Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	June 5, 2023	**Revised Date:**	June 2023
Date Reviewed:	May 2023		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Care management is the range of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions. This policy is intended to provide the Plan's reimbursement direction for these services.

DEFINITIONS:

Term	Definition
Advance Care Planning (ACP)	A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.
Transitional Care Management (TCM)	Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of twenty-nine (29) days.
Chronic Care Management (CCM)	Services encompassing the oversight and education activities by health care professionals to help patients with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.
Principal Care Management Services (PCM)	Principal care management represents services that focus on the medical and/or psychological needs manifested by a single, complex chronic condition expected to last at least three (3) months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease.

Psychiatric Collaborative Care Management (PCCM)	Behavioral health services delivered via a specific evidence-based model. Care is managed by a behavioral health care manager (BHCM), who has master's/doctoral-level education or specialized training in behavioral health, under direction of a treating physician or qualified health care professional (QHP) in consultation with a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications.
General Behavioral Health Integration Care Management (BHI)	The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.
Care Coordination	The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.
Primary Care	Health care provided by a physician or an individual license to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes internal medicine, family practice, general practice, pediatrics, CRNP PCP, geriatric medicine, and multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, pediatrics, CRNP PCP, PA PCP, or geriatric medicine).
Comprehensive Care	The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.
Qualified Healthcare Professional (QHP)	An individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. QHPs are distinct from clinical staff.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Care Management Services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional (QHP) or may be provided personally by a physician or other QHP to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. Care management services improve care coordination, reduce avoidable hospital services, improve patient engagement, and decrease care fragmentation. The physician or other QHP provides or overseas the management and/or coordination of care management services, which include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

There are three (3) general categories of care management services: chronic care management, complex chronic care management, and principal care management. Complex chronic care management addresses all of the patient's medical conditions, and principal care management services addresses a single

condition. Each of the three (3) categories is further subdivided into those services that are personally performed by the physician or other QHP.

Code selection for these services is based on time in a calendar month, and time used in reporting these services may not represent time spent in another reported service. Chronic care management services do not require moderate to high-level medical decision making and may be reported for a shorter time threshold than complex chronic care management services. Both chronic care and complex chronic care management address, as needed, all medical conditions, psychosocial needs, and activities of daily living. Principal care management services are disease-specific management services. A patient may have multiple chronic conditions of sufficient severity to warrant complex chronic care management but may receive principal care management if the reporting physician or other QHP is providing single disease rather than comprehensive care management.

Care Planning

A plan of care for health problems is based on a physical, mental, cognitive, social, functional, and environmental evaluation. It is intended to provide a simple and concise overview of the patient and his or her medical condition(s) and be a useful resource for patients, caregivers, health care professionals, and others, as necessary.

The care management office/practice must have the following capabilities:

1. Provide 24/7 access to physicians or other QHPs or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of the week;
2. Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
3. Provide timely access and management for follow-up after an emergency department visit or facility discharge;
4. Utilize an electronic health record system for timely access to clinical information;
5. Be able to engage and educate patients and caregivers as well as coordinate and integrate care among all professionals, as appropriate for each patient;
6. Reporting physician or other QHP overseas activities of the care team;
7. All care team members providing services are clinically integrated.

◆ Chronic Care Management (CCM) Services: 99490, 99491, 99437, and 99439

CCM services are management and support services provided by clinical staff, under the direction of a physician or other QHP or may be provided personally by a physician or other QHP to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

Care management activities performed by clinical staff, or personally by the physician or other QHP, typically include includes:

1. Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. Communication with home health agencies and other community services utilized by the patient;
3. Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family;
7. Management of care transitions not reported as part of transitional care management (99495, 99496)
8. Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above;
9. Development, communication, and maintenance of a comprehensive care or disease specific (as applicable) care plan;
10. Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
11. A copy of the plan of care must be given to the patient and/or caregiver

◆ **Complex Chronic Care Management (CCM) Services: 99487, 99489**

99487: Complex chronic care management services, with the following required elements:

- Multiple (2+) 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 a comprehensive care plan
- Moderate or high complexity medical decision making
- First 60 minutes of clinical staff time directed by a physician or other QHP, *per calendar month*

Note: Complex chronic care management services require moderate or high medical decision making as defined in the Evaluation and Management (E/M) guidelines.

