

Care-Management Programs Cheat Sheet

Audience: MSO leadership and member practices.

Use: High-level comparison to decide fit and implement compliantly.

Note: Always confirm payer-specific policies and 2026 MPFS updates before launch.

Item	CCM – Chronic Care Management	RPM – Remote Physiologic Monitoring	TCM – Transitional Care Management	PCM – Principal Care Management
What it is	Monthly, non-face-to-face care coordination for patients with multiple chronic conditions.	Tech-enabled monitoring of physiologic data from connected devices, with monthly management .	30-day episode after hospital/SNF discharge to home, coordinating transitions, meds, follow-ups.	Monthly care management focused on a single serious condition expected to last ≥3 months.
Best suited for	Primary care; cardiology, nephrology, endocrinology, pulmonology, etc.	Any specialty managing conditions measurable via devices (cardiology, primary care, pulm).	Primary care and relevant specialists frequently receiving discharges (cards, IM, geriatrics).	Specialists driving a single high-risk/problem list item (cards, endo, rheum, heme/onc, pulm).
Typical patient eligibility	≥2 chronic conditions posing significant risk; patient consent required.	Condition where regular device data will inform treatment; patient consent required.	Discharged from inpatient/SNF to community; moderate or high complexity.	1 complex condition requiring focused mgmt; not duplicative of CCM by same practitioner.

Key activities	Comprehensive, patient-centered care plan; coordination; med mgmt; outreach; social/SDOH support; 24/7 access to care needs.	Device setup/supply ; daily data capture (per payer policy); review/triage; treatment mgmt with interactive communication.	Post-discharge contact ≤ 2 business days; med reconciliation; scheduling and coordinating care; face-to-face visit in required window.	Focused care plan for the principal condition; coordination; med mgmt; clinician revisions as status changes.
Time/interaction rules	Time-based monthly totals (clinical staff or clinician). No double-counting with other services.	Monthly device supply + ≥ 20 min treatment mgmt time with live/interactive component for mgmt codes (per policy).	One episode per discharge; interactive contact ≤ 2 business days; face-to-face within 7 or 14 days (complexity-based).	Time-based monthly totals (clinical staff or clinician). No double-counting with other services.
Common CPTs	99490 (20 min); +99439 (each add'l 20); 99487/99489 (complex); 99491 (clinician-time).	99453 (init/setup); 99454 (monthly device supply); 99457 (20-min mgmt); +99458 (add'l 20).	99495 (mod complexity, visit ≤ 14 d); 99496 (high complexity, visit ≤ 7 d).	99424/99425 (clinician-time); 99426/99427 (clinical-staff time, incident-to).
Supervision & who can deliver	OnCare360 Care managers under the General supervision of referring Physician	OnCare360 Care managers under the General supervision of referring	Typically performed by the billing practitioner supported by OnCare360	OnCare360 Care managers under the General supervision of referring Physician or

		Physician; interactive mgmt required for 99457/99458.	Care managers	clinician personally (code-dependent).
Care plan	Required, comprehensive and shareable; update regularly.	Plan of care references how device data informs management .	Required post-discharge plan with med reconciliation and follow-ups.	Focused, problem-specific plan tied to the principal condition.
Consent	Required; document ongoing participation and rights to opt out.	Required; include device expectations and data use.	Implied by service delivery; best practice to document patient agreement.	Required; document condition focus and non-duplication with CCM (same practitioner/month).
Can bill with	RPM in same month (no double-counted minutes); TCM in same month if distinct and time not double-counted.	CCM in same month (no double-counting); often compatible with AWW/E/M if distinct.	CCM same month allowed if distinct; AWW/E/M as appropriate.	Generally mutually exclusive with CCM by the same practitioner in the same month; different practitioners may bill different services if coordinating and non-duplicative.
Common conflicts	Typically not concurrent with PCM (same practitioner/month) or other	Must meet device-data days per policy for 99454; avoid	Only one TCM episode per discharge; must meet	Not concurrent with CCM (same practitioner/m

	care-mgmt bundles; avoid double-counting.	double-counting mgmt time with CCM/PCM.	timing windows.	onh); avoid overlap with other bundles.
Documentation must-haves	Problem list; individualized care plan; time logs; interventions; coordination notes; consent.	Device assignment; setup/education; data review logs; interactive mgmt notes; consent.	Date/time of outreach; complexity; med reconciliation; scheduled visits; face-to-face details; care coordination.	Principal diagnosis; focused plan; time logs; interventions; consent; rationale for PCM vs CCM.
Tech/Infrastructure	OnCare360 platform supporting care plans, time capture, secure messaging, audit trails.	FDA-class device(s) as applicable; OnCare360 platform; alerting; audit trails.	OnCare360 platform; discharge feed (ADT) if available; tracking of timelines.	Same as CCM but focused templates in OnCare360 and tracking for the single condition.
Compliance watch-outs	No inducements/kickbacks; clear patient consent; incident-to rules; privacy/HIPAA; accurate time capture.	Device medical necessity; data-day thresholds; interactive mgmt; privacy/HIPAA; incident-to; avoid “free device” inducements.	Strict timing windows; med reconciliation; documentation completeness.	Clear rationale for single-condition focus; no duplication with CCM; incident-to and consent requirements.
2026 update highlights (verify payer policies)	No material program-rule changes reported at this time; verify CY-2026 rates/telehealth	Adds **99445** for device supply when **2–15 days** of data are captured in a	No material program-rule changes reported; continue strict timing (contact ≤2 business days;	Potential rate adjustments only; confirm payer specifics. Ensure non-duplication with CCM

