Vivo Care

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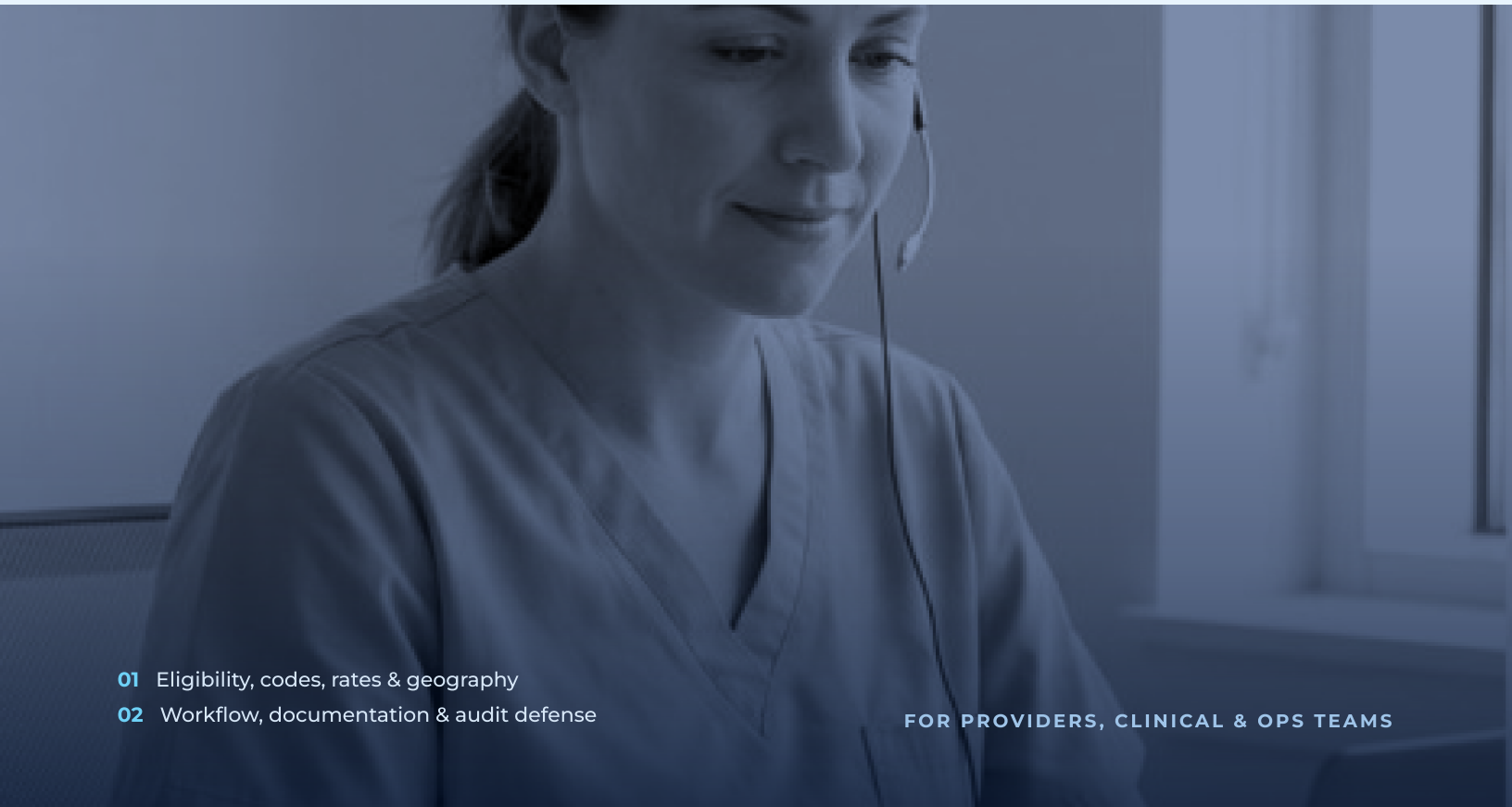
THE VIVO CARE GUIDE

Chronic Care Management

CCM

Standing up and running a chronic care management program in 2026: eligibility, the codes, the documentation, and the operating model.