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes, in a calendar month, are *not* reported separately.

Complex Chronic Care Management

Total Duration of Staff Care Management Services	Complex Chronic Care Management
less than 60 minutes	Not separately reported
30 - 89 minutes (1 hour - 1 hr. 29 minutes)	99487 x 1
90 - 119 minutes (1 hr. 30 min - 1 hr. 59 minutes)	99487 x 1 and 99489 x 1
120 minutes or more (2 hours or more)	99487 x 1 and 99489 x 2 and 99489 for each additional 30 minutes

99490: Chronic care management services, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, *per calendar month*, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99439: Chronic care management services; 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)

- Elements for 99490 apply
- Report code 99439 in conjunction with 99490
- Do not report 99439 more than twice per calendar month

Note: Do not report 99439, 99490 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99437, 99487, 99489, 99491, 99605, 99606, 99607.

Note: Do not report 99439, 99490 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

99491: Chronic care management services, provided personally by a physician or other qualified health care professional, first 30 minutes of physician or other qualified health care professional time, *per calendar month*, 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

99437: Chronic care management services; each additional 30 minutes of clinical staff time directed by a physician or other QHP, *per calendar month* (list separately in addition to code for primary procedure)

- Elements for 99491 apply
- Report code 99437 in conjunction with 99491

Note: Do not report 99437, 99491 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99439, 99487, 99489, 99490, 99605, 99606, 99607.

Note: Do not report 99437, 99491 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99495, 99496, 99605, 99606, 99607.

CCM Documentation Requirements:

- The eligible practitioner can only bill **one CCM code per month per qualifying patient**.
- The initiation of CCM services **must occur during a face-to-face visit** with the billing practitioner.
- Obtaining **advance consent from the patient is required**. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:
  1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
  2. As the central coordinator of the patient's care plan the billing CCM codes is intended for PCP use. However, other specialties may bill CCM codes if they are the *primary* coordinator of the patient's continuing care (e.g., Oncology) Only a **single practitioner can furnish and be paid for CCM services once per calendar month per patient**.
  3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.
- **Documentation of a Comprehensive Care Plan is required**. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
  1. Problem list
  2. Expected outcomes and prognosis
  3. Measurable treatment goals
  4. Cognitive and Functional assessments
  5. Planned interventions and identification of the individuals responsible for each intervention
  6. Medication and symptom management
  7. Environmental evaluation
  8. Caregiver assessment
  9. Interaction and coordination with resources and health care professionals and others outside the practice, as necessary, with description of how outside services will be directed
  10. Schedule for periodic review and when required, revision of the care plan
- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.

- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the practitioner may choose that date as the date of service and need not hold the claim until the end of the month. For complex CCM (99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

◆ Principal Care Management Services (PCM): 99424, 99425, 99426, 99427

PCM closely mimics Chronic Care Management (CCM) requirements, and may not be billed concurrently with CCM, behavioral health integration services. Like CCM, a verbal consent is required and must be documented in the patient's chart.

99424: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation /decompen-sation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other QHP, *per calendar month*.

99425: Each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

- Elements for 99424 apply
- Report code 99424 in conjunction with 99425

Note: Do not report 99424, 99425 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491, 99605, 99606, 99607.

Note: Do not report 99424, 99425 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

99426: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation /decompen-sation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other QHP, *per calendar month*.

99427: Each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

- Elements for 99426 apply
- Report code 99426 in conjunction with 99427

Note: Do not report 99426, 99427 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99437, 99439, 99487, 99489, 99490, 99491, 99605, 99606, 99607.

