that personnel have the necessary knowledge, skills, training, and experience to serve the target population. A trained Chronic Disease Self-Management Program (CDSMP) lay leader, health coach, or other person with training and background in chronic disease management and care coordination may be appropriate for this role.

2. **If we use health coaches to provide CCM services, are there specific credentialing requirements for health coaches that must be met?**

   There are no uniform national standards for credentialing health coaches, but they should obtain training as deemed appropriate by the qualified Medicare provider in coordination with the community-based organization (CBO). The American Medical Association (AMA) has developed an online training module, [Implementing Health Coaching](http://www.ama-assn.org), for physicians who want to incorporate health coaches into their practices.

3. **We provide all of the CCM services listed. However we have Registered Nurses that carry out these services. Would we be able to serve as the provider, or would we need a nurse practitioner or physician assistant?**

   The registered nurses can provide CCM services under the care plan, but a physician, nurse practitioner, or physician assistant must supervise the services. You could develop a partnership with a Medicare provider for the supervision or you could serve as the Medicare provider yourself if you have a physician, physician assistant, or nurse practitioner available to provide the supervision and meet the other requirements for delivery of Medicare Part B CCM services. NCOA’s [CCM Information Resource](http://www.ncoa.org) provides more information about these requirements.

4. **If we serve as the provider, does the physician assistant or nurse practitioner have to be a staff member or could we contract for the service?**

   If you decide to serve as the provider, you can hire or contract with a qualified physician or non-physician provider (nurse practitioner or physician assistant) for the supervision. In fact, you could even recruit a retired health professional who meets the qualifications to volunteer the services. In addition to the Medicare requirements, the provider must meet all the regulatory requirements of the state in which the practice occurs. State regulatory requirements are separate from the Medicare requirements.

   The qualified provider would need to have a national provider identifier that is linked to your organization. Additionally, if your organization becomes the provider, you would have to conduct the initiating visit that is required to offer CCM services, provide 24-hour provider accessibility, and use a “meaningful use” electronic health record (EHR) system. The [CCM Information Resource](http://www.ncoa.org) on NCOA’s website describes some example...
implementation models for CCM services, along with the advantages and disadvantages of each model (see pages 11-14).

5. **Can more than one clinical team member provide CCM services during a calendar year?**

There is nothing in the regulations that precludes more than one clinical team member from providing CCM services during a calendar year as long as all the regulatory requirements for CCM services are met. The organization should provide appropriate coverage to meet the needs of individuals who are receiving services, coordinate care among personnel who offer the services, and ensure continuity of care over time. Below are two different examples of situations in which more than one clinical team member contributes to the delivery of CCM services. Note - The following are only examples, and there may be other appropriate practices involving more than one team member delivering the services.

**Example 1:**
The person responsible for providing CCM services might be on annual leave, resign from the position, or accept other duties. In each of these instances, it would be appropriate for another person to step in and provide the services.

**Example 2:**
Clinical team members operating within their scope of practice may each contribute to the delivery of CCM services for a beneficiary during a specific month. Each service would be aggregated together to represent the sum total of CCM services for that month.

**CCM and Complex CCM:**

1. **What is the difference between CCM and Complex CCM?**

CCM (also referred to as regular or non-complex CCM) covers 20 minutes of clinical staff time per month (CPT code 99490) for ongoing oversight, management, and care planning. In 2017, the CCM benefit was expanded to include complex CCM (CPT code 99487), which covers 60 minutes of time and allows for moderate to high complexity decision making. A second CPT add-on code (99489) was also included to allow for an additional 30 minutes of clinical staff beyond the initial 60 minutes of time each month under complex CCM. All CCM services (regular and complex) must be provided under the supervision of a physician or non-physician provider (nurse practitioner or physician assistant).
2. Can CCM and Complex CCM be provided during the same month?

During any given month, a Medicare beneficiary can receive CCM or complex CCM, but NOT both. Only one qualified provider entity can bill for CCM services each month.

Documentation and Billing:

1. Does the patient consent have to be provided in writing?

Advance consent for CCM services may be verbal or written. If the consent was verbal, there should be documentation in the electronic health record reflecting this.

2. Is it a requirement to use an electronic health care technology system to document CCM?

The health care provider responsible for billing CCM services must have a meaningful use certified electronic health record (EHR). The person-centered plan developed to initiate CCM services must be shared with all members of the team. It is acceptable for coordination of the person-centered plan to occur via fax or some other means.

While the provider must use an EHR, the CBO providing CCM under the supervision of a qualified health care provider is NOT required to use the EHR to document CCM services. There are a variety of ways that the CBO can document CCM services, e.g., a paper process or an electronic system. Regardless of the process that is used, the information must be shared with the qualified health care provider’s office and incorporated into the EHR. (Note - All EHR’s are able to scan information, which can be included as part of the record.)

Additionally, the CBO needs to establish a process to track start and stop time for services delivered, a list of the beneficiaries that receive services, and the volume of services. This process may include a superbill, encounter form, spreadsheet, or other methods. The billing information must be submitted to the qualified health care provider billing entity. There should be a clear process for how the clinical and billing information is documented, submitted to the provider, and incorporated into the EHR.

3. If we provide more than 20 minutes of CCM services during a calendar month, but not enough to bill for complex CCM, can we bill more than one unit for CPT code 99490?

No, you cannot bill for two units of CCM services during a calendar month. You can only bill for one unit of CCM services (20 minutes) during a calendar month.

4. Is copayment or coinsurance required?

Original Medicare pays 80% of the fee schedule rate for all Part B services. CCM is a Part B service; therefore, the coinsurance applies. The 20% coinsurance is the
responsibility of the beneficiary. Many beneficiaries have a private Medigap policy that covers the 20%. Others are covered by Medicare and Medicaid (dual eligibles). Medicaid serves as the Medigap policy for dual eligibles and as such, covers the coinsurance. Providers are expected to attempt to collect the coinsurance from the beneficiary or bill the appropriate Medigap policy.

CCM and DSMT:

1. **Can someone who is receiving DSMT services also receive CCM services?**

CCM services can be offered in conjunction with other Medicare Part B benefits, such as Diabetes Self-Management Training (DSMT). For example, if a beneficiary who is receiving DSMT needs assistance with transportation or has concerns about managing co-occurring chronic condition(s), CCM services can be provided to address those unmet needs. Further, CCM services can be provided prior to the start of DSMT for outreach, engagement, and transportation assistance and after the DSMT services are completed for ongoing diabetes self-management education and support and other chronic disease-related services. Offering multiple services provides a more comprehensive approach to meet the needs of the organization’s target population. Additionally, offering a menu of services from which health care providers select can give your organization a competitive advantage in the marketplace.

This project was supported, in part by grant number 90CS0058, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.