FAQ: Chronic Care Management and Principal Care Management

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Ambulatory Care Practitioners

Purpose

This document aims to answer frequently asked questions about the provision of and billing for Chronic Care Management and Principal Care Management services. Other opportunities for revenue generation are not discussed here. All services must be furnished in accordance with applicable State law.

For other billing information, please review other documents in the ASHP Resource Center.

What are CCM and PCM?

Chronic Care Management (CCM) is a program designed to provide additional support and coordination for Medicare Part B beneficiaries with two or more chronic conditions that are expected to last at least 12 months, or until the death of the patient.

Principal Care Management (PCM) is a program designed to support Medicare Part B beneficiaries with a single, high-risk disease or complex chronic condition who require significant management for their condition outside of the primary care setting. PCM services may be expected to last 3 months to 1 year, or until the death of the patient.

Under CCM and PCM, eligible patients receive non-face-to-face care coordination services from their healthcare providers. These services typically include:

- Development and update of a care plan (single disease for PCM; comprehensive for CCM)
- Coordination of care between healthcare providers
- Regular follow-up with patients to monitor the condition(s) and ensure adherence to the care plan and medications
- Management of transitions of care, such as hospital discharges
- Access to 24/7 telephone or electronic communication with healthcare providers
- Patient and caregiver education and support to promote self-management of the condition(s)

Although CCM and PCM services are typically provided non-face-to-face, if activities are provided face-to-face for convenience or patient benefit, the time may be counted towards CCM/PCM. Examples of face-to-face activities are patient education or motivational counseling. The time and effort for face-to-face services cannot count towards any other code if it is counted towards CCM/PCM (i.e., cannot count face-to-face time for an encounter towards both E/M office visit and CCM/PCM).

CCM and PCM aim to improve care coordination, reduce healthcare costs, and ultimately enhance the quality of life for patients with chronic conditions. While CCM and PCM have many similarities, CCM may be better suited for use in the primary care setting, while PCM may be better suited for use in a specialist setting where there is an emphasis on a single high-risk condition and the coordination of care for that condition.

Where can CCM and PCM services be provided?

Physicians' offices (both independent and hospital-owned), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Critical Access Hospitals (CAHs). Please note that RHCs and FQHCs have different billing codes.

Initiating CCM and PCM Services

For new patients or patients not seen within a year prior to the start of CCM/PCM services, CCM/PCM must be initiated by a qualified healthcare provider during a "comprehensive" Evaluation/Management (E/M) office visit (99212-99215), Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE). This initial *face-to-face* visit is not part of the CCM/PCM service and can be billed separately. E/M visits and AWVs provided via telehealth can serve as the CCM/PCM initiating visit. Established patients seen within the past year can have CCM/PCM initiated without the need for a separate in-office visit, but patient consent should still be documented in the patient's medical record.
Patient consent can be either written or verbal and must include informing patient of the CCM/PCM service available, the potential cost sharing responsibilities to the beneficiary, that only one practitioner can furnish and bill CCM services per calendar month, and that they can stop CCM/PCM services at any time (effective the end of the calendar month). Patients only need to provide informed consent once per provider. Of note, most dual-eligible (Medicare with supplementary Medicaid) and those with Medigap or other supplemental coverage are not responsible for monthly cost-sharing.

Who can provide and bill for CCM and PCM?

The following qualified healthcare providers (QHPs) can provide and bill for CCM/PCM services: physicians (MD, DO), nurse practitioners (NP), physician associates (PA), clinical nurse specialists (CNS), and certified nurse midwives (CNM). Only one QHP per patient may be paid for CCM services for a given calendar month, while multiple practitioners per patient may be paid for PCM services for a given calendar month.

CCM services may also be provided by clinical staff that meet Medicare's "incident to" rules. Licensed clinical staff include the following: clinical pharmacists, nurses (RN, LPN), licensed clinical social workers (LCSW), or medical assistants (MA, CMA). The time spent by clinical staff members providing CCM services directed by a QHP counts towards the time thresholds. Non-clinical staff time cannot be counted.

Payment and applicable HCPCS/CPT codes for CCM and PCM

Billing codes and reimbursement can vary based on who is furnishing the service and the duration of time spent with the patient. Below is a summary of HCPCS and CPT codes currently available for

services furnished around CCM and PCM. Please note the code descriptors in their full detail can be found in the CMS MLN document.[1]

Chronic Care Management

Initiating Visit:
QHP who personally furnish extensive assessment and care planning outside the usual effort described by the initiating visit and CCM codes may also bill HCPCS code G0506. This code can only be billed once per patient, as part of the initiating visit.

