ChronicCareIQ

Dispelling the top 5 myths of Chronic Care Management

Executive Summary

Ninety-three percent of Medicare spend goes toward patients with two or more chronic diseases like heart disease, cancer, diabetes, stroke, and arthritis. The data — and the clinical value for patients — is just one of the many reasons the Centers for Medicare & Medicaid Services (CMS) introduced Chronic Care Management (CCM) codes in 2015. The codes compensate practices for the services they provide outside of traditional office settings to manage such conditions. Over the last decade, the breadth of reimbursable services has expanded significantly.

But while research finds that CCM lowers total health spending and reduces emergency room and in-patient hospital visits, less than 10% of all providers who participate in Medicare actually bill for CCM. That means there's an enormous opportunity — so what's the problem?

Perceived challenges like low payment thresholds, a high volume of additional work required, and a lack of patient dedication stymie providers who could be optimizing their clinical, financial, and operational outcomes for their practices and patients.

Here are insights to help separate fact from fiction when starting or optimizing a chronic care management program.

MYTH 1

Chronic Care Management needs to be a 20-minute phone call

Medication recommendations and refills. Coordinating care with a specialist. Scheduling patients' labs, or talking to their loved ones about their care. Other numerous, routine tasks performed by office staff.

All of these "in between" moments add up to better care, and a better patient experience.

But for far too long, those non-face-to-face activities weren't compensated adequately — if at all. The introduction of CCM codes in 2015 changed all of that, but few practices optimize how comprehensive their reimbursements can be when care management activities *tracked over the course of a month* add up to 20 minutes or longer.

The potential impacts of CCM reimbursements are magnified for providers in value-based care arrangements, since VBC measures patient satisfaction, continuous engagement, and care gap closure. All of those are integral to CCM, too.

Put time spent behind the scenes front and center

The work you're already doing qualifies for chronic care management – and can earn you an average of $103 per patient, per month. Learn more here.

CPT code highlights

CPT code 99490 bills CMS for the first 20 minutes of non-face-to-face CCM services, including telephonic care administered by clinical staff at the direction of a physician or qualified healthcare professional. These 20 minutes can be administered in one session or cumulatively over the course of 30 days. Code 99490 can be billed once per calendar month, every calendar month of the year.

CPT code 99439 is an add-on code, and is used to bill CMS for every additional 20 minutes of non-complex CCM services after CPT code 99490 is billed.

MYTH 2

Chronic Care Management doesn’t pay well

When Chronic Care Management was introduced, there were just five reimbursement codes. The base care management code compensated doctors’ offices $42 per patient per month when they could establish that they spent at least 20 minutes of non-face-to-face activity caring for a patient with chronic diseases — and a host of other complexities.

Since then, Medicare has eliminated most of those complexities and expanded to eight different connected care management programs. Reimbursements have been added to the program – including the ability to bill for three increments of 20 minutes, or two increments of 90 minutes – and these are typically enhanced with annual modifications to the Physician Fee Schedule.

$170M+
generated for care management activities

$13,300
average monthly per-provider reimbursement increase for athenahealth customers partnered with ChronicCareIQ*

1.74M+
hours of staff activities documented for billing

Source: ChronicCareIQ, January 2025

*variable by EHR

Reimbursement analysis

Wondering what your potential reimbursement would be if you capture work that you’re already performing for patients with chronic conditions?

Get your personalized reimbursement analysis here.

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MYTH 3

Chronic Care Management patients don't stay the course

Whether you're a provider or a patient, you know that one of the biggest chronic disease challenges is communication. While patients want to be seen, they also want to be heard. ChronicCareIQ facilitates just that, *and* much more.

As shared in Myth #1, CCM does *not* have to involve 20-minute phone calls. Optimizing communication channels — and convenience — are just two ways ChronicCareIQ enhances patient satisfaction.

Using the app is easy for patients, who answer simple, easy-to-read questions tailored to their condition (or conditions). Patients can also self-report vital signs from a connected device or a device they already have in their home. The responses are sent back to providers and scored on a color-coded dashboard, enabling clinicians to reach out to the patients who need help the most. Patients can also communicate with their physician's office easily via the ChronicCareIQ app — functionality they can share with loved ones, friends, or caretakers. This patient-centered approach enhances patient satisfaction, and referrals.