FOR PROVIDERS, CLINICAL & OPS TEAMS

WRITTEN BY THE VIVO CARE CLINICAL TEAM · REVIEWED BY DR. AAMIR IQBAL, MD, MEDICAL DIRECTOR · AUGUST 2026

INTRODUCTION

What chronic care management is, and what it requires

Chronic Care Management (CCM) is a Medicare-covered service in which a care team delivers documented, non-face-to-face care coordination each month to patients with two or more chronic conditions, under a comprehensive electronic care plan directed by the billing practitioner.

CCM pays for the work practices already do between visits and mostly cannot bill for: medication reconciliation, specialist coordination, refill management, preventive care oversight, and patient outreach. Medicare created the benefit because roughly two thirds of beneficiaries live with two or more chronic conditions, and the month between appointments is where those conditions are actually managed or lost.

Unlike remote patient monitoring, CCM requires no device and no physiologic data. The billable unit is documented clinical staff time spent coordinating care each calendar month, under a care plan the patient has agreed to.

What CCM requires, at a glance

01	02	03	04	05
Two or more qualifying chronic conditions	**An initiating visit, where one applies**	**Documented patient consent**	**A comprehensive electronic care plan**	**Monthly staff time, logged and non-duplicative**

THE PROVIDER STAYS THE DECISION-MAKER

CCM extends the provider's reach between visits. **It does not replace clinical judgment.** The billing practitioner directs the care plan, supervises the program, and retains medical decision-making. The care team executes and documents.

ELIGIBILITY

Who qualifies for CCM

CCM covers patients with two or more chronic conditions expected to last at least 12 months or until death that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline.

The two-condition threshold

CMS does not publish a fixed condition list. Hypertension plus diabetes, CKD plus CAD, COPD plus heart failure, arthritis plus depression, all qualify when the risk standard is met. What matters is that both conditions are documented, expected to persist 12 months or longer, and that the record supports the risk language.

TWO DIAGNOSIS CODES ARE NOT ELIGIBILITY

The chart has to carry the 12-month expectation and the risk language, not just the codes on the claim. This is exactly the gap the OIG opened a new audit into in March 2026, which makes claims filed today the audit population.

The initiating visit

New patients, and patients not seen within the prior 12 months, need a face-to-face visit before CCM starts: an evaluation and management visit, an Annual Wellness Visit, or an Initial Preventive Physical Exam. Established patients seen within 12 months can enroll without a new visit.

A QUICK EXAMPLE

A patient with hypertension and type 2 diabetes who came in for a physical three months ago already meets the initiating-visit requirement. The care team can enroll them now: document consent, build the care plan, and start logging the monthly coordination time. No extra visit is needed. For most established primary care panels this is the common case, which is why identification usually starts with patients the practice already sees.

ELIGIBILITY

Consent, cost-sharing, and who does not qualify

Consent has to be documented before services begin, and the conversation about what the patient pays is what determines whether they stay enrolled past the first statement.

Consent

Verbal or written consent must be documented before services begin, covering what CCM is, the patient's cost-sharing responsibility, the right to stop at any time, and that only one practitioner can furnish CCM in a month.

THE RETENTION LEVER

Cost-sharing disclosure at consent is both a requirement and the best defense against surprise-bill drop-off

What the patient actually pays

CCM carries the standard 20% Part B coinsurance, which applies toward the patient's annual Part B deductible the same way a routine office visit does. Once the deductible is met for the year, supplemental or secondary coverage usually absorbs the coinsurance, so many patients owe little or nothing out of pocket. Explaining this at enrollment is what keeps patients in the program.

Who does not qualify, or where to be careful

- ☑ Patients with one chronic condition. PCM is the fit there.
- ☑ Patients already receiving CCM from another practitioner that month.
- ☑ Patients enrolled in APCM with the same practice.
- ☑ Any patient whose chart cannot support the risk language behind the two conditions.

