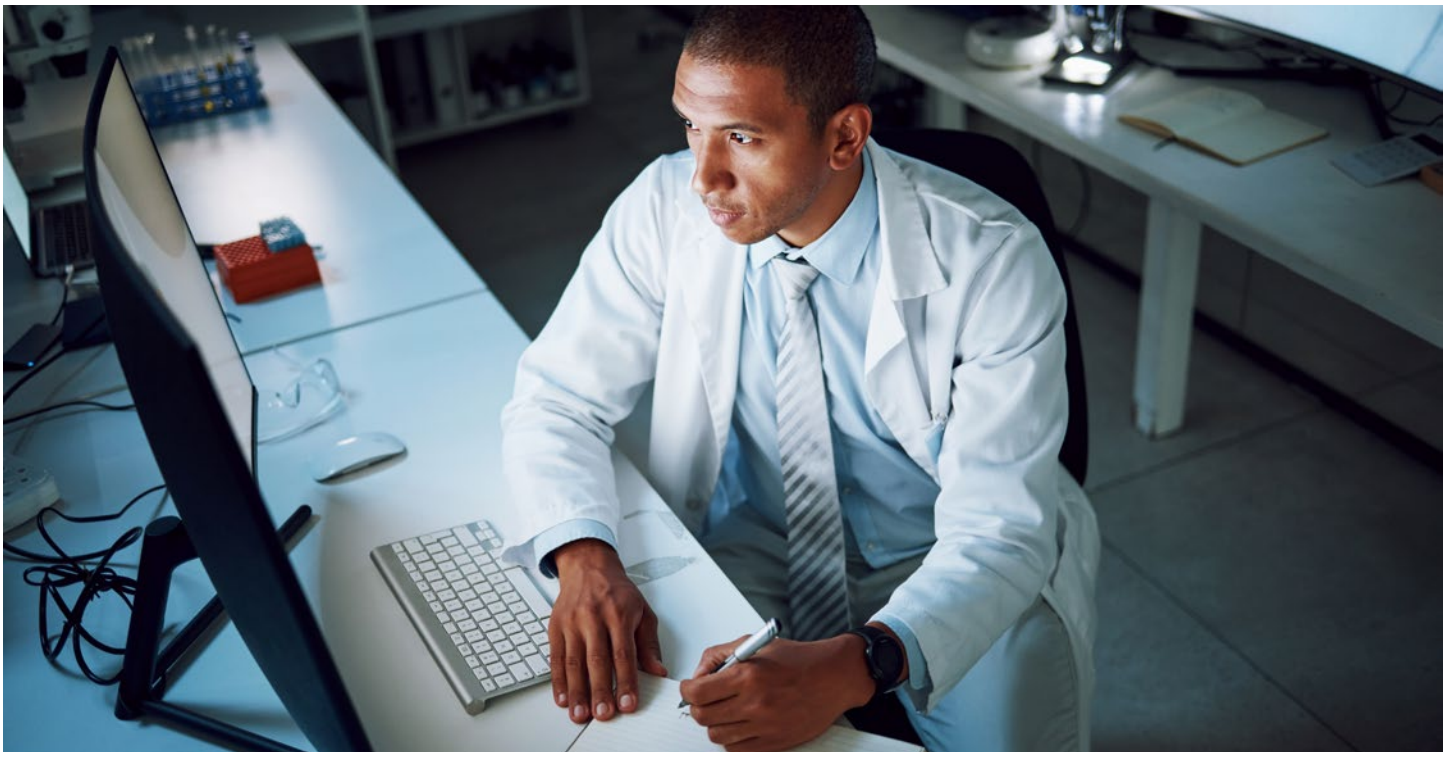
# Providing and Billing Medicare for Care Management Services

## Chronic Care Management, Complex Chronic Care Management, Principal Care Management, Advanced Primary Care Management, and Care Plan Development

Updated February 2025

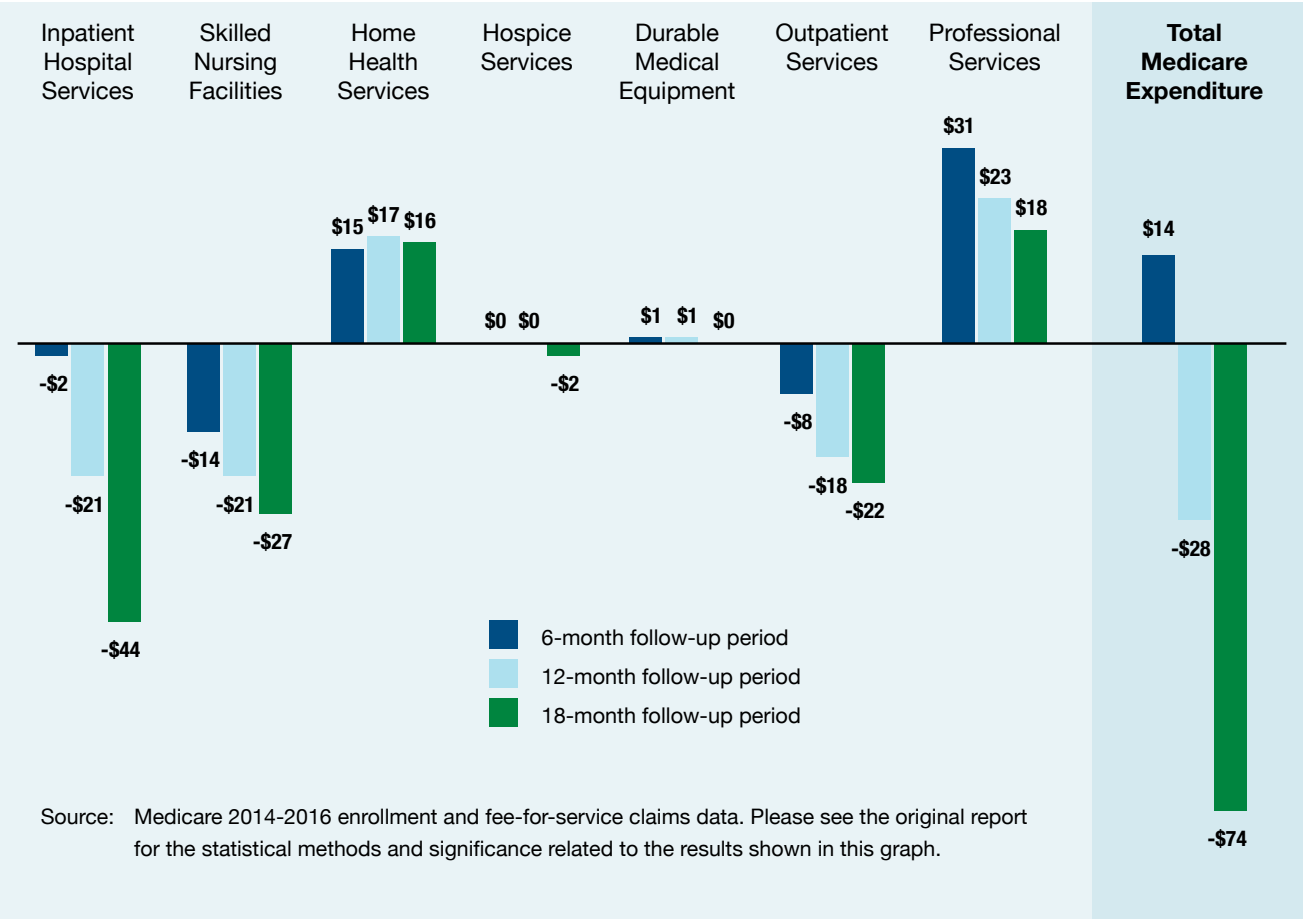


# Background

Medicare began reimbursing physicians for chronic care management (CCM) services in January 2015 under CPT® 99490[1] in response to anecdotal evidence that care management services reduce the total costs of care and improve patient outcomes.

In November 2017, the Centers for Medicare & Medicaid Services' (CMS) evaluation contractor, Mathematica, published its analysis of CCM's impact on Medicare spending from 2014 to 2016. The results were impressive: per-beneficiary-per-month (PBPM) expenditures ***decreased by $74*** for CCM beneficiaries after 18 months. Most of these savings were realized in inpatient and post-acute care, while Medicare payments to physicians actually increased.

