**Chronic Care Management CPT CODE 99490 BILLING FAQ’S**

1. **Q. What other CPT codes CANNOT be billed during the same service period as CPT Code 99490 Chronic Care Management (CCM)?**
2. CPT codes 99495-99496 (Transitional Care Management), 90951-90970 (Certain End-Stage Renal Disease Services).
3. **Q. What Healthcare Common Procedure Coding (HCPCS) Codes cannot be billed during the same service period as CPT 99490?**
4. **G0181/G0182 (**Home Health Care Supervision/Hospice Care Supervision
5. **Q. Where can I find CPT instructions for additional codes that cannot be billed during the same service period as CPT code 99490?**
6. There may be additional restrictions on billing for Practitioners participating in a CMS sponsored model or demonstration program. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup> on the CMS website.
7. **Q Can Physicians bill for G0180 and G0179 (Home Health Certification and Recertification?**
8. **YES.** G0180 is the code used when the patient has not received Medicare-covered home health care for at least 60 days. A physician must first certify a patient before they can receive home health services covered by Medicare. GO179 is the code used when patients have received Medicare-covered home health services over the past 60 days. The billing for recertification should be reported only once every 60 days, unless the patient starts a new episode before 60 days have elapsed and requires a new plan of care to start a new episode.
9. **Q. What is included in Go180 Home Health Certification**?
10. Ordering the plan of care, signing the 485, documenting the face-to-face encounter.
11. **Q. What is the average reimbursement for Certification and Recertification?**
12. On average $53.48 for the initial certification and $41.40 for the recertification which again the recertification is only billed every **60 days** while the patient remains on home health services only. Part B patient Co-pays still apply.
13. **Q What are the criteria to bill for Home Health Supervision and why can’t Supervision be billed during the same service period as CCM services?**
14. GO181 Home Health Supervision does pay on average $106/month for supervision however the patient must be on home health services and the following criteria must be met:
    1. 30 minutes minimum time or more of Physician services are required for care plan supervision. The following Inclusions:
    2. Review of charts, reports, treatment plans, or lab and study results outside the initial patient review.
    3. Communication with other health care professionals involved with the patient’s care
    4. Discussion with a pharmacist about a patient’s pharmacological needs
    5. Coordination of services that require your skills as a physician
    6. Documenting the services provided (includes time to write a note about service provided, decision making performed, amount of time spend on countable services), Time spent on activities undertaken on day of hospital discharge separately documented as occurring after physical discharge from hospital.
15. CMS does not allow CPT 99490 to be billed during the same service period as home health care supervision (HCPCS G0181), hospice care supervision (HCPCS G0182) or certain ESRD services (CPT 90951-90970) because care management is an integral part of all of these services.
16. **Q. What services are not included or counted towards 30 min/month of Home Health Supervision?**
17. Time spent by staff getting or filing charts, calling HHA’s, or patients/families; Physician telephone calls to patient/family, even to adjust medication or treatment; Physician time spent telephoning prescriptions to pharmacist; travel time; time spent preparing/processing claims; initial time spent reviewing results of tests ordered during face-to-face encounter; time spent on day of hospital discharge to manage discharge plan.
18. **Q.** Can someone else perform and track the physician’s supervision for G0181?
19. NO.
20. **Q. What date of service should be used on the physician claim and when should the claim be submitted when billing for CCM 99490?**
21. The service period for CPT 99490 is one calendar month, and CMS expects the billing practitioner to continue furnishing services during a given month as applicable after the 20 minute time threshold to bill the service is met (see #3 above). However practitioners may bill the PFS at the conclusion of the service period or after completion of at least 20 minutes of qualifying services for the service period. When the 20 minute threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month.
22. **Q. If a physician arranges to furnish CCM services to his/her patients “incident to” using a case management entity outside the billing practice, does the billing physician need to ever see the patient face-to-face?**
23. Yes, as provided in the CY 2014 final rule (78 FR 74425), CCM must be initiated by the billing practitioner during a comprehensive Evaluation & Management (E/M) visit, annual wellness visit (AWV) or initial preventive physical exam (IPPE). This face-to-face visit is not part of the CCM service and can be separately billed to the PFS, but is required before CCM services can be provided directly or under other arrangements. The billing practitioner must discuss CCM with the patient at this visit. While informed patient consent does not have to be obtained during this visit, it is an opportunity to obtain the required consent. The face-to-face visit included in transitional care management (TCM) services (CPT 99495 and 99496) qualifies as a comprehensive visit for CCM initiation. CPT codes that do not involve a face-to-face visit by the billing practitioner or are not payable by Medicare (such as CPT 99211, anticoagulant management, online services, telephone and other E/M services) do not meet the requirement for the visit that must occur before CCM services are furnished. If the practitioner furnishes a comprehensive E/M, AWV, or IPPE and does not discuss CCM with the patient at that visit, that visit cannot count as the initiating visit for CCM.
24. **Q. Medicare and CPT specify that CCM and TCM cannot be billed during the same month. Does this mean that if the 30-day TCM service period ends during a given calendar month and 20 minutes of qualifying CCM services are subsequently provided on the remaining days of that calendar month, CPT code 99490 cannot be billed that month to the PFS?**
25. CPT 99490 could be billed to the PFS during the same calendar month as TCM, if the TCM service period ends before the end of a given calendar month and at least 20 minutes of qualifying CCM services are subsequently provided during that month. However we expect that the majority of the time, CCM and TCM will not be billed during the same calendar month.