CODES & REIMBURSEMENT

The 2026 CCM CPT codes and rates

The 2026 CCM code set covers clinical staff time, physician-personal time, and complex care management, and every CCM code received a rate increase for 2026. The rates below are CMS national non-facility amounts and vary by locality.

CODE	WHAT IT COVERS	THRESHOLD	2026 RATE	VS 2025
99490	CCM, clinical staff time, first 20 minutes	20+ minutes per month, general supervision	$66.13	**+9.4%**
99439	CCM, clinical staff time, each additional 20 minutes	Add-on to 99490	$50.43	**+9.9%**

Rate basis: CMS 2026 Physician Fee Schedule, national non-facility, GPCI 1.0. Actual reimbursement varies by locality, Medicare Administrative Contractor, and payer.

WHAT CCM EARNS, MONTHLY

$66.13
99490 alone, per patient per month

$116.56
Per month, adding one 99439

$793.56
Per patient per year, base code

~$13,200
Per month, a 200-patient panel on the base code

This table covers CCM furnished by clinical staff, which is how most programs run. Two other code families exist.

99491 · 99437

Physician-personal CCM

Requires the physician's or QHP's own documented time, 30 minutes then each additional 30. A distinct delivery model, not an upgrade.

99487 · 99489

Complex CCM

For months requiring 60 or more minutes and moderate-to-high complexity decision making, with care plan establishment or substantial revision.

Rates are reimbursement, not revenue. This guide presents CMS rates only, not Vivo Care pricing.

BILLING MECHANICS

Two rules that decide whether a claim holds

Bill cleanly

1. **One practitioner, one tier**
   Only one practitioner bills CCM for a patient in a calendar month, and only one tier: non-complex (99490/99439 or 99491/99437) or complex (99487/99489), never both.

2. **Clinical staff time and personal time are different currencies**
   99490 time can be furnished by clinical staff under general supervision. 99491 requires the physician's or QHP's own time, and staff minutes do not count toward it.

COMMON AUDIT FINDING

Time must be exclusive. Minutes counted toward CCM cannot also count toward RPM, PCM, BHI, TCM, or an evaluation and management visit in the same month. Overlapping time is exactly the error the OIG has recovered money on, and it is one of the most common findings in CCM review.

THE OPERATING CONSEQUENCE

If a patient is enrolled in more than one program, the time log has to prove separation month by month

This is a documentation problem before it is a billing problem. A program running RPM and CCM on the same patient needs two distinct, dated time records with staff identification, not one combined note that a reviewer has to divide after the fact. Building the separation into the workflow is what makes concurrent enrollment defensible.

WHERE THE PLATFORM CARRIES THE LOAD

The Vivo Care platform logs CCM minutes against the enrolled program with dated entries and staff identification, and **flags a single-practitioner conflict before the claim goes out.**

COUNTABLE TIME

What counts toward CCM time?

The billable unit is documented non-face-to-face clinical staff time. Knowing which minutes count, and which a reviewer will remove, is the difference between a program that clears the threshold honestly and one that cannot defend its log.

Typically counts

NON-FACE-TO-FACE CLINICAL STAFF TIME

- ✓ Phone or portal outreach to the patient or caregiver
- ✓ Medication reconciliation and refill coordination
- ✓ Reviewing lab results and specialist notes
- ✓ Coordinating with specialists, pharmacy, and community resources
- ✓ Developing, reviewing, and revising the care plan
- ✓ Transitions-of-care follow-up after an ED visit or discharge
- ✓ Patient and caregiver education and self-management support

Does not count

REMOVED FROM THE MONTHLY THRESHOLD

- ✗ Any minute already counted toward RPM, PCM, TCM, BHI, or an E/M visit that month
- ✗ Face-to-face visit time, which is billed as the E/M
- ✗ Clerical or scheduling work by non-clinical staff
- ✗ Travel time

The threshold is cumulative across the calendar month and across the care team working under the billing practitioner's direction. It is not one long call. A patient who receives a seven-minute refill call, an eight-minute lab review, and a six-minute specialist coordination note in the same month has met the 20-minute threshold for 99490, provided each entry is dated, attributed to the staff member who did the work, and counted nowhere else.