Note: Do not report 99426, 99427 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

Table for Reporting Principal Care Management Services

Total Duration Principal CM Services	Staff Type	Principal Care Management
less than 30 minutes	Not separately reported	Not separately reported
30 - 59 minutes	Physician or other QHP	99424 x 1
	Clinical Staff	99426 x 1
60 - 89 minutes	Physician or other QHP	99424 x 1 and 99425 x 1
	Clinical Staff	99426 x 1 and 99427 x 1
90 - 119 minutes	Physician or other QHP	99424 x 1 and 99425 x 2
	Clinical Staff	99426 x 1 and 99427 x 2
120 minutes or more	Physician or other QHP	99424 x 1 and 99425 x 3, as appropriate see illustrated reporting examples above
	Clinical Staff	99426 x 1 and 99427 x 2

Table for Reporting Care Management Services

Code	Service	Staff Type	Total Duration (Time Span)	Unit Max Per Month
99490	Chronic CM	Clinical Staff	20 minutes (20 - 39 minutes)	1
+99439	Chronic CM	Clinical Staff	40 - 59 minutes x 1 (60+ x 2)	2
99491	Chronic CM	Physician or other QHP	30 minutes (30 - 59 minutes)	1
+99437	Chronic CM	Physician or other QHP	30 minutes (60 minutes or more)	No limit
99487	Complex CCM	Clinical Staff	60 minutes (60 - 89 minutes)	1
+99489	Complex CCM	Clinical Staff	30 minutes (less than 90 minutes x 1) (less than 120 minutes x 2, etc.)	No limit
99424	Principal CM	Physician or other QHP	30 minutes (30 - 59 minutes)	1
+99425	Principal CM	Physician or other QHP	30 minutes (60 minutes or more)	No limit
99426	Principal CM	Clinical Staff	30 minutes (30 - 59 minutes)	1
+99427	Principal CM	Clinical Staff	30 minutes (60 minutes or more)	2+

Note: If the treating physician or other QHP personally performs any of the care management services and those activities are not used to meet the criteria for a separately reported code (99424, 99491), then his or her time may be counted toward the required clinical staff time to meet the elements of 99426, 99487, 99490 as applicable.

◆ Transitional Care Management (TCM) Services: 99495, 99496

Codes 99495 and 99496 are used to report TCM. These services are for a new or established patient who's medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other QHP and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan.

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other QHP may include:

1. Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. Communication with agencies and other community services utilized by the patient;
3. Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other QHP may include:

1. Obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);
2. Reviewing need for or follow-up on pending diagnostic tests and treatments;

3. Interaction with other QHPs who will assume or reassume care of the patient's system-specific problems;
4. Education of patient, family, guardian, and/or caregiver;
5. Establishment or reestablishment of referrals and arranging for needed community resources;
6. Assistance in scheduling any required follow-up with community providers and services.

Transitional Care Management Services

Type of Medical Decision Making	Face-to-Face Visit Within 7 Days	Face-to-Face Visit Within 14 Days
Moderate Complexity	Use code 99495	Use code 99495
High Complexity	Use code 99496	Use code 99495

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services IF they have primary responsibility for post-discharge care coordination – secondary consulting specialists or other secondary practitioners are not eligible for separate reimbursement.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day in which the discharge day management services are reported.
- You may not bill TCM services that are within a post-operative global period (TCM services will not be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner).
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).
- The place of service should correspond to the place of service of the required face-to-face visit.
- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.
- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Evidence of the patient's consent to participate in TCM services and an acknowledgement service may be subject to additional cost share responsibilities.
- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision-making actions and the level of complexity (moderate or high).

◆ Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a PCP physician or other qualified PCP health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion along with beginning and ending times.
- Patient/surrogate/family "given opportunity to decline;"
- Details of discussion (e.g., Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of ACP services, the patient must provide consent and consent must be documented in the medical record in addition to an acknowledgement service may be subject to additional cost share responsibilities.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.

- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- **Reimbursement for 99497 and 99498 are limited to the following specialties: PCP specialties (NP's and PA's)**
- 99498 must be reported in conjunction with 99497

◆ Psychiatric Collaborative Care Management Services (PCCM): 99492, 99493, 99494, G2214

PCCM services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99492: Initial psychiatric collaborative care management, first 70 minutes in the *first calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other QHP;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

99493: Subsequent psychiatric collaborative care management, first 60 minutes in a *subsequent month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a *calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP. (List separately in addition to code for primary procedure)

- Use 99494 in conjunction with 99492, 99493
- Elements of 99492 and/or 99493 apply

Note: If the treating physician or other QHP personally performs BH care manager activities and those activities are not used to meet criteria for separately reported code, his or her time may be counted toward the required BH care manager time to meet the elements of 99492, 99493, 99494.