## Estimated PBPM impact of CCM on total expenditures and by expenditure category: follow-up periods of 6,12, and 18 months




Source: Medicare 2014-2016 enrollment and fee-for-service claims data. Please see the original report for the statistical methods and significance related to the results shown in this graph.

1 Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association.

In February 2019, Mathematica published its qualitative study of Medicare beneficiaries' experience with chronic care management, finding that "[p]atients reported multiple benefits of participating in CCM services, including better access to their primary care team, improved continuity of care, and improved care coordination."

These findings make a compelling case for CCM for providers participating or preparing to participate in risk-based contracts. As CMS noted in the 2020 Medicare Physician Fee Schedule Final Rule, CCM is "increasing patient and practitioner satisfaction, saving costs, and enabling solo practitioners to remain in independent practice."

Despite this, CCM continues to be underutilized. Although two-thirds of traditional Medicare beneficiaries—about 35 million individuals— suffer from multiple chronic conditions, only a small percentage receive these services. In the year CCM was introduced (2015), approximately 8,000 physicians and non-physician practitioners billed around 1 million CCM services (CPT 99490) for about 320,000 Medicare beneficiaries. In 2022 (the most recent year for which Medicare utilization data is available), those numbers had grown to approximately 26,000 physicians and non-physician practitioners, 4.7 million CCM services, and 970,000 Medicare beneficiaries. (The 2022 numbers are only slightly higher than the numbers for 2021.)

Since 2015, CMS has made multiple revisions to the CCM billing rules and expanded coverage for related services, all for the purpose of expanding beneficiary access to care management services. In 2022, CMS adjusted the relative value units (RVUs) assigned to CCM and related services, resulting in a significant increase in Medicare reimbursement for most of these services as compared to prior years.

Also, CMS has published extensive guidance on providing and billing for these services. In fact, the agency maintains a website devoted exclusively to CCM resources.

To help providers understand the rules for billing care management services, we have condensed the regulations and related agency guidance (i.e., webinar presentations, FAQs, and Medicare Learning Network fact sheets) into the following summary.

This summary includes CCM, complex CCM, principal care management, advanced primary care management (APCM, new in 2025), and care plan development. The billing rules for remote physiologic and therapeutic monitoring (including their relationship with the CCM billing rules) are the subject of a separate PYA white paper, Providing and Billing Medicare for Remote Patient Monitoring.

***Please note:*** *Questions highlighted in yellow are those for which substantive changes have been made since 2024.*

# Chronic Care Management (CPT 99490 and 99439)

## 1. Potential Revenue

### What is the Medicare reimbursement for CCM?

As of January 1, 2025, the national payment rates for the CCM codes are as follows:

| | Non-Facility | Facility |
|---|---|---|
| CPT 99490 | $60.49 | $47.87 |
| CPT 99439 | $45.93 | $32.99 |

These rates are lower than 2024, given the 2.83% decrease in the conversion factor for 2025.

For CCM services billed as hospital outpatient department services (see discussion that follows regarding appropriate place of service for billing CCM services), CMS has assigned CPT 99490 to APC 5822, with a 2025 payment rate of $92.50 (not adjusted for labor costs). CPT 99490 has been assigned to status indicator "S," which means it is a procedure or service paid under the Medicare Outpatient Prospective Payment System (OPPS) with a separate APC payment and that no multiple procedure discount is applied. CMS has not assigned CPT 99439 to any APC.

### Does CCM qualify as a preventive service exempt from beneficiary cost-sharing?

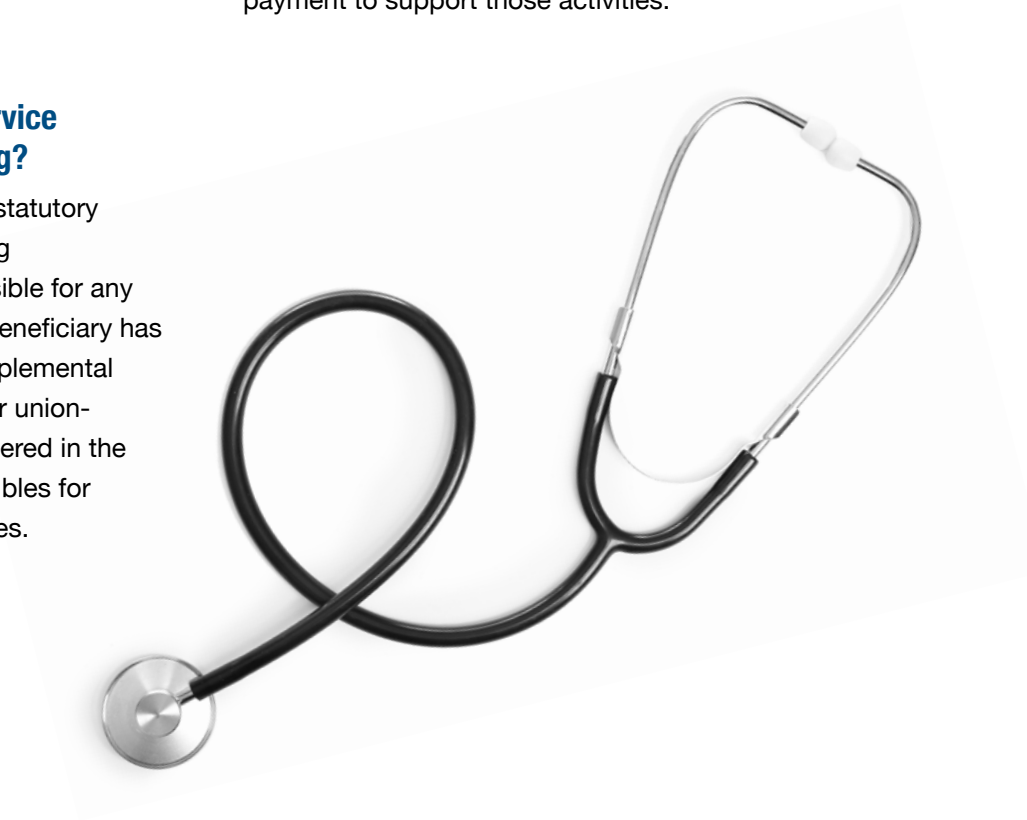
No. CMS determined it does not have the statutory authority to exempt CCM from cost-sharing requirements. A beneficiary will be responsible for any co-payments or deductible amounts. If a beneficiary has coverage under Medicaid, a Medicare Supplemental Insurance (Medigap) policy, or employer- or union-sponsored plan, these amounts will be covered in the same manner as co-payments and deductibles for regular office visits and other Part B services.

### Will Medicare Advantage (MA) plans reimburse for CCM? Commercial payers?

An MA plan must offer its enrollees at least traditional Medicare benefits, which include CCM. Many MA plans are paying for CCM in the same manner as they now pay for other physician services. Some MA plans, however, are not paying for CCM, claiming the plan itself is providing care management services directly to beneficiaries. Commercial plan coverage and payment for CCM varies.

### Are there other financial benefits associated with developing a CCM program?

In addition to direct revenue, CCM offers practitioners a bridge over the chasm between fee-for-service and risk-based contracting. By developing and implementing a CCM program, a practitioner will grow skill sets and internal processes critical to population health management, all the while receiving fee-for-service payment to support those activities.



## 2. Eligible Practitioners

### Which practitioners are eligible to bill Medicare for CCM?

Physicians (regardless of specialty), advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse-midwives (or the provider to which such individual has reassigned his/her billing rights) are eligible to bill Medicare for CCM.

Other non-physician practitioners and limited-license practitioners (e.g., clinical psychologists, registered dieticians, social workers, pharmacists) cannot bill for CCM. These practitioners, however, can participate in CCM delivery as "clinical staff," as discussed below.

### Can more than one practitioner bill for CCM for the same beneficiary for the same calendar month?

No. CMS will pay only one claim for CCM per beneficiary, per calendar month. CMS has not stated how competing claims will be resolved.

