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Chronic Care Management Care Plan Requirements – 2026

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). This resource was developed utilizing Centers for Medicare & Medicaid Services (CMS) guidelines and requirements and can be referenced for further details.

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.

CMS recommends that the comprehensive care plan focusing on managing chronic conditions 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

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Additional Required Service Elements for CCM

- Medicare covers CCM who have two or more chronic conditions expected to last 12 months or until their death.
- Document verbal consent with the patient's acknowledgement of being informed of the following:, defined as informing the patient/caregiver of the availability of the service and its components, 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 the applicable cost-sharing responsibilities.
- An initiating visit which is required for new patients or patients not seen within the past twelve months. This service is separately payable. The initiating visit can be part of an annual wellness visit (AWV) or initial preventive physical exam (IPPE).
- 24/7 access to care, and health information.
- Continuous patient 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 Care Management should include, a needs assessment (medical, functional and psychosocial), timely preventative services, medication reconciliation and oversight of self-management.
- Management of care transitions (e.g., follow up post-discharge and ED visits) by creating and exchanging care documents in a timely manner by following up on the need and execution of referrals for other services.
- Home and community-based care coordination through communication with, home and community-based clinical providers, and documenting the patient's psychosocial needs and functional deficits.
- Offer enhanced communication opportunities, such as non-face-to-face methods other than telephones, such as secure email or patient portals.

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Available CCM CPT Codes

CPT Code	Descriptor
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
99439	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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).
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).
99491	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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99437 (add-on) to 99491)	Each additional 30 minutes of a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

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