Collaborative Care Management

Type of Service	Total Duration of Collaborative Care Management Over Calendar Month	Codes
Initial - 70 minutes	less than 36 minutes	Not separately reported
	36 - 85 minutes (36 minutes - 1 hr. 25 minutes)	99492 x 1
Initial plus each additional increment up to 30 minutes	86 - 115 minutes (1 hr. 26 min. - 1 hr. 55 minutes)	99492 x 1 *and* 99494 x 1
Subsequent - 60 minutes	less than 31 minutes	Not separately reported
	31 - 75 minutes (31 minutes - 1 hr. 15 minutes)	99493 x 1
Subsequent plus each additional increment up to 30 minutes	76 - 105 minutes (1 hr. 16 min. - 1 hr. 45 minutes)	99493 x 1 *and* 99494 x 1

G2214: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

PCCM Service Requirements:

- An initiating visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric services. This can be an Evaluation and Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE).
- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:
  1. Information on the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during calendar month.
  3. That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. The patient is giving permission to consult with relevant specialists.
- At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric services, furnished;
  a) Under the direction of the physician, NP, PA, or CNM, and;
  b) By a practitioner or Behavioral Health Care Manager under general supervision.

Patient must have a behavioral health or psychiatric condition that is being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants psychiatric services. PCCM Services require a team that includes the following:

- Practitioner (physician, NP, PA, or CNM) who:
  1. Directs the behavioral health care manager or clinical staff.
  2. Oversees; the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.
  3. Remains involved through ongoing management, collaboration and reassessment.
- Behavioral Health Care Manager who:
  1. Provides assessment and CM services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant.
  2. Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the care team.
  3. Is available to contact the patient outside of regular hours as necessary to conduct the behavioral health care manager's duties.
- Psychiatric Consultant who:
  1. Participates in regular reviews of the clinical status of patients receiving services;
  2. Advises the practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments.
  3. Facilitate referral for direct provision of psychiatric care when clinically indicated.

◆ General Behavioral Health Integration Care Management (BHI): 99484

BHI services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other QHP time, *per calendar month*, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Note: Clinical staff time spent coordinating care with the emergency department may be reported using 99484, but time spent while the patient is inpatient or admitted to observation status may not be reported using 99484. Do not report 99484 in conjunction with 99492, 99493, 99494 in the same calendar month.

Note: E/M services, including care management services (99424, 99425, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491, 99495, 99496), and psychiatric services (90785-90899) may be reported separately by the same physician or other QHP on the same day or during the same calendar month, but time and activities used to meet criteria for another reported service do not count toward meeting criteria for 99484.

Note: Do not report G0323 for Commercial products, instead report 99484.

General BHI Care Management Service Requirements:

- An initiating Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services.
- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by the practitioner or clinical staff;
  can be written or verbal, must be documented in the medical record and includes information:
  1. On the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during a calendar month.
  3. On the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. Permission to consult with relevant specialist.
- At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the physician, NP, PA, or CNM, and b) by a practitioner, or by clinical personnel under general supervision.
- Patient must have one of the following two options:
  a) Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, or;
  b) Any behavioral health or psychiatric condition being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants BHI services.
- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:
  1. Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.
  2. 24/7 access to physicians or other QHPs or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
  3. Comprehensive CM including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all prescribed preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
  4. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental

(re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.
5. Care plan information made available electronically (including fax) in a timely manner as appropriate and a copy of the plan of care given to the patient and/or caregiver.
6. Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
7. Coordination with home and community-based clinical service providers, and documentation of communication to and from home and community-based providers regarding the patient's psychosocial needs and functional deficits in the medical record.
8. Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

1. Initial assessment/follow-up monitoring, including use of applicable validated rating scales
2. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
3. Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)
4. Continuity of care with a designated member of the care team