### Must a practice be recognized as a patient-centered medical home (PCMH) to provide CCM?

At one point, CMS proposed PCMH recognition as a condition to provide CCM, but the agency did not finalize that proposal. Instead, CMS requires a practice to have five specific capabilities to bill for CCM. Each of these capabilities is covered in detail later.

### Are there specific services the billing practitioner must furnish to a beneficiary as a prerequisite to providing CCM for that beneficiary?

If the billing practitioner has not seen the beneficiary in the last 12 months (or if the beneficiary is a new patient), the practitioner must discuss CCM with the beneficiary as part of a regular office visit, annual wellness visit, or initial preventive physical exam prior to billing for CCM for that beneficiary. The face-to-face visit is not a component of the CCM service, and thus may be billed separately. Such initiating visit may be conducted using telehealth only if the visit meets all the applicable requirements for coverage for a telehealth service.

An initiating visit is not required for the practitioner to bill for CCM services as long as the practitioner has had a similar visit with the beneficiary in the last 12 months.

### Are there services for which the same practitioner cannot bill for the same beneficiary during the same calendar month as CCM?

CCM cannot be billed during the same period as home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182), or certain ESRD services (CPT 90951-90970).

Also, the CPT codes for CCM provided by clinical staff (CPT 99490 and 99439) cannot be reported in the same calendar month as CPT for CCM services furnished directly by a physician/NPP (CPT 99491 and 99437) or for complex CCM (CPT codes 99487 and 99489).

Transitional care management (CPT 99495 and 99456) may be billed concurrently with CCM codes when relevant and medically necessary and if time and effort are not counted more than once.

## 2. Eligible Practitioners (cont.)

### Is CCM recognized as a rural health clinic (RHC) service and/or a federally qualified health center (FQHC) service?

Prior to 2025, RHCs and FQHCs billed for general care management services (a specified list of services including all codes discussed in this white paper with the exception of HCPCS G0506) under HCPCS G0511. Between January 1 and June 30, 2025, RHCs may continue to bill for these services under HCPCS G0511 or bill under the appropriate CPT code. Effective July 1, 2025, RHCs and FQHCs must bill under the appropriate CPT code for the service provided; reimbursement under HCPCS G0511 will be discontinued. RHCs and FQHCs will be reimbursed for general care management services billed under the appropriate CPT code at the non-facility national payment rate (with Part B deductibles) not the RHC all-inclusive rate or the FQHC PPS rate.

### Can Medicare Shared Savings Program (MSSP) participants bill for CCM?

Physician practices participating in CMS' Primary Care First program cannot bill CCM for their attributed beneficiaries. Otherwise, participation in other CMS initiatives—including the MSSP—does not disqualify a practitioner from billing CCM for any beneficiary. All CCM payments will be included in CMS' calculations of total costs of care for purposes of shared savings and bundled payment programs. Also, note CCM is included on the list of primary care services for purposes of beneficiary attribution in the MSSP.

## 3. Eligible Beneficiaries

### Who is an eligible beneficiary?

A beneficiary is eligible to receive CCM if he or she has been diagnosed with two or more chronic conditions, expected to persist at least 12 months (or until death), that place the individual at significant risk of death, acute exacerbation/decompensation, or functional decline.

CMS has not provided a definition or definitive list of "chronic conditions" for the purposes of CCM. Nor has the agency offered guidance for determining or documenting the specified acuity level. However, CMS has stated it intends for CCM services to be broadly available.

### Is there a list of chronic conditions on which a practitioner can rely?

CMS maintains a Chronic Conditions Data Warehouse (CCW), which organizes data for 70 specified chronic and other potentially disabling conditions. However, the CCW list is not an exclusive list of chronic conditions, and CMS may recognize other conditions for the purposes of providing CCM.

## 4. Beneficiary Consent

### What type of consent is required?

A signed consent form is not required as a condition of payment. Instead, the practitioner must inform the beneficiary of: (1) the availability of CCM services, (2) that only one physician can furnish and be paid for CCM during a calendar month, (3) that the beneficiary has the right to stop CCM services at any time, effective at the end of the calendar month, and (4) that the beneficiary may incur copayment/deductible responsibilities.

The practitioner must document in the beneficiary's medical record that the required information was provided and that the beneficiary explicitly accepted the services.

### When and how must the consent be obtained from the beneficiary?

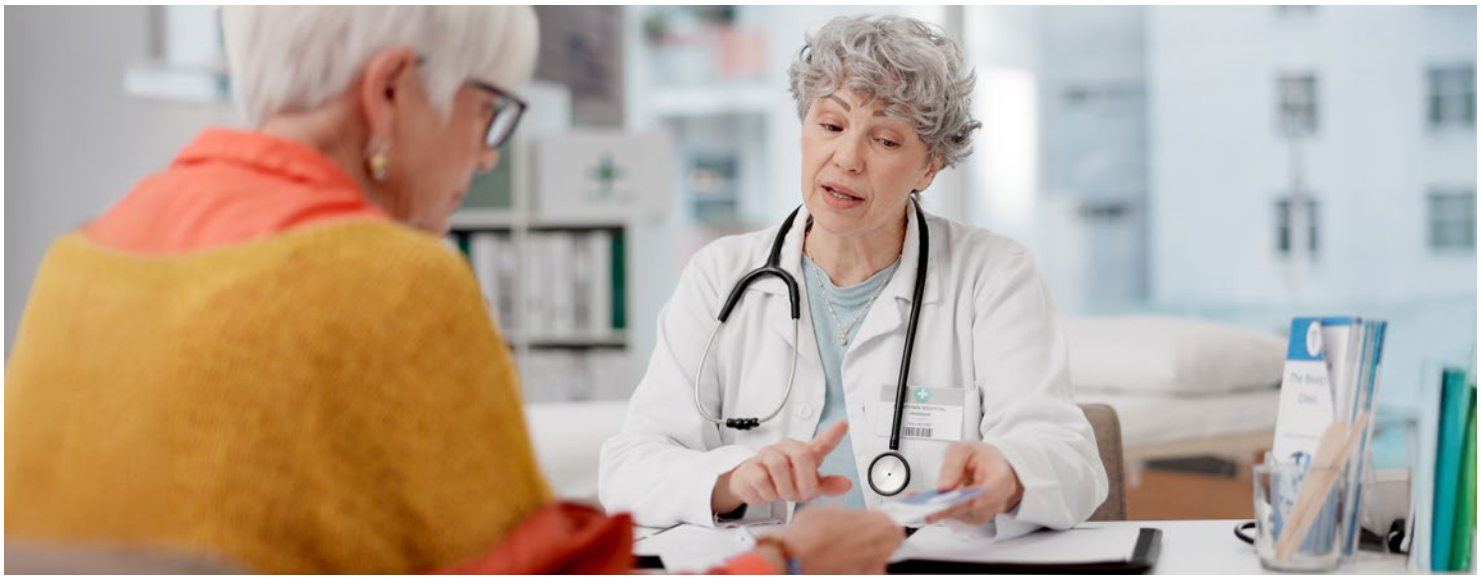
Consent must be obtained prior to submitting a claim for CCM. It is not necessary to "renew" consent; it remains effective until revoked by the beneficiary or his/her representative. A practitioner should follow his or her practice's existing policies and procedures for obtaining consent for treatment. If the beneficiary is not competent to give his or her consent to receive CCM, the required information should be provided to an individual with legal authority under applicable state law to consent to treatment on behalf of the beneficiary.

### What happens if a beneficiary revokes his or her consent?

If a beneficiary revokes his or her consent to receive CCM from a specific practitioner, that practitioner cannot bill for CCM after the then-current calendar month. The practitioner may bill for CCM for the month in which the revocation is made if the practitioner has furnished the minimum number of minutes of non-face-to-face care management services for the beneficiary.

### How does a beneficiary revoke consent?

CMS does not specify the manner in which a beneficiary must revoke consent. Presumably, if a beneficiary gives written or verbal consent to a second practitioner to furnish CCM, that action will revoke the consent given to the first practitioner. However, this can create confusion (and billing issues) if the first practitioner is unaware of the consent given to the second practitioner. CMS will presumably make payment on the first claim it receives, and deny a claim subsequently received from another provider. It would be up to this provider to appeal the denial and raise the issue of beneficiary consent.