THE PRACTICAL TEST

If a reviewer removed every minute that overlaps another program, would the month still clear the threshold

HOW RATES ARE SET

Why the same code pays differently by geography

The same CCM code pays a different amount depending on where the practice sits, because Medicare adjusts every rate for local costs.

Each service is built from three cost components: the clinician's work, the practice expense, and malpractice insurance. Medicare adjusts those three for your locality using Geographic Practice Cost Indices, then multiplies by the annual conversion factor to get the payment. The national figures are the baseline. Your locality moves the number up or down.

LOCALITY	99490, INITIAL 20 MINUTES	99490	99439
NYC Outer Boroughs, NY 13202-02		**$76.02**	$58.16
Los Angeles Metro, CA 01182-18		**$72.28**	$55.48
National payment amount GPCI 1.0		**$66.13**	$50.43
Mississippi 07302-00		**$61.30**	$46.47

CMS 2026 Physician Fee Schedule, non-facility. Bars are to scale from zero.

THE SPREAD IS REAL MONEY AT PANEL SCALE

The same 99490 pays 24% more in the NYC outer boroughs than in Mississippi. On a 200-patient panel billing the base code monthly, that is a difference of roughly $2,900 per month between those two localities for identical work. Budget a CCM program on your locality's numbers, not the national baseline.

Three other things move the number

Site of service

Non-facility (physician office) rates run higher than facility rates because the practice absorbs the overhead. All rates here are non-facility, where CCM is typically furnished.

The 80/20 split

The fee schedule amount is the total approved payment. Medicare pays 80%; the patient owes 20% coinsurance unless supplemental coverage picks it up.

Participating status

Participating providers accept the approved amount as payment in full. Non-participating providers not accepting assignment can bill up to 115%, with the difference falling to the patient.

Every locality's rate is published in the CMS Physician Fee Schedule Look-Up Tool: cms.gov/medicare/physician-fee-schedule/search

WHAT CHANGED

What changed for CCM in 2026

CCM's structure did not change for 2026. The clinical-staff codes pay roughly 9 to 10 percent more, FQHCs and RHCs now bill the individual CCM codes instead of the retired G0511 bundle, and CMS signaled where chronic care is heading.

1 **Rates up across the board**

At the national payment amount, 99490 is up 9.4% and 99439 is up 9.9% versus 2025, with locality-adjusted increases in the same 9-to-10-percent band.

2 **G0511 is gone**

As of September 30, 2025, FQHCs and RHCs no longer bill the bundled G0511 and instead bill the individual CCM codes at national non-facility rates. For those organizations, 2026 is the first full year of code-level CCM billing, which raises the documentation bar and the revenue ceiling at the same time.

3 **The direction of travel**

CMS finalized optional behavioral health add-on codes for APCM and introduced the ACCESS Model, both signals that Medicare is consolidating around monthly, accountable, between-visit care management.

> "Practices that build CCM discipline now are building the operating muscle every one of these programs runs on."

THE VIVO CARE CLINICAL TEAM
On why the 2026 changes point in one direction

OPERATIONS

How a CCM program actually runs

A working program moves a patient through identification, consent, and care plan creation once, then holds a documented monthly rhythm of coordination, outreach, and time tracking, with the provider supervising and the care team executing.

SET UP, ONCE PER PATIENT

1

Identify

Risk-stratify the panel for two or more qualifying conditions and confirm benefit eligibility. Most EHRs generate this list from problem-list and diagnosis data, so it is a report you run, not a manual chart review.

2

Consent and enroll

Document verbal or written consent, including cost-sharing, the one-practitioner rule, and the right to revoke.