Additional BHI Documentation Requirements:

- Beginning and ending times, along with total minutes, must be documented in the patient's medical record and made available for audit review as required.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows published CMS guidelines for Care Coordination services. See the reference section below for sources. This is representative of some guidelines and not an all-inclusive list.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-035: Correct Coding Guidelines

REFERENCES:

- Chronic Care Management Services; Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- Delaware PCP / Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743

- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs

- Cognitive Assessment and Care Planning Services https://www.alz.org/careplanning/downloads/cms-consensus.pdf

- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section. *Current Procedure Terminology Manual* (CPT®) is copyright American Medical Association. All rights Reserved. The AMA assumes no liability for the data contained in this policy.

- AAP News and Journals Gateway https://www.aappublications.org/news/2017/11/02/Coding110217

- Behavioral Health Integration Services; Department of Health and Human Services Centers for Medicare & Medicaid Services, MLN Matters Booklet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs); Centers for Medicare & Medicaid Services, MM10175. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

- Advanced Care Planning; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

- Behavioral Health Integration Services; Centers for Medicare & Medicaid Services, MLN Booklet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Transitional Care Management Services; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

POLICY UPDATE HISTORY INFORMATION:

1 / 2019	Implementation
5 / 2019	Clarified that TCM services during global period cannot be billed by the same practitioner
1 / 2020	Added codes G2058, G2064 and G2065
4 / 2020	Added codes 99484, 99492, 99493 and 99494 eligible for all regions. Added 99487, 99489, 99490 and 99491 eligible for WV and PA
3 / 2021	Removed code G2058. Added codes 99439 and G2214.
11 / 2021	Added NY region applicable to the policy

1 / 2022	Added Delaware Medicare Advantage applicable to the policy. Added code 99424, 99425, 99426, 99427 and 99437. Added and edited information throughout the policy.
6 / 2022	Removed codes G2065 and G2064 and advisory reference guide link.
1 / 2023	Added note for G0323
6 / 2023	Administrative policy review with no changes in policy direction

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	January 1, 2023	**Revised Date:**	January 2023
Date Reviewed:	December 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Care management is the range of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions. This policy is intended to provide the Plan's reimbursement direction for these services.

DEFINITIONS:

Transitional Care Management (TCM): Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of twenty-nine (29) days.

Advance Care Planning (ACP): A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

Chronic Care Management (CCM): Services encompassing the oversight and education activities by health care professionals to help patients with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.

Principal Care Management Services (PCM): Principal care management represents services that focus on the medical and/or psychological needs manifested by a single, complex chronic condition expected to last at least three (3) months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease.

Psychiatric Collaborative Care Management (PCCM): Behavioral health services delivered via a specific evidence-based model. Care is managed by a behavioral health care manager (BHCM), who has master's/doctoral-level education or specialized training in behavioral health, under direction of a treating physician or qualified health care professional (QHP) in consultation with a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications.

General Behavioral Health Integration Care Management (BHI): The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Care Coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

Primary Care: Health care provided by a physician or an individual license to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes internal medicine, family practice, general practice, pediatrics, CRNP PCP, geriatric medicine, and multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, pediatrics, CRNP PCP, PA PCP, or geriatric medicine).

Comprehensive Care: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

Qualified Healthcare Professional (QHP): An individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. QHPs are distinct from clinical staff.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Care Management Services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional (QHP) or may be provided personally by a physician or other QHP to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. Care management services improve care coordination, reduce avoidable hospital services, improve patient engagement, and decrease care fragmentation. The physician or other QHP provides or overseas the management and/or coordination of care management services, which include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

There are three (3) general categories of care management services: chronic care management, complex chronic care management, and principal care management. Complex chronic care management addresses all of the patient's medical conditions, and principal care management services addresses a single condition. Each of the three (3) categories is further subdivided into those services that are personally performed by the physician or other QHP.

Code selection for these services is based on time in a calendar month, and time used in reporting these services may not represent time spent in another reported service. Chronic care management services do not require moderate to high-level medical decision making and may be reported for a shorter time threshold than complex