## 5. Five Specified Capabilities

### What are the five specified capabilities a practitioner must possess to bill for CCM?

The five specified capabilities include: (1) using a certified electronic health record (EHR) for specified purposes, (2) maintaining an electronic care plan, (3) ensuring beneficiary access to care, (4) facilitating transitions of care, and (5) coordinating care.

When a practitioner submits a claim for CCM, the practitioner is, in effect, attesting to possessing each of these capabilities for providing CCM. Each is addressed in the following sections.

### For what purposes must a practitioner use a certified EHR in furnishing CCM (1st capability)?

A practitioner must use a version of certified EHR that is acceptable under the EHR Incentive Programs as of December 31 of the preceding year to record the beneficiary's demographics, problems, medications, and medication allergies. A full EHR list of problems, medications, and medication allergies must inform the care plan, care coordination, and ongoing clinical care.

### What is the requirement for an electronic care plan (2nd capability)?

The practitioner must develop and regularly update (at least annually) an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment of the beneficiary's needs. In the 2025 Medicare Physician Fee Schedule final rule, CMS clarified that "a member of the care team could draft the care plan, as appropriate, and send to the practitioner for review and approval."

The plan should include a list of current practitioners and suppliers who are regularly involved in providing medical care to the beneficiary, the assessment of the beneficiary's functional status related to chronic health conditions, the assessment of whether the beneficiary suffers from any cognitive limitations or mental health conditions that could impair self-management, and an assessment of the beneficiary's preventive healthcare needs.

The plan should address all health issues (not just chronic conditions) and be congruent with the beneficiary's choices and values.

### What items are typically included in a care plan?

According to CMS, a care plan should include the following:

- Problem list, expected outcome and prognosis, and measurable treatment goals
- Symptom management and planned interventions (including all recommended preventive care services)
- Cognitive and functional assessment
- Interaction and coordination with outside resources and practitioners and providers
- Medication management (including a list of current medications and allergies, reconciliation with review of adherence and potential interactions, and oversight of patient self-management)
- Responsible individual for each intervention
- Requirements for periodic review/revision

### Does the care plan have to be created, maintained, and updated using a certified EHR?

CMS requires a practitioner to "use some form of electronic technology tool or services in fulfilling the care plan element," but acknowledges that "certified EHR technology is limited in its ability to support electronic care planning at this time." Accordingly, practitioners "must have flexibility to use a wide range of tools and services beyond EHR technology now available in the market to support electronic care planning."

## 5. Five Specified Capabilities (cont.)

### Who must have access to the electronic care plan?

The regulations impose two requirements with respect to access to the beneficiary's care plan:

- The practitioner should timely share the care plan electronically with individuals involved in the beneficiary's care, both within and outside the billing practice.
- The practitioner must provide a copy of the care plan to the beneficiary and/or caregiver in a format consistent with patient/ caregiver preference (e.g., hard copy, electronic, or verbal).

### What is required with respect to beneficiary access to care (3rd capability)?

A practitioner furnishing CCM must:

- Provide a means for the beneficiary to access a member of the care team (who qualifies as a "member of the care team" is explained in a later section) on a 24/7 basis to address acute/urgent needs in a timely manner.
- Ensure the beneficiary can receive successive routine appointments with a designated practitioner or member of the care team.
- Provide enhanced opportunities for beneficiary-provider (or caregiver-provider) communication by telephone and asynchronous consultation methods (e.g., secure messaging).

### What is required with respect to transitions of care (4th capability)?

A practitioner must have the capability to do the following:

- Follow up with the beneficiary after an ER visit.
- Provide post-discharge TCM services as necessary (although the practitioner cannot bill for TCM and CCM during the same month except as previously noted).
- Coordinate referrals to other clinicians.
- Create and exchange timely continuity-of-care documents with other practitioners and providers (see previous information on summary care record and electronic care plan).

### What is required with respect to coordination of care (5th capability)?

The practitioner must have the capability to coordinate with home- and community-based clinical service providers (including providers of home health and hospice, outpatient therapies, durable medical equipment, transportation services, and nutrition services) to meet the beneficiary's psychosocial needs and functional deficits.

The practitioner's communication with these service providers must be documented in the beneficiary's medical record.

## 6. 20 Minutes of Care Management Services

### What level of service must be furnished to bill for CCM?

At least 20 minutes of care management services must be performed on a beneficiary's behalf during a calendar month for a practitioner to bill CPT 99490 for that month.

Prior to January 1, 2020, a practitioner would receive the same reimbursement regardless of whether 20 or 40 minutes of care management services were provided in a given month. Effective January 1, 2020, a practitioner can bill CPT 99490 for the first 20 minutes of clinical staff time spent performing CCM activities in a given calendar month and can bill CPT 99439 for the second and third 20-minute increments. We understand that some Medicare Administrative Contractors have denied claims for more than one unit of CPT 99439 in a given month for the same beneficiary, despite CMS having stated that up to two units of CPT 99439 is permitted.

### What types of services constitute care management services?

In the context of CCM, CMS identifies the following types of services performed on a beneficiary's behalf as counting toward the 20-minute time requirement: (1) performing medication reconciliation and overseeing the beneficiary's self-management of medications, (2) ensuring receipt of all recommended preventive services, and (3) monitoring the beneficiary's condition (physical, mental, and social).

This list, however, is not exclusive; other types of services may count toward the 20-minute requirement. In the context of TCM, for example, CMS identified the following additional services as non-face-to-face care management services: (1) providing education and addressing questions from the patient, family, guardian, and/or caregiver; (2) identifying and arranging for needed community resources; and (3) communicating with home health agencies and other community service providers utilized by the beneficiary.

### Can face-to-face services be included in CCM time?

According to CMS, CCM involves activities not typically or ordinarily furnished face-to-face. CMS has cautioned against including face-to-face time for CCM due to concerns about double-counting—i.e., the time counted for CCM should, in fact, be considered a component of an office visit. However, CMS has recognized there are some circumstances in which face-to-face CCM services are appropriate: "If the practitioner believes a given beneficiary would benefit or engage more in person, or for similar reasons recommends a given beneficiary receive certain CCM services in person, they may still count the activity as billable time. In all cases, the time and effort cannot count towards any other code if it is counted towards CCM."

## Who may perform care management services?

CMS anticipates "clinical staff will provide CCM services incident to the services of the billing physician" or non-physician practitioner. However, if the billing practitioner provides some services directly, his or her time also may count toward the 20-minute minimum, assuming those services are not content of another service billed by the practitioner.

The agency references the CPT definition of "clinical staff": "a person who works under the supervision of a physician or other qualified health care professional 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."

CMS clarifies that "time spent by clinical staff may only be counted if Medicare's 'incident to' rules at 42 CFR 410.26 are met for auxiliary staff (which include clinical staff)." It is the responsibility of the billing practitioner to determine if a clinical staff member is competent and capable of performing a specific service under appropriate supervision. CMS also notes that "other staff may help facilitate CCM services, but only time spent by clinical staff may be counted towards clinical staff time."

According to CMS, "[t]he billing practitioner must retain a certain level of involvement in CCM. The CCM service codes for reporting clinical staff time are valued to include a certain amount of ongoing practitioner work, including oversight, management, collaboration, and reassessment by the billing practitioner consistent with the included service elements. This work cannot be delegated or subcontracted to any other individual."

The agency also explains that a billing practitioner may arrange to have clinical staff external to the practice (e.g., a case management company) provide care management services for his or her patients, but only if all requirements for "incident to" billing are satisfied, including general supervision (see following section). CMS cautions, however, that "if there is little oversight by the billing practitioner or a lack of clinical integration between a third party providing CCM and the billing practitioner, we do not believe CCM could actually be furnished, and therefore the practitioner should not bill for CCM." Also, Medicare rules prohibit billing for services furnished by individuals located outside the U.S.

## What level of supervision is required for clinical staff providing care management services?

Initially, CMS proposed requiring direct supervision of clinical staff (i.e., billing practitioner present in the same suite of offices and immediately available to provide assistance while non-face-to-face care management services were being provided), with a limited exception for services furnished outside normal business hours.