3

Build the care plan

A comprehensive electronic care plan shared with the patient and available to anyone furnishing CCM.

THEN EVERY CALENDAR MONTH

4

Deliver the work

Medication reconciliation, refill coordination, specialist and community-resource coordination, transitions-of-care support, preventive reminders, and patient education.

5

Document time

Every minute logged with staff identification, dated entries, and clear separation from any other billable program's time.

6

Review and bill

Confirm threshold minutes, the required service elements, and the single-practitioner check before the claim goes out.

Behind the workflow sit three structural requirements: 24/7 access to a care team member for urgent needs, continuity with a designated care team member, and a certified EHR for the care plan and clinical summaries.

THE MONTHLY TIME IS THE PROGRAM

At Vivo Care the CCM staffing target is **one care navigator per 130 patients**, licensed US-based nurses working as an extension of the provider team. Practices running CCM in-house should staff against that same math before enrolling, not after.

DOCUMENTATION

What a billable CCM month has to leave behind

A billable CCM month has to leave a paper trail across four artifacts: the eligibility record, the consent, the care plan, and the monthly time log. This checklist is what an auditor reconstructs the claim from.

At enrollment, once per patient

- ☑ Initiating visit documented for new patients or patients not seen in 12 months (E/M, Annual Wellness Visit, or IPPE).
- ☑ Two or more chronic conditions on the problem list, each expected to last at least 12 months or until death, **with the risk language in the note, not just diagnosis codes.**
- ☑ Patient consent captured and dated, verbal or written.
- ☑ Comprehensive electronic care plan created and shared with the patient.

Every billed month

- ☑ Total clinical staff time for the month, logged with dated entries and the name of each person who furnished time.
- ☑ At least the threshold minutes for the code billed: 20 minutes for 99490, plus each additional 20 for 99439.
- ☑ The coordination work itself documented: medication reconciliation, specialist or community-resource coordination, transitions-of-care follow-up, patient or caregiver outreach.
- ☑ Care plan reviewed, and revised if the patient's condition changed.
- ☑ **Single-practitioner check.** Confirmation that no other practitioner billed CCM for this patient this month, through the patient's Medicare eligibility and claims history using your MAC's provider portal or clearinghouse eligibility check, and by confirming with the patient at enrollment.
- ☑ Time separation: CCM minutes not also counted toward RPM, PCM, TCM, BHI, or an E/M visit.

Who does what

Provider (billing practitioner)

- Clinical direction and medical decision-making
- Supervises the care team
- Biller of record

Vivo Care clinical team (care navigators)

- Monthly care coordination and patient outreach
- Care plan execution and documentation
- Time logging

Practice billing team

- Eligibility and single-practitioner check
- Consent and cost-sharing on file
- Final claim review and submission

DOCUMENTATION

The care plan and the consent, element by element

These two artifacts carry the most audit weight and are the most often incomplete. Use them as a template.

The care plan has to contain

- [x] Problem list.
- [x] Expected outcomes and prognosis.
- [x] Measurable treatment goals.
- [x] Medication management and symptom management.
- [x] Planned interventions and the responsible care team member for each.
- [x] Coordination of services with other providers and community resources.
- [x] A schedule for periodic review and revision.

Consent has to cover

- [x] That the patient is enrolling in CCM and only one practitioner can furnish it in a calendar month.
- [x] The patient's cost-sharing responsibility: 20% coinsurance under Medicare Part B unless supplemental coverage applies.
- [x] The patient's right to stop CCM at any time, effective at the end of the calendar month.
- [x] That the patient's health information will be shared with other treating providers for care coordination.

GENERATED AS THE WORK HAPPENS

Vivo Care builds consent capture, the electronic care plan, and the monthly time log into the workflow, so **the artifacts an auditor asks for are generated as the work happens rather than reconstructed later.** Consent form and care plan templates aligned to this checklist are part of onboarding.

