

CHRONIC CARE MANAGEMENT GUIDE

CCM/PCM Patient Criteria, Care Plan Tracking, and Log Rules

CHRONIC CARE MANAGEMENT (CCM) CRITERIA

CCM allows practices to bill for non-face-to-face care coordination services provided to complex patients living with multiple long-term health conditions.

PATIENT ELIGIBILITY REQUIREMENTS

The patient must be diagnosed with **two or more chronic health conditions** that are expected to last at least 12 months (or until the death of the patient) and place them at a significant risk of functional decline or hospital admission.

PRIMARY CCM BILLING CODE REFERENCE

CPT CODE	PERSONNEL & TIME RULE	MANDATORY DOCUMENTATION ACTIONS
99490	Minimum 20 minutes of clinical staff time per calendar month.	Requires an electronic care plan. Time must be logged down to the exact minute. Covers phone check-ins, portal coordination, and pharmacy tracking.
99439	Each additional 20 minutes of clinical staff time (Add-on code).	Can be billed a maximum of two times per month in combination with code 99490.
99491	Minimum 30 minutes of personal physician or mid-level provider time.	Time must be spent directly by the MD, NP, or PA on care plan updates. Staff and provider hours cannot be combined.

AUDIT PREVENTION RULE

Every CCM claim must be backed by a clear electronic log showing dates, precise start/end times, staff names, and specific actions taken. Guessing or rounding up time values is illegal.