However, the regulations now require only general supervision, meaning the billing practitioner is responsible for determining the individual has the experience and expertise to perform delegated tasks and for remaining available to provide assistance as required. There is no physical (or virtual) presence requirement for general supervision. To comply with the "incident to" rule, the physician or other practitioner billing for the service must be the same individual who provides general supervision of the clinical staff.

## What documentation is required?

CMS does not list explicit documentation requirements for care management services. In the event of an audit, a practitioner would be well-served to have the following documentation available in the beneficiary's record:

- Date and amount of time spent providing non-face-to-face services (preferably start/stop time, although this is not explicitly required)
- Clinical staff furnishing services (with credentials)
- Brief description of services

Because CCM is furnished under general supervision, it is unnecessary for the billing practitioner to review each note regarding care management services furnished by clinical staff.

In our experience, auditors are looking for variation in the care plan and the care management notes based on the patient's specific needs and circumstances. Documentation that is highly templated, and that appears to lack customization, is likely suspect.

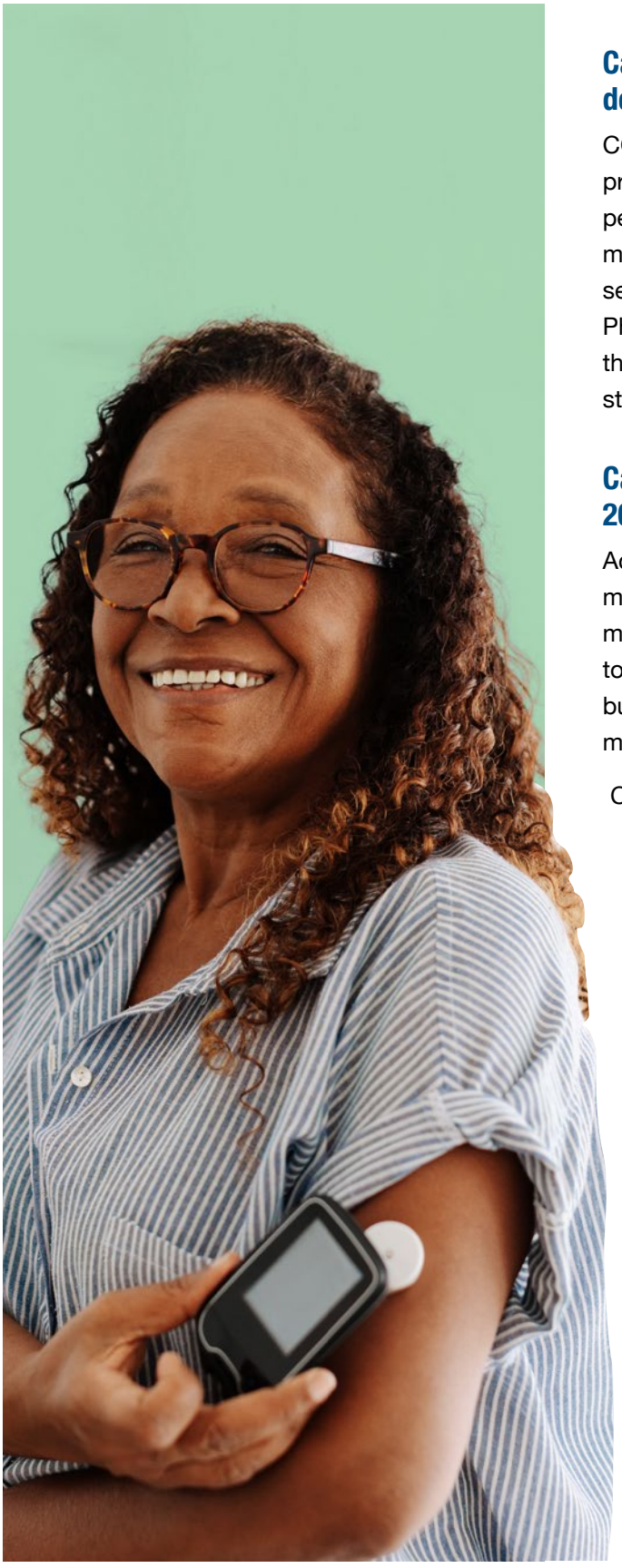
## What time counts toward the 20-minute minimum requirement?

Time spent providing services on different days, or by different clinical staff members in the same calendar month, may be aggregated to total 20 minutes, depending on the CCM code. However, if two staff members are furnishing services at the same time, only the time spent by one individual may be counted. Time of fewer than 20 minutes during a calendar month cannot be rounded up to meet this requirement, nor may time be carried over from a prior month.

If clinical staff provide CCM services to multiple beneficiaries at the same time, or perform a single activity that will benefit multiple beneficiaries, the time spent by clinical staff must be split among the beneficiaries (as opposed to counting the same time toward multiple beneficiaries).

## Can CCM services furnished on the same day as an office visit be counted toward the 20-minute minimum requirement?

CMS has stated that "[t]ime or effort that is spent providing services within the scope of the CCM service, on the same day as an E/M visit or other E/M service that Medicare and CPT allow to be reported during the CCM service period, can be counted towards CCM codes as long as the time is not counted towards other reported E/M code(s). We note that time and effort cannot be counted twice, whether face-to-face or non-face-to-face, and Medicare and CPT provisions specify certain codes that can never be billed during the CCM service period."



## Can a practitioner practicing in a hospital outpatient department bill for CCM? Can the hospital bill for CCM?

CCM is billed with the site of service at which the billing practitioner primarily practices. While "incident to" billing is not permitted in a facility setting, CMS has clarified CCM services may be furnished in a hospital outpatient department. In this setting, the billing practitioner is reimbursed under the Medicare Physician Fee Schedule for the supervision of hospital staff while the hospital is reimbursed for the expenses associated with such staff under the Hospital Outpatient Prospective Payment System.

## Can remote monitoring be counted as part of the 20-minute time requirement?

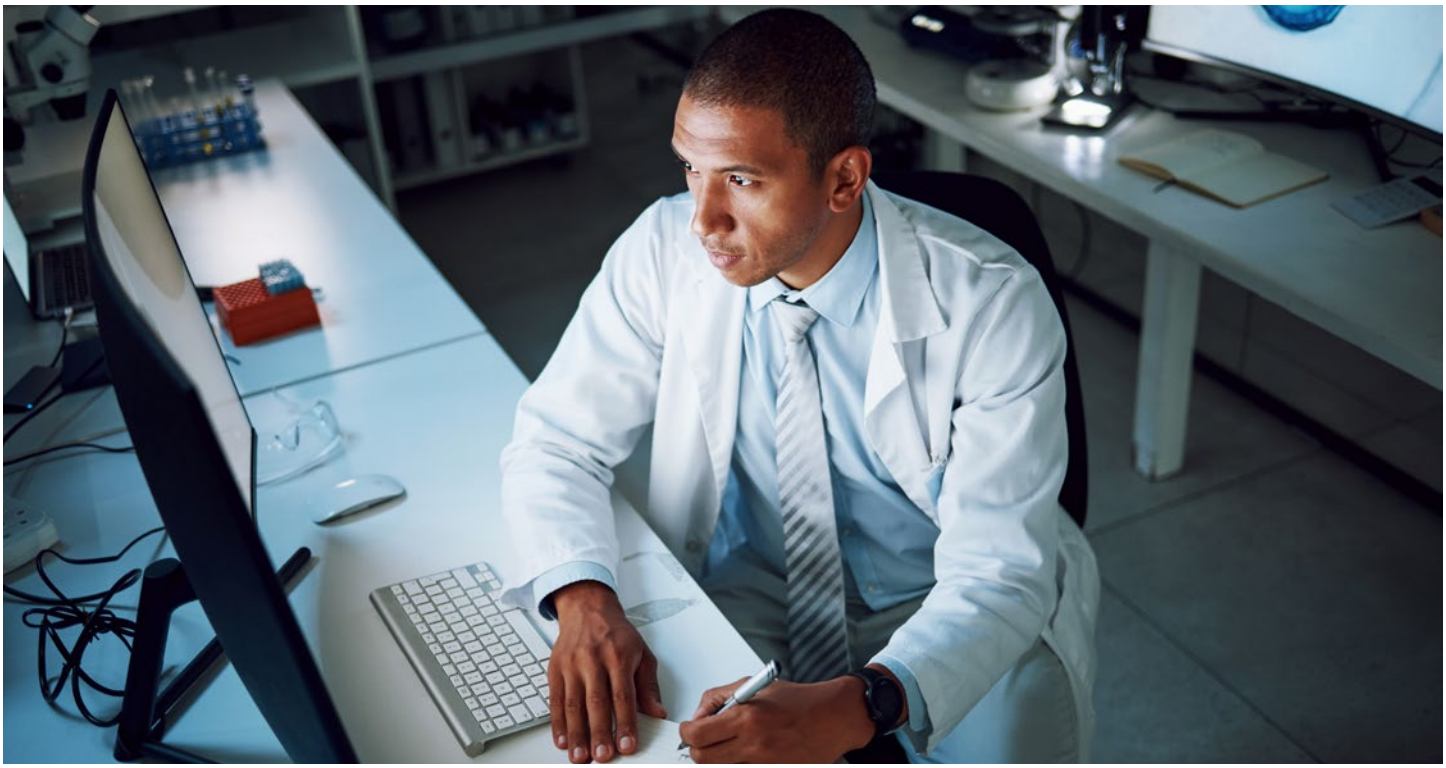
According to CMS, "[p]ractitioners who engage in remote monitoring of patient physiological data of eligible beneficiaries may count the time they spend reviewing the reported data towards the monthly minimum time for billing the CCM code, but cannot include the entire time the beneficiary spends under monitoring or wearing a monitoring device."