COMPLIANCE & AUDIT

Where CCM programs go wrong

The OIG has recovered CCM overpayments for duplicate and overlapping billing, and opened a new 2026 audit into whether billed patients actually meet the two-condition requirement. Eligibility documentation and time separation are the two walls a program has to hold.

THE PRIOR RECORD, OIG AUDIT A-07-19-05122

$1.9M
in CCM overpayments across 50,192 claims, covering 2017 to 2018.

$1.4M
from the same or multiple providers billing CCM twice for one patient in one month.

$438,262
from CCM billed alongside overlapping care management services for the same period.

$540,680
overcharged to beneficiaries in cost sharing as a result.

THE SCRUTINY IS CURRENT

In March 2026 the OIG added a work plan audit of Medicare Part B CCM payments at risk of noncompliance with the requirement for multiple chronic conditions, citing substantial growth in CCM payments from 2019 through 2024. The report is expected in FY 2028, which means **claims being filed right now are the audit population.**

What an auditor looks for

- ☑ Two documented chronic conditions with the 12-month expectation and the risk language, not just two diagnosis codes.
- ☑ Documented consent including cost-sharing disclosure.
- ☑ A care plan that was established, shared, and actually revised over time.
- ☑ Time logs with dates, minutes, and staff identification for every billed month.
- ☑ Proof the practice checked that no other practitioner billed CCM that month.
- ☑ Clean separation of CCM minutes from RPM, PCM, TCM, BHI, and E/M time.
- ☑ The initiating visit on record for patients new to the practice.

PROGRAM FIT

CCM, RPM, or APCM: which fits which patient

CCM and RPM stack for the same patient in the same month because they cover different work. APCM replaces CCM entirely. The real design question is which management chassis each patient segment runs on.

PROGRAM	WHO IT FITS	2026 NATIONAL RATE	WITH CCM?
CCM 99490 / 99439	Two or more chronic conditions, time-based coordination	$66.13 first 20 min, $50.43 each additional 20	The baseline row
RPM	Patients needing device-based physiologic monitoring	Billed on its own code set	**Stacks, if no minute is counted twice**
APCM G0556 / G0557 / G0558	Flat monthly care management, no time thresholds	$16.37 · $53.77 · $117.23 by condition count and QMB status	Mutually exclusive
PCM 99426 / 99427	Single-condition patients needing the same coordination	$67.80 first 30 min, $54.11 each additional 30	Different code family

CMS 2026 Physician Fee Schedule, national non-facility. RPM rates are covered in the Vivo Care RPM guide.

> **THE DECISION THAT MATTERS**
>
> A two-condition patient pays $53.77 flat under APCM versus $66.13 plus add-ons under time-based CCM, so the chassis choice turns on documented monthly time, patient complexity, and QMB mix. RPM can be billed alongside either. At 2026 national rates, RPM, CCM, and behavioral health add-ons can stack to $170 to $260+ per patient per month before locality adjustment.

Complex CCM. For the patient whose month genuinely requires 60 or more minutes and moderate-to-high complexity decision making, complex CCM (99487/99489) pays for the heavier lift. Programs that never bill it are usually under-documenting, not under-working.

> **"Rather than doing a one size fits all, we really look at our patients and tailor which programs would they benefit from."**
>
> **DR. AAMIR IQBAL**
> Medical Director, Vivo Care, and Practicing Primary Care Physician

BUILD VS PARTNER

Run CCM in-house, or with a partner?

The decision comes down to clinical staffing, documentation capacity, and whether the monthly coordination work will survive contact with a busy clinic. The 20-minute monthly threshold per patient is the load practices most often underestimate.

01 · Clinical staffing

Every enrolled patient needs 20+ documented minutes of real coordination each month. 200 patients at 20 minutes is 67+ staff hours per month before any add-on time. At scale that is dedicated headcount, not spare capacity.

02 · Documentation capacity

The discipline has to hold every month. CCM audits are won in the time log.

03 · Consistency

CCM revenue is recurring only if the work recurs. Programs that skip months when the clinic gets busy leak both revenue and compliance standing.

