2020 Chronic Care Management (CCM) Summary

Chronic Care Management services (CCM) rendered to chronically-ill patients, play a very important role as the healthcare industry transitions into a value-based care environment. The patient-centered focus of CCM promotes effective communication, improved patient engagement, seamless transitions of care, better outcomes, reduction of readmissions and overall healthcare expenses.

Starting in calendar year 2015, the Centers for Medicare and Medicaid Services (CMS) began reimbursing for non-face-to-face CCM services. The scope of non-complex chronic care management services is defined by CPT code 99490, including at least 20 minutes of clinical staff time directed by a physician or other qualified professional, per calendar month, with the following required elements:

- At least 2 or more chronic conditions expected to last 12 months, or until death of patient;
- Chronic conditions cause patient to be considered at significant risk of death, acute exacerbation/decompensation, or functional decline;
- A comprehensive, patient-centered care plan is established, implemented, monitored and revised.

CMS expanded their coverage of CCM in January of 2017 to include "complex" CCM services which requires a higher level of medical decision making (MDM). Complex CCM services are billable with CPT code 99487, consisting of 60 minutes of clinical staff time. Each additional 30 minutes may be billed with CPT code 99489.

In 2019, CMS established a new CPT code, 99491, for 30+ minutes of non-complex or complex CCM services provided each calendar month, personally by a physician or other qualified health professional (QHP). These services are not provided by clinical support staff and may be either complex or non-complex in nature.

CMS' Final Rule which was published on November 15, 2019 and made effective on January 1, 2020, implemented a newly created non-complex CCM add-on code, G2058. This code defines up to two additional 20-minute increments of non-complex CCM time. This HCPCS code has an allowable amount of $37.89 per unit/increment. As a result, providers may receive an average of $118 for an hour or more of non-complex CCM services.

2020 CCM BILLING CODES:

- G0506 - Comprehensive assessment of, and care planning by, the physician or other qualified health care professional for patients requiring chronic care management service, including assessment during the provision of a face-to-face service
    - wRVU = .87
    - Average CMS Allowable (based on locality) = $63.52 +/-
    - Billable only one time per CCM billing provider

- 99490 – Chronic Care Management Services – 20 minutes non-face-to-face, non-complex clinical staff time per calendar month
    - wRVU = .61
    - Average CMS Allowable (based on locality) = $42.21 +/-

- G2058 – Chronic Care Management Services – each additional 20 minutes non-face-to-face, non-complex clinical staff time per calendar month (up to 2 units)
    - wRVU = .54
    - Average CMS Allowable (based on locality) = $37.89 +/-

- 99487 – Complex Chronic Care Management Services – 60 minutes non-face-to-face clinical staff time per calendar month
    - wRVU = 1.0
    - Average CMS Allowable (based on locality) = $92.39 +/-

- 99489 – Complex Chronic Care Management Service - Each additional 30 minutes of non-face-to-face clinical staff time per calendar month
    - wRVU = .5
    - Average CMS Allowable (based on locality) = $44.75 +/-

- 99491 – Non-Complex or Complex Chronic Care Management Service – 30+ minutes non-face-to-face time personally performed by a physician or QHP, per calendar month
    - wRVU = 1.45
    - Average CMS Allowable (based on locality) = $84.09 +/-

The base reimbursement for non-complex CCM services can significantly increase the annual revenue of eligible providers as evidenced by the following numbers. Statistics from The Annals of Family Medicine show that the average US primary care panel size is 2,300 patients.[1] Per the Center for Medicare and Medicaid Services, 68.60% of Medicare patients suffer from two or more chronic diseases.[2] The United States Census Bureau published that 15.7 percent of the patient population is covered by Medicare.[3] Applying CMS' new average CCM monthly payment rate of $42.21[4], the potential increase in gross revenue is in excess of $125,000.

Average number of patients	**2,300**	
Percent of US patients covered by Medicare	**15.7%**	**(2,300 * 15.7%)**
Average number of Medicare patients	**361**	
Percent of patients with 2+ chronic conditions	**68.60%**	**(361 * 68.60%)**
Average number of patients with 2+ chronic conditions	**248**	
Average CCM monthly payment rate	**$42.21**	**(42.21 * 12) * 248**
Estimated average increase in gross revenue	**$125,612**	

CCM has proven to be an integral part of ensuring clinicians get paid for the non-face-to-face work they have been doing for years, while working to coordinate the care and improve the overall outcomes for our nation's highest risk patient population.

[1] Ann Fam Med September/October 2012 vol. 10 no. 5 396-400
[2] CMS.gov – County Level Multiple Chronic Conditions Table: 2012 Prevalence, National Average
[3] US Census Bureau -blogs.census.gov/2013/09/17/medicare-and-medicaid-age-and-income
[4] CMS CY 2017 Physician Fee Service Final Rule