CMS has clarified that "in order to bill CPT 99490, such activity cannot be the only work that is done—all other requirements for billing CPT 99490 must be met in order to bill the code."

CMS now provides separate reimbursement for remote physiologic monitoring (RPM) under CPT 99453, 99454, 99091, 99457, and 99458, and for remote therapeutic monitoring (RTM) under CPT 98976, 98977, 98978, 98980, and 98981. For a complete description of the Medicare RPM and RTM billing rules, please see our white paper, "Providing and Billing Medicare for Remote Patient Monitoring."

CMS describes remote monitoring as "complementary to CCM," and therefore, can be billed once per patient during the same service period as CCM, as long as requirements for both codes are met independently.

Remember, time spent furnishing these services cannot be counted toward both codes for a single month.



## 7. Billing for CCM

### When filing a claim for CCM, what should be listed as the date of service?

The billing practitioner may list the date of service as the day on which the 20-minute minimum requirement is satisfied, or any day thereafter through the end of the calendar month. Because it is considered an add-on code, claims for CPT 99439 must have the same date of service as the claim for CPT 99490. If the beneficiary dies during the month, the claim for CCM will be paid only if the date of service is prior to the date of death.

### What should be listed as the place of service?

The billing practitioner must list the place of service as the location at which he or she would ordinarily furnish a face-to-face office visit with the beneficiary. Thus, a practitioner who practices in a hospital outpatient department must list “22” as the place of service on the CCM claim form, triggering payment at the facility rate.

According to CMS, one can provide CCM services to beneficiaries in skilled nursing facilities, nursing facilities, assisted living, or other facility settings. Again, the place of service would be the location at which the practitioner would ordinarily furnish a face-to-face office visit with the beneficiary.

# Chronic Care Management (CPT 99491 and 99437)

## How does one bill for care management services furnished by a practitioner directly (as opposed to services furnished by clinical staff under the general supervision of a practitioner)?

Effective January 1, 2019, CMS reimburses for CCM services personally performed by a practitioner (as opposed to services furnished by clinical staff under a practitioner's supervision) under CPT 99491. To bill for this service in a given month, a practitioner (as opposed to 20 minutes for CPT 99490) must perform a minimum of 30 minutes of CCM services. For the second and third 30-minute increments, the practitioner may bill CPT 99437. The entire 30 minutes must be personally performed by the practitioner. If, for example, in a given month, clinical staff performs 10 minutes of service and the practitioner performs 20 minutes, the practitioner could only bill CPT 99490. Otherwise, the billing rules for CPT 99491 and 99437 are the same as the rules that apply to 99490 and 99439.

## What is the Medicare reimbursement for CCM for which the practitioner personally performs the care management services?

As of January 1, 2025, the national payment rates are as follows:

| | Non-Facility | Facility |
|---|---|---|
| CPT 99491 | $82.16 | $72.46 |
| CPT 99437 | $57.58 | $47.87 |

For CCM services billed as hospital outpatient department services, CMS has not assigned CPT 99491 or 99437 to any APC.

## What payment is available for time spent by a physician or non-physician practitioner outside usual office visits addressing an individual patient's needs?

Prior to 2023, CMS reimbursed physicians and non-physician practitioners for prolonged E/M services under CPT 99358 (first 60 minutes) and 99359 (each additional 30 minutes). However, CMS eliminated this reimbursement in 2023.

In their place, CMS created HCPCS G2212 to be used for prolonged E/M services that exceed the maximum time for a level 5 office/outpatient E/M visit (CPT 99205 or 99215) by at least 15 minutes on the date of service.

| Code | Description | Non-Facility | Facility |
|---|---|---|---|
| G2212 | Prolonged office or other outpatient E/M service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact | $31.05 | $29.76 |

# Complex CCM (CPT 99487 and 99489)

## What is the difference between CCM and complex CCM?

Effective January 1, 2017, practitioners can bill CPT 99487 for complex CCM. The billing rules for CCM and complex CCM are the same, except: (1) complex CCM requires 60 minutes of non-face-to-face care management services per month, as compared to 20 minutes for CCM, and (2) the beneficiary's condition must be such as to require medical decision-making of moderate-to-high complexity on the part of the billing physician.

## Is there additional reimbursement available if more than 60 minutes of care management services are provided?

CMS will pay for an add-on code, CPT 99489, with complex CCM (CPT 99487), for each 30-minute increment that goes beyond the initial 60 minutes of non-face-to-face care management services in a given month.

Neither CPT 99487 nor CPT 99489 may be billed in the same month as CPT 99490 or 99491.

Note there is no CPT code (and no separate Medicare reimbursement) for complex CCM for which a practitioner personally performs the care management services.

## What is the reimbursement for complex CCM?

As of January 1, 2025, the national payment rates are as follows:

| Code | Non-Facility | Facility |
|---|---|---|
| 99487 | $131.65 | $87.01 |
| 99489 | $70.52 | $47.23 |

For CCM services billed as hospital outpatient department services, CMS has assigned CPT 99487 to APC 5823 with a 2025 payment rate of $160.67 (not adjusted for labor costs). CPT 99487 has been assigned to status indicator "S," which means it is a procedure or service paid under the Medicare OPPS with a separate APC payment and that no multiple procedure discount is applied. CMS has not assigned CPT 99489 to any APC.

## What guidance is available to providers regarding complex CCM?

All the billing rules for CCM (CPT 99490) apply to complex CCM, except the time and medical decision-making requirements.

# Principal Care Management (CPT 99424, 99425, 99426, and 99427)

## Does CMS reimburse for care management services for beneficiaries who have only one chronic condition?

Effective January 1, 2020, CMS reimburses for principal care management (PCM) furnished to beneficiaries with a single chronic condition to stabilize that condition following exacerbation or hospitalization. Unlike CCM, which requires management of total patient care, PCM focuses on disease-specific care. While CCM typically is furnished by primary care physicians, PCM typically is furnished by specialists.

## How do the billing rules for PCM differ from CCM?

*First*, PCM requires 30 minutes of care management services per month, as opposed to 20 minutes. Effective January 1, 2022, CMS reimburses for additional 30-minute increments of PCM services. Although CMS has not explicitly limited the number of units of CPT 99425 and 99427 (the PCM add-on codes) that may be billed in a given month, the National Correct Coding Initiative includes a Medically Unnecessary Edit (MUE) limiting both codes to two units per day.

*Second*, a practitioner billing for PCM must document in the patient's record ongoing communication and care coordination between all practitioners furnishing care to the beneficiary.