04 · Time to a working program

Panel identification, consent capture, and care plan creation are front-loaded work that determines whether month two exists.

	SELF-MANAGED	MANAGED CLINICAL
Who coordinates	Your own clinical staff, on the Vivo Care platform	Vivo Care licensed care navigators, staffed to the 1:130 CCM ratio
What the platform delivers	Compliant time tracking, the care plan, and the documentation billing depends on	The same, plus the monthly coordination, outreach, and documentation
Staying current with CMS	You track CMS coding and rule changes each year	Vivo Care tracks CMS changes and keeps the program compliant for you
The tradeoff	More control, more internal load	Provider supervises and retains medical decision-making

THE SIGNAL THAT SEPARATES STRONG PROGRAMS FROM WEAK ONES

Month-over-month billing consistency, not enrollment volume. Billable patient adherence across the Vivo Care platform is **96.9% year to date in 2026**, which is what a program running with real staffing discipline sustains.

FREQUENTLY ASKED

Chronic care management FAQ

Q What are the CMS requirements for CCM?

Five things have to be in place: the patient has two or more chronic conditions expected to last at least 12 months, an initiating visit is on record where one is required, the patient has given documented consent, a comprehensive electronic care plan exists and is shared with the patient, and the billing practitioner or clinical staff furnish and document the monthly coordination time.

Q What conditions qualify a patient for chronic care management?

Any two or more chronic conditions expected to last at least 12 months or until death that put the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. CMS does not publish a fixed list. Common qualifying pairs include hypertension and diabetes, CKD and CAD, and COPD and heart failure.

Q Does CCM require patient consent?

Yes, documented before services begin. It can be verbal or written, and it has to cover the patient's cost-sharing, that only one practitioner can furnish CCM per month, and the right to stop at any time. Documenting consent, including cost-sharing, is both a CMS requirement and the best defense against surprise-bill disenrollment.

Q What documentation does CCM billing require?

For every billed month: a time log with dated entries and staff identification showing at least the threshold minutes, the coordination work performed, evidence the care plan was reviewed and revised as needed, and a check that no other practitioner billed CCM for that patient that month. At enrollment: the initiating visit, the two qualifying conditions, consent, and the care plan.

Q Who can provide CCM services?

Clinical staff under the general supervision of the billing practitioner for 99490, 99439, 99487, and 99489. The 99491 and 99437 codes require the physician's or QHP's personal time. State scope-of-practice rules govern who counts as clinical staff. The billing practitioner retains medical decision-making and oversight.

FREQUENTLY ASKED

CCM FAQ, continued

Q What does a CCM patient pay out of pocket?

CCM carries the standard 20% Part B coinsurance, applied toward the annual Part B deductible like a routine visit. Once the deductible is met, supplemental or secondary coverage usually absorbs the coinsurance, so many patients owe little or nothing. Explaining this at enrollment is what keeps patients in the program.

Q Does CCM require a device or daily readings?

No. CCM is care coordination, not physiologic monitoring. No device, no transmission thresholds. Patients who also need device-based monitoring can be enrolled in RPM alongside CCM.

Q Can CCM and RPM be billed for the same patient in the same month?

Yes, when each program's requirements are met independently and no minute of staff time is counted toward both. They cover different work and commonly run together.

Q Can CCM and APCM be billed together?

No. APCM bundles care management into a monthly payment and cannot be billed in the same month as CCM for the same patient. Practices choose one chassis per patient. RPM can run alongside either.

Q What has to be in the care plan?

A comprehensive, patient-centered electronic plan: problem list, expected outcomes and prognosis, measurable goals, medication management, responsible care team members, and coordination needs. It must be shared with the patient and revised as the patient's condition changes.

Q Does CCM require a face-to-face visit first?

For new patients and patients not seen within the prior 12 months, yes: an E/M visit, Annual Wellness Visit, or IPPE. Established patients seen within 12 months can enroll without a new visit.

FREQUENTLY ASKED

CCM FAQ, continued

Q Can two providers bill CCM for the same patient?