Code	Descriptor
G0506	Comprehensive assessment of and initial care planning by the QHP for patients requiring CCM services

The following CPT codes may be billed for CCM services furnished by either the QHP, or clinical staff directed by the QHP (e.g., pharmacists):

Code	Descriptor
99490	**CCM Base:** First 20 minutes of CCM services per calendar month; max 1 unit per month
99439	**CCM Base Add-on:** Each additional 20 minutes of CCM services per calendar month; max 2 units per month
99487	**Complex CCM:** First 60 minutes per calendar month; requires substantial revision of comprehensive care plan, moderate or high complexity medical decision making; max 1 unit per month
99489	**Complex CCM Add-on:** Each additional 30 minutes per calendar month; requires substantial revision of comprehensive care plan, moderate or high complexity medical decision making

The following CPT codes may be billed for CCM services furnished **directly by the QHP**:

Code	Descriptor
99491	**CCM Provider:** First 30 minutes of QHP time per calendar month; max 1 unit per month
99437	**CCM Provider Add-on:** Each 30 minutes of QHP time per calendar month; max 2 units per month

CCM payment considerations and exclusions:

- CCM Base, Complex CCM, and CCM Provider CPT codes cannot be billed for the same calendar month.
- CCM codes cannot be billed during the same service period as Home Healthcare Supervision (HCPCS G0181 or G0182) and certain End-Stage Renal Disease services (CPT 90951-90970).
- Complex CCM codes cannot be billed during the same service periods as above and the same

calendar month as prolonged Evaluation and Management (E/M) services.
- CCM and Complex CCM can be billed for services furnished during the 30-day TCM service period (CPT 99495, 99496).
- You cannot count time toward the CCM service code for any other billed code.

Principal Care Management

The following CPT codes may be billed for PCM services furnished by either the QHP, or clinical staff directed by the QHP (e.g., pharmacists)

Code	Descriptor
99426	**PCM Base:** First 30 minutes of PCM per calendar month; max 1 unit per month
99427	**PCM Base Add-on:** Each additional 30 minutes of PCM per calendar month; max 2 units per month

The following CPT codes may be billed for CCM services furnished **directly by the QHP**:

Code	Descriptor
99424	**PCM Provider:** First 30 minutes of QHP time per calendar month; max 1 unit per month
99425	**PCM Provider Add-on:** Each 30 minutes of QHP time per calendar month; max 2 units per month

PCM payment considerations and exclusions:
- PCM Base and PCM Provider CPT codes cannot be billed for the same calendar month.
- CCM and PCM cannot be billed by the same practitioner for the same patient in the same month.
- It is allowable for a primary care provider to offer CCM and a specialist to offer PCM, as appropriate.
- If CCM and PCM are provided concurrently, two care plans are required.

RHCs and FQHCs

The following CPT code may be billed for CCM and/or PCM services furnished **within an RHC or FQHC**:

Code	Descriptor
G0511	**CCM RHC or FQHC:** 20 minutes of general care management (including CCM) per calendar month; max 1 unit per month for each service

Medicare Reimbursement for CCM and PCM

Exact payment information can be found at CMS Physician Fee Schedule Look-up Tool and is dependent upon geography and if the billing location is a facility or non-facility setting.
Be sure to regularly review the MAC* regulations in your region, as each MAC has the discretion to interpret the regulations and provide additional requirements. More information regarding your

state's MAC can be found at Find Your Medicare Administrative Contractor (MAC).

**Note: Medicare Administrative Contractors (MACs) are third parties that have responsibility for processing Medicare Part A and B and durable medical equipment claims for a specific geographic region. MACs administer the operational contract between Medicare and healthcare providers.*

As "clinical staff," pharmacists can contribute to time counted towards CCM Base, Complex CCM, and PCM Base CPT codes. Since pharmacists are currently not designated as QHPs, they cannot contribute time for HCPCS code G0506 for the initial CCM visit, CCM Provider, or PCM Provider CPT codes.

Resources and References:
1. Centers for Medicare and Medicaid Services, Medicare Learning Network. Chronic Care Management Services.
2. Description on MAC
3. 2016 CMS CCM FAQ
4. 2022 CMS CCM FAQ

Pharmacist Engagement in CCM and PCM Services

Under CMS guidelines, pharmacists are recognized as "clinical staff" who can provide CCM and PCM services within their scope of practice under general supervision of a QHP. The pharmacist can be directly employed, or under contract (independent contractor), or a leased employee of the qualified billing healthcare professional that is providing CCM and/or PCM services. The QHP must be able to provide general supervision of CCM/PCM services provided by a pharmacist but is not required to be physically present or co-located (must be available by phone).

Under CMS guidelines, a pharmacist cannot develop a comprehensive care plan, or directly bill for CCM/PCM services. As a member of the care team, a pharmacist may perform the following CCM/PCM services: collect structured data, maintain/inform updates for the care plan, manage care, provide 24/7 access to care, document CCM/PCM services, and provide support services to facilitate CCM/PCM.

Resources and References:
1. Chronic Care Management Services
2. Rural Health Clinics Center
3. Federally Qualified Health Centers (FQHC)

How to Implement CCM Services

A. Meet core requirements needed to bill for CCM.
B. Create educational materials for CCM services:
    - Provide handouts to eligible patients that highlight the benefits of CCM services and costs to the patient.
    - Provide in-service education to QHPs, clinical staff, and clerical staff about the benefits of CCM, required CCM information disclosure, patient consent, and referral process.