*Third*, a practitioner cannot bill for interprofessional consultations or other care management services (excluding RPM) for the same beneficiary for the same period as PCM. Otherwise, the same requirements apply to CCM and PCM.

## What is the reimbursement for PCM?

PCM services involving care management services furnished by clinical staff under general supervision are billed under CPT 99426 and 99427, while services personally performed by a practitioner are billed under CPT 99424 and 99425. Here are the 2025 national payment amounts for these codes:

| | Non-Facility | Facility |
|---|---|---|
| 99424 | $80.87 | $72.13 |
| 99425 | $58.87 | $49.17 |
| 99426 | $61.78 | $47.55 |
| 99427 | $50.46 | $34.29 |

For PCM services billed as hospital outpatient department services, CMS has assigned CPT 99426 to APC 5822, with a 2024 payment rate of $92.50 (not adjusted for labor costs). CPT 99426 has been assigned to status indicator "S," which means it is a procedure or service paid under the Medicare OPPS with a separate APC payment and that no multiple procedure discount is applied. CMS has not assigned CPT 99424, 99425, or 99427 to any APC.

## Can CCM and PCM be billed concurrently?

According to CMS, CCM and PCM cannot be billed by the same practitioner for the same patient in the same month. However, it is allowable, for instance, for a primary care practitioner to offer CCM and a specialist to offer PCM (or vice versa, as appropriate). The conditions being addressed by CCM and PCM must be different.

If CCM and PCM are provided concurrently, two care plans would be required. Note, however, that for PCM, the care plan needs only to be "disease-specific."

# Medicare Coverage and Reimbursement for Advanced Primary Care Management

## What's the purpose of advanced primary care management (APCM)?

Since 2012, the Center for Medicare & Medicaid Innovation (CMMI) has sponsored a series of voluntary alternative payment models involving capitated payments for primary care providers to implement and sustain patient-centered team-based care, including the Comprehensive Primary Care initiative (2012-2016), Comprehensive Primary Care Plus (2017–2021), Primary Care First (2021–2025), and Making Care Primary (2024–2034).

In each model, the amount of the capitated payment is tied to the number of Medicare beneficiaries attributed to the participating provider. A beneficiary is attributed to a provider based on historical services, such as having furnished the plurality (i.e., more than any other provider) of primary care services for the beneficiary during a specified time period. These capitated payments fund the establishment and maintenance of the infrastructure to provide advance primary care services, including staff and technology.

Applying the lessons learned from these models, CMS created new reimbursement under the Medicare Physician Fee Schedule for advanced primary care management (APCM) effective January 1, 2025. Rather than a capitated payment based on beneficiary attribution, however, providers bill for a monthly bundle on a per beneficiary basis, the amount of which is based on the complexity of the beneficiary's condition as opposed to the amount of time spent furnishing services to the beneficiary.

APCM combines elements of several existing care management and communication technology-based services for which Medicare separately reimburses. The monthly bundle reflects the essential elements of advanced primary care, including CCM, PCM, and transitional care management, as well as communication technology based services (virtual check-ins, remote evaluations of pre-recorded patient information, interprofessional consultations).

## Who can bill for APCM?

Physicians and non-physician practitioners can bill for APCM for those beneficiaries for whom they are responsible for all primary care services and for whom they are the focal point for all needed healthcare services. CMS has not provided any specific standards to be applied in determining whether a practitioner meets these criteria with respect to a specific beneficiary (i.e., minimum number of services provided). APCM billing is not limited to practitioners in specific specialties.

## What is the Medicare reimbursement for APCM?

| Service | Qualifying Condition | Non-Facility National Payment Rate | Facility National Payment Rate |
|---|---|---|---|
| G0556 | None | $15.20 | $11.97 |
| G0557 | 2 or more chronic conditions expected to last ≥ 12 months or until patient's death that place patient at significant risk of death, acute exacerbation/ decompensation, or functional decline | $48.84 | $36.23 |
| G0558 | Same and G0057 + individual is a Qualified Medicare Beneficiary | $107.07 | $79.90 |

For APCM billed as hospital outpatient department services, CMS has assigned G0556 and G0557 to APC 5821 with a 2025 payment rate of $29.72 (not adjusted for labor costs) and G0558 to APC 5822 with a 2025 payment rate of $92.50. All three codes have been assigned to status indicator "S," which means it is a procedure or service paid under OPPS with a separate APC payment and that no multiple procedure discount is applied.

APCM can be billed once per beneficiary per calendar month. According to CMS, "[T]his helps remove some of the burden of billing with individual, time-based care management codes," approximating a capitated payment within a strictly fee-for-service model. CMS further states, "[Y]ou can bill using an APCM HCPCS code once per month when you meet the billing requirements," presumably with the last day of the month as the date of service. CMS has not addressed whether APCM can be billed for a partial month, (e.g., beneficiary consent is not given until the 15th of the month).

## Is APCM exempt from beneficiary cost-sharing?

No. CMS determined it does not have the statutory authority to exempt APCM from cost-sharing requirements. A beneficiary will be responsible for any co-payments or deductible amounts. If a beneficiary has coverage under Medicaid, a Medicare Supplemental Insurance (Medigap) policy, or employer- or union-sponsored plan, these amounts will be covered in the same manner as co-payments and deductibles for regular office visits and other Part B services.

## Does APCM require consent and an initiating visit?

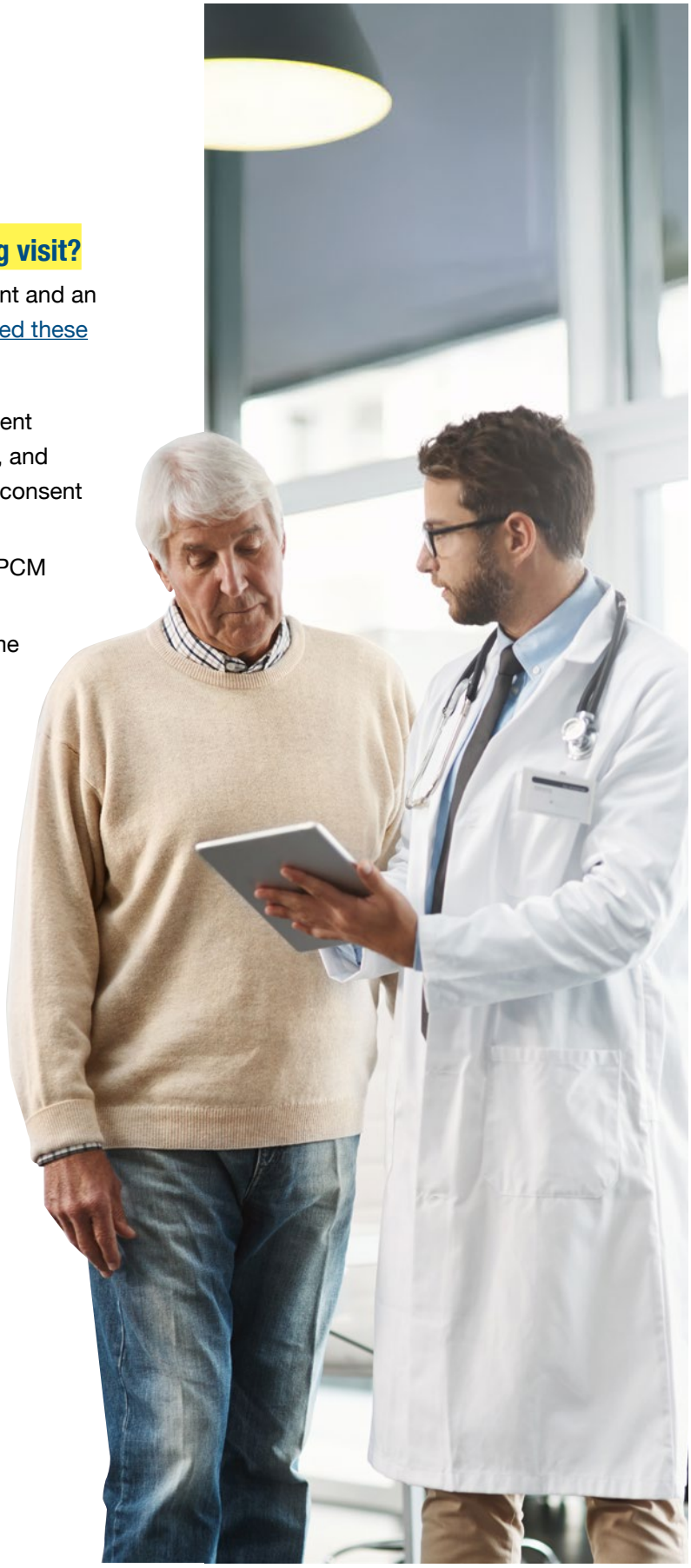
Like CCM and PCM, APCM requires patient consent and an initiating visit for new patients. CMS has summarized these requirements as follows:

- ***Get patient consent.*** Get written or verbal consent from the patient to participate in APCM services, and document it in the patient's medical record. The consent must inform your patient that:
  - Only 1 provider can furnish and be paid for APCM services during a calendar month
  - They have the right to stop services at any time
  - Cost sharing may apply to the patient

  Get consent before you start APCM services. You only need to get consent once.