No. One practitioner per patient per calendar month, and one tier of CCM. Checking this before claims go out is a core compliance step. Duplicate billing was the largest error category in the OIG's CCM audit.

Q What changed for FQHCs and RHCs?

The bundled G0511 code retired on September 30, 2025. FQHCs and RHCs now bill the individual CCM codes at national non-facility rates, which means code-level time documentation.

Q When is complex CCM (99487/99489) the right code?

When the month's work requires 60 or more minutes and moderate-to-high complexity medical decision making, with establishment or substantial revision of the care plan. It is a documentation-supported judgment, not a volume upgrade.

Q Why is my CCM reimbursement different from the national rate?

National rates are the GPCI 1.0 baseline. Medicare adjusts each code's work, practice expense, and malpractice components for local input costs, then multiplies by the annual conversion factor, so the same code pays differently by locality. The 2026 spread runs from $61.30 in Mississippi to $76.02 in the NYC outer boroughs for the same 99490. Site of service, participating status, and the 20% patient coinsurance also change what actually lands.

Q How does Vivo Care support CCM billing?

The billing practitioner remains the biller of record. Vivo Care supports the program with consent capture, care plan documentation, time logs, and monthly reporting that billing depends on. Specific billing-support arrangements depend on the engagement model and are covered in a consultation.

Q How do we know the monthly time is actually there?

The time log is the program's operating report, not just an audit artifact. Reviewing which patients are short of the threshold before month end is what keeps billing consistent, and it is the difference between a program that bills every month and one that bills in bursts.

SOURCES & REVIEW

Sources and medical review

1 CMS Calendar Year 2026 Medicare Physician Fee Schedule Final Rule. *Rates, conversion factor, APCM add-ons.*

2 CMS Physician Fee Schedule Look-Up Tool, cms.gov/medicare/physician-fee-schedule/search. *Locality rates, RVUs, GPCIs, conversion factor, facility vs non-facility, assignment and limiting charge.*

3 CMS MLN, *Chronic Care Management Services* booklet (MLN909188).

4 HHS Office of Inspector General, *Medicare Continues To Make Overpayments for Chronic Care Management Services*, A-07-19-05122, issued August 2021.

5 HHS Office of Inspector General Work Plan, *Audit of Medicare Payments for Chronic Care Management Services at Risk of Noncompliance*, announced March 2026, report expected FY 2028.

MEDICALLY REVIEWED BY

Dr. Aamir Iqbal

Medical Director, Vivo Care · Practicing Primary Care Physician

A Physician Partner at AFP Health in Thousand Oaks, California, Dr. Iqbal has run remote care programs on the platform now known as Vivo Care since December 2020. He reviews Vivo Care's clinical and billing resources for accuracy against current CMS guidance.

ACROSS THE VIVO CARE PLATFORM

96.9%
billable patient adherence, year to date 2026.

1 : 130
care navigator to patient CCM staffing ratio.

Disclaimer. *This guide is for general educational purposes and does not constitute legal, billing, or reimbursement advice. Coverage, coding, supervision rules, and reimbursement vary by payer, region, and Medicare Administrative Contractor. Confirm current CMS guidance and payer policy before billing. Rates shown are CMS 2026 Physician Fee Schedule, non-facility. Reviewed by Dr. Aamir Iqbal, Medical Director, Vivo Care. Last updated August 2026. Platform figures: 120,000+ patients supported (cumulative), 350+ active healthcare organizations, 25.9M+ documented engagement minutes (2023 to 2025).*

SCOPE YOUR PROGRAM

Want a CCM program scoped for your panel and your locality? **A Vivo Care specialist will walk through eligibility, staffing math, and documentation for your practice.**

vivocaresolutions.com/ccm-consult

Scope a CCM program for your panel. Request a consultation.

RELATED READING

CCM requirements, compliance & clinical outcomes
vivocaresolutions.com/resource/ccm-requirements-compliance-clinical-outcomes/

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