C. Identify CCM eligible patients:
- Consider prioritizing those who are moderate or high resource users, including those with multiple ER visits or hospitalizations, require assistance with activities of daily living, and/or have identified social determinants of health barriers.
- Consider prioritizing those with polypharmacy, high-risk medications, history of nonadherence to medications and/or treatment plans, lack of understanding of medications, or barriers to medication costs in the past.

D. CCM QHP to obtain and document patient consent:
- A QHP must document that an AWV, IPPE, or a comprehensive E/M visit was furnished prior to initiating CCM services, obtain consent (written or verbal) from the patient, and document consent within EHR.
- Documentation is required if the patient declines CCM services or indicates that he or she is participating in CCM services elsewhere.

E. Provision of CCM services
- Once enrolled, the pharmacist may also provide non-face-to-face telephonic or other support CCM services in which patient contact is not directly made (such as refills, prior authorization, coordination of care, etc.)
- Partner with other clinical staff already providing CCM services
    - Often there are others care team members in an organization already engaged in providing CCM services, including nurse care management staff. Find out who else in the organization is already doing this work and what systems have already been developed. Many of the processes already in place may be utilized by pharmacists in providing CCM services with the need for little to no customization. Work together to develop processes that maximize the delivery of CCM services to the patient while minimizing duplication.
- Establish a referral process for the CCM eligible provider
    - “Automatic” referrals to CCM for certain patient populations
        - Multiple ER visits or hospitalizations
        - High risk disease states including uncontrolled diabetes, CHF, COPD/asthma not at goal or with frequent exacerbations
        - Patients failing certain practice ACO or payer quality measures related to their chronic conditions
- Leverage EHR and facility's informatics team
    - Run reports based on higher risk identifiers
    - Create CCM-specific follow-up codes QHPs can utilize during initiating visit for patient to then be identified by pharmacist for telephonic outreach
    - Electronic/telemedicine consult/referral to clinical pharmacist for CCM services
- Documentation and communication of plan
    - Some EHRs will have CCM care plan building integrated into their system
    - Ensure documentation in EHR is appropriate for level of care and the time spent on encounter. A written or electronic copy of the care plan must be provided to the patient and/or caregiver
    - Route clinical documentation (within EHR), fax, or secure message CCM-referring QHP to meet general supervision requirement

Resources and References:

1. NASPA CCM
2. HQIN CCM Toolkit
3. Chronic Care Management Services
4. CMS CCM Toolkit

Implementation Examples and Other Resources

Traditional Practice Model

1. Fixen DR, Linnebur SA, Parnes BL, Vejar MV, Vande Griend JP. Development and economic evaluation of a pharmacist-provided chronic care management service in an ambulatory care geriatrics clinic. *Am J Health Syst Pharm*. 2018;75(22):1805-1811. doi:10.2146/ajhp170723
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RHC/FQHC

1. Schweitzer P, Atalla M. Medicaid reimbursement for pharmacist services: A strategy for the pharmacy profession. Am J Health Syst Pharm. 2021;78(5):408-415. doi:10.1093/ajhp/zxaa390
2. ASHP FQHC FAQ

ASHP Certificate: Billing and Reimbursement for Patient Care Clinical Services

The Billing and Reimbursement for Patient Care Clinical Services Certificate is intended for pharmacists who are engaged in providing clinical services in a variety of practice settings, and others who are involved in billing for these services. Mary Ann Kliethermes, BS Pharm, PharmD, FAPhA, FCIOM; a recognized leader in reimbursement for pharmacist care services; serves as the editor for this one-of-a-kind, comprehensive resource. Through recorded presentations and readings, this Certificate's curriculum includes, but is not limited to, the following topics:

- Language of healthcare billing
- Reimbursement models including fee-for-service and value-based care models
- Medicare, Medicaid, and commercial insurance payers
- Rules related to eligibility of healthcare professionals to bill for services
- Collaborative practice agreements
- Medical vs. prescription benefits
- Payer mix
- "Incident to" as a billing mechanism
- Facility fee billing
- Care management services – chronic care, principal care, and transitional care
- Medicare Annual Wellness Visits
- Medicare Diabetes Prevention Program and Diabetes Self-Management Training
- Medication Therapy Management
- Continuous glucose monitoring and home INR monitoring
- Telehealth
- Reimbursement in federally qualified health centers (FQHCs) and rural health clinics (RHCs)
- Pharmacist prescribing and reimbursement opportunities at the state level
- Building the business case for pharmacist patient care clinical services
- Outside opportunities to fund patient care clinical services
- Preparing for successful implementation and growth of services
- Engaging with commercial insurance payers to be reimbursed for patient care clinical services
- Healthcare billing cycle
- Electronic billing
- Managing claims before and after adjudication
- Staying current with billing and reimbursement rules and opportunities

Ambulatory Care Practitioners

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