- ***Conduct an initiating visit*** (paid separately) for new patients. You don't need to conduct this visit if you or another provider in your practice have:
  - Seen the patient within the past 3 years
  - Provided another care management service (APCM, CCM, or PCM) to the patient within the past year

  The Medicare Annual Wellness Visit (AWV) may qualify as the initiating visit if the provider that will be responsible for providing APCM care performs the AWV.



## What practice capabilities are required for APCM?

To bill for APCM, the provider must have specified practice capabilities and provide these services for the beneficiary when clinically appropriate. Like CCM, these services may be furnished by clinical staff under the general supervision of the billing practitioner. Not all services must be provided each month, and a minimum number of minutes of service is not required. CMS has summarized the required practice capabilities as follows, which are substantially similar to the requirements for CCM and PCM:

- ***Provide 24/7 access and continuity of care***, including:
  - 24/7 access for your patients or their caregivers with urgent needs to contact you or another member of the care team
  - Real-time access to the patient's medical information
  - The ability for the patient to schedule successive routine appointments with a designated member of the care team
  - Care delivery in alternative ways to traditional office visits, like home visits or expanded hours
- ***Provide comprehensive care management***, including:
  - Systemic needs assessments (medical and psychosocial)
  - System-based approaches to ensure receipt of preventive services
  - Medication reconciliation, management, and oversight of self-management
- ***Develop, implement, revise, and maintain an electronic patient-centered comprehensive care plan.***
  - The care plan must be available within and outside the billing practice, as appropriate, to individuals involved in the patient's care
  - Members of the care team must be able to routinely access and update the care plan
  - You must also give a copy of the care plan to the patient or caregiver
- ***Coordinate care transitions*** between and among health care providers and settings, including:
  - Referrals to other providers
  - Follow-up after an emergency department visit
  - Follow-up after discharge from a hospital, skilled nursing facility (SNF), or other health care facility

  Coordination of care transitions must include:
  - Timely exchange of electronic health information with other health care providers
  - Timely follow-up communication (direct contact, phone, or electronic) with the patient or caregiver within 7 days of discharge from an emergency department visit, hospital, SNF, or other health care facility, as clinically indicated
- ***Coordinate practitioner, home-, and community-based care.*** You must provide ongoing coordinating communication and documentation on the patient's psychosocial strengths, functional deficits, goals, preferences, and desired outcomes from practitioners, home- and community-based service providers, community-based social service providers, hospitals, SNFs, and others.
- ***Provide enhanced communication opportunities***. You must:
  - Offer asynchronous, non-face-to-face consultation methods other than the phone, like secure messaging, email, internet, or a patient portal
  - Be able to conduct remote evaluation of pre-recorded patient information and provide interprofessional phone, internet, or electronic health record (EHR) referral services
  - Be able to use patient-initiated digital communications that require a clinical decision, like virtual check-ins, digital online assessment and management, and evaluation and management (E/M) visits (or e-visits)

## Must a provider satisfy additional prerequisites to bill APMC?

In addition to these practice capabilities, a provider must engage in patient population-level management and measure and report performance in a specified manner to be eligible to bill for APCM for any beneficiary. CMS has summarized these prerequisites as follows:

- ***Conduct patient population-level management***. You must
  - Analyze patient population data to identify gaps in care
  - Risk-stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients
- ***Measure and report performance***, including assessment of primary care quality, total cost of care, and meaningful use of Certified EHR Technology (CEHRT). You can either
  - Report the value in Primary Care MIPS Value Pathway (MVP). A provider must report CY2025 performance for this MVP by the 2026 MIPS reporting deadline.

    or
  - Participate in a Medicare Shared Savings Program Accountable Care Organization (ACO), Realizing Equity, Access, and Community Health (REACH) ACO, Making Care Primary model, or Primary Care First model

## What services cannot be billed in the same month as APCM?

A practitioner cannot bill for any of the following services in the same calendar month for which the practitioner bills APCM:

- Chronic care management – CPT 99487, 99489, 99490, 99491, 99439, 99437, and HCPCS G0506
- Principal care management – CPT 99424-99427
- Transitional care management – CPT 99495, 99496
- Interprofessional internet consultations – CPT 99446-99449, 99451, 99452
- Remote evaluation of patient videos/images – HCPCS G2250
- Virtual check-in – HCPCS G2251, G2252

A practitioner, however, may bill concurrently for other medically necessary care management services, including behavioral health integration, community health integration, principal illness navigation, principal illness navigation – peer support, SDOH risk assessment, remote physiologic monitoring, and remote therapeutic monitoring.

## If a practitioner has furnished CCM or PCM for a beneficiary on an ongoing basis but fails to meet the required number of minutes in a given month, can the practitioner bill for APCM for that month? Could the practitioner then bill for CCM or PCM in the following month if the minimum number of minutes requirement was satisfied?

In the 2025 Medicare Physician Fee Schedule final rule, CMS notes, "[P]ractitioners who currently furnish monthly care management services may already be providing APCM services in a variety of clinical circumstances, documenting all necessary aspects of the patient-centered care furnished monthly to the patient without meeting the requirements to bill for care management services, such as satisfying the administrative requirement to count clinical staff minutes to reach specific time-based thresholds." CMS gives a specific example of a practitioner who does not meet the requirements to bill PCM in a given month having only furnished 20 minutes of care coordination during that month (PCM requires 30 minutes per month).

CMS implies a practitioner could bill APCM in such circumstances, provided (1) the patient has consented to receive APCM (prior consent for CCM or PCM would not be sufficient); and (2) the practitioner maintains the required practice capabilities, conducts patient population-level management, and measures and reports performance as specified above. In effect, APCM provides a reimbursement "floor" to maintain the infrastructure for care management services for those months when the practitioner cannot bill CCM or PCM.

# Care Plan Development

## How are practitioners reimbursed for their time and effort in developing a patient's care plan?

Prior to January 1, 2017, CMS considered the reimbursement for E/M services to include care plan development. Now, CMS will pay practitioners for care plan development under a new code, HCPCS G0506. This add-on code is to be listed separately, in addition to the CCM-initiating visit, and billed separately from monthly care management services.

There is no specific time requirement associated with G0506. However, CMS cautions providers that this code should be billed only if the time and effort involved in care plan development are beyond the usual time and effort involved in the underlying E/M service. Also, the code may be billed only one time, at the initiation of CCM services. Time and effort involved in revising a beneficiary's care plan still are not separately reimbursed.

CMS has clarified that the date of service for G0506 should be the same as the base initiating-visit code. The face-to-face assessment should be performed the same day as the initiating visit, although CMS recognizes that some, or all, care planning could be completed on a subsequent day.

RHCs and FQHCs cannot bill for G0506.

## What is the reimbursement for care plan development?

The 2025 national payment amounts for G0506 are $60.81 (non-facility) and $41.73 (facility). CMS has not assigned any APC to G0506.

For more information about providing and billing Medicare for chronic care management, principal care management, advanced primary care management, and related services, contact:

**Martie Ross**
Principal
mross@pyapc.com
(800) 270-9629

**Lori Foley**
Principal
lfoley@pyapc.com
(800) 270-9629





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