HCCIntelligence™ PREMIER

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Chronic Care Management Care Plan Requirements – 2024

Purpose

This resource is intended for home-based primary care (HBPC) providers and practice staff and provides an overview of the required elements for the Chronic Care Management (CCM) Care Plan. This resource may be utilized as a guide to create a standard CCM Care Plan but is not all-inclusive. Refer to CMS guidelines[1] for full details and requirements.

CCM Service Elements

Practices providing CCM services must utilize structured recording of patient health information using certified Electronic Health Record (EHR) technology, inclusive of maintaining a comprehensive electronic care plan, managing transitions, coordinating and sharing of patient health information promptly both inside and outside of the practice and other care management services.

As a result of the 2024 Medicare Physician Fee Schedule final rule[2], changes were made to the requirements of the CCM care plan. CMS recommends that the comprehensive care plan for all health issues include but is not limited to the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers
- Requirements for periodic review
- When applicable, revision of the care plan

Additional Required Service Elements for CCM

- CCM codes require patients to have two or more chronic conditions expected to last 12 months or until their death.
- Document verbal consent, defined as informing the patient/caregiver of the availability of the service, that only one practitioner can bill per month, the patient's right to stop services at the end of any service period, and make the patient aware of applicable cost-sharing.
- Initiating visit, which is required for new patients or patients not seen within the past twelve months. This service is separately payable.
- 24/7 access to care, defined as offering on-call services including after-hours coverage, so the patient has access to clinical advice and guidance.

[1] https://www.cms.gov/medicare/payment/fee-schedules/physician/care-management

[2] https://www.cms.gov/medicare/payment/fee-schedules/physician

- Relationship with a designated care team member to promote continuity of care.
- Comprehensive Care Management, defined as systematic needs assessment (medical and psychosocial), ensure receipt of preventative services, and medication reconciliation including management and oversight of self-management.
- Comprehensive electronic care plan, requirements described earlier in this resource. CMS also requires the care plan is timely available within and outside of the practice (e.g., fax), a copy of the care plan provided to the patient/caregiver (format not prescribed), and that the care plan is established, implemented, monitored, and revised, as appropriate.
- Management of care transitions (e.g., follow up post-discharge and ED visits) and referrals, defined as creating and exchanging care documents in a timely manner. Following up on the need and execution of referrals for other services.
- Home and community-based care coordination, defined as coordination with any home and community-based clinical service-based providers, and documenting communication with those professionals regarding psychosocial and functional deficits.
- Enhanced communication opportunities, defined as offering non-face-to-face methods other than telephones, such as secure email or patient portals.

Available CCM CPT Codes

CPT Code	Descriptor
99487	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of comprehensive care plan, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.
99489	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or significant revision of comprehensive care plan, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month (List separately in addition to code for primary procedure).
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.
99491	Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of a physician or other qualified healthcare professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored.

New CCM CPT Codes

A new code was created for physicians and qualified providers, reimbursing for an additional 30 minutes of provider-delivered CCM services. This code is an add-on to the original 99491 code.

CPT Code	Descriptor
99437 (add-on) to 99491)	Additional 30 minutes of a physician or qualified professional time each month for patients with two or more chronic conditions.

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