99.9%	99.7%	99.2%	87%	4.7
of patients like that their doctors get updates on their medical status	of patients say ChronicCareIQ is easy to use	of patients feel more connected to their doctor	patient retention year over year	average user ratings in both Google Play and Apple App Store (out of 5)

What patients say

"I like it because care managers are keeping up with me constantly every day, and I feel much more confident knowing my doctor is aware of what's going on. If I didn't have ChronicCareIQ, I'd probably forget to track what I need to."

Dilys Smith, *Alabama*

"It's hard on seniors to get out, come into the doctor's office, and sit in a waiting room. That's why ChronicCareIQ is friendly, and useful."

Fred Kreitlein, *Alabama*

Hear more about other ChronicCareIQ patient experiences in this video.

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MYTH 4

Chronic Care Management is just one program

Chronic care management is just one category of reimbursements that most practices are eligible for. Since CCM was introduced, the type and profitability of reimbursable services has multiplied exponentially. The year 2025, for instance, sees the introduction of new codes and new service categories including Advanced Primary Care Management Services (APCM), which provides a flat fee per primary care patient per month with no need to track time. These myriad other programs with separate codes complement CCM, including:

Remote Patient Monitoring (RPM): Under RPM – also called remote physiological monitoring – provider teams can capture device-based vital signs and self-reported subjective data to help slow disease progression. Learn more here.

Transitional Care Management (TCM): TCM prevents gaps in care when your team is informed about patients transitioning between care settings. Learn more here.

Principal Care Management (PCM): Principal Care Management (PCM) reimburses medical professionals (typically specialists) for the care management services they provide to patients with a single, high-risk condition. Learn more here.

Behavioral Health/Coordinated Care Management (BHI/CoCM): Advancements in appreciation for wellness — the inter-connectedness between a patient's mental and physical health — has led to BHI and CoCM codes that support collaboration and coordination between primary care and behavioral health. Learn more here.

Advanced Primary Care Management Services (APCM): APCM can be billed for patients with one or fewer chronic conditions who are treated for less than 20 minutes, when other rules are met. Learn more here.

Remote Therapeutic Monitoring (RTM): RTM codes allow for reimbursement for providers who are using medical devices to remotely collect non-physiological patient data, such as a patient's self-reported shoulder pain, difficulty breathing, or medication adherence.

MYTH 5

Chronic Care Management isn't time effective

Many providers, and their teams, believe that chronic care management takes too much time and thus stymies practice operations. If you're doing it the old-fashioned way – managing patients via sticky notes and spreadsheets – that may indeed be the case. Now consider what your day-to-day would be like with easy-to-use dashboards with filters, and reporting tools that surface the data you need, when you need it. By operationalizing CCM with efficient workflows, and tools with a great user experience, providers, their staff, and *entire* patient panels benefit.

2-3 WEEKS

average onboarding time, agreement authorization to go-live

4-5 HOURS

average time to train a new ChronicCareIQ clinical user

"Prior to ChronicCareIQ, managing patient calls and ensuring timely care was a significant challenge. Our front desk was overwhelmed, and there was a clear need for a more efficient system. From an efficiency standpoint, ChronicCareIQ has been instrumental in optimizing patient communications, which has significantly eased the workload on our front desk staff. They are some of the biggest advocates for the system."

Chief Operating Officer Gina Baxter

Chesapeake & Washington Heart Care, Maryland

Read more here.

"What we do takes multiple tasks off of the entire clinical floor team on a daily basis, giving providers more time to perform sick visits, review labs and diagnostics, perform peer-to-peer reviews, or to chart. Our CCM program has an incredible impact on the patients, their families, and our office staff."

Kristy Townsend, PhD

Better Weighs to Better Health, Alabama

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ChronicCareIQ's story – and mission, to relieve suffering – is personal. When co-founder and CEO Matt Ethington was 30, he was almost comatose when admitted to the emergency room. He was diagnosed with Type I diabetes, and essentially became a high-needs patient like so many of those ChronicCareIQ serves. Ethington set out more than 10 years ago to solve healthcare's communication problem. Today, ChronicCareIQ connects clinicians with patients in between appointments, improving clinical, financial, and operational results.