	flexibilities with payers.	30-day period; existing **99454** applies when **16–30 days** are captured. Confirm payer adoption and any local policy nuances.	visit window 7/14 days).	remains enforced.
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Quick Fit Guide

- **Primary Care/Internal Medicine/Geriatrics:** Start with CCM for broad chronic panel; layer RPM for hypertension/CHF/COPD subsets; use TCM for post-discharge patients; consider PCM when a single condition dominates.
- **Cardiology/Endocrinology/Nephrology/Pulmonology:** Lead with RPM for condition-specific cohorts; add PCM if one principal condition drives utilization; add CCM for multi-morbidity coordination.
- **High Hospital/SNF Discharge Volume:** Ensure TCM is operational; combine with CCM post-episode for longitudinal support.

Implementation Checklist (compliance-first)

- Identify eligible patients (chronic conditions, recent discharges, device-appropriate diagnoses).
- Obtain/document consent (CCM/RPM/PCM); explain services and opt-out rights.
- Create/share care plans (comprehensive for CCM; focused for PCM; device-linked for RPM; transition plan for TCM).
- Stand up workflows & staffing (general supervision; incident-to protocols; escalation pathways).
- Time & event capture (separate tallies per program; no double-counting).
- Billing hygiene (correct CPTs, frequency limits, device-day thresholds for RPM, TCM timing windows).
- QA & audit readiness (monthly internal review; documentation completeness; HIPAA safeguards).

Notes & Cautions

- Code sets and supervision rules can change; verify current CMS and payer guidance before billing.
- Where services occur in the same month, ensure distinct, non-duplicative work and clear documentation.
- Commercial payer policies may differ from Medicare; confirm coverage and modifiers.

2026 Concurrency & Billing Notes

- RPM device supply now reflects two thresholds: 2–15 days (99445) and 16–30 days (99454) within a 30-day period; do not bill both in the same period.
- CCM + RPM in the same month remains permissible when work is distinct and minutes are not double-counted, document separately.
- PCM remains non-concurrent with CCM by the same practitioner in the same month; different practitioners may coordinate distinct services if non-duplicative.
- TCM can overlap with CCM/RPM if the episode and monthly services are distinct and fully documented.

Eligibility quick screeners

- CCM: ≥2 chronic conditions with expected 12-month risk; consent on file.
- RPM: Diagnosis where ongoing device data will inform care; device medical necessity documented; consent on file.
- TCM: Discharged to home/community; moderate/high complexity; meet contact/visit timing windows.
- PCM: One serious, principal condition; non-duplication with CCM (same practitioner/month).

Program fit by specialty

- Primary Care/IM/Geriatrics: CCM baseline; RPM cohorts (HTN/CHF/COPD); TCM for discharges; PCM selectively.
- Cardiology/Endocrinology/Nephrology/Pulmonology: RPM-first cohorts; PCM where a single condition dominates; CCM for multimorbidity.

Staffing & supervision

- General supervision for clinical-staff time where applicable; clear escalation to clinician.

- Define roles for outreach, monitoring, documentation, and billing review.

Workflow & timing anchors

- TCM: contact ≤ 2 business days; visit in 7 or 14 days (complexity-based).
- RPM: device-day thresholds (2–15 vs 16–30); interactive management requirements for monthly management codes.
- CCM/PCM: monthly time capture; no double-counting.

Documentation checklists

- Consent; individualized care plans; time logs; device assignment; interactive contacts; med reconciliation (for TCM).

Billing hygiene

- Correct CPT selection; frequency limits; RPM thresholds; TCM timing windows; concurrency rules documented.

Data, devices, and security

- Device logistics options; SOPs for loss/replacement; alert thresholds tied to clinical protocols.
- EHR/ADT integrations; HIPAA/SOC-2 posture; exportable audit trails.

KPIs & ROI to monitor

- Enrollment %, active monitoring %, average CCM/RPM minutes, TCM completion rate, readmission reduction, clean-claim rate, payer-mix impact.

Commercial payer variance

- Flag plan-by-plan differences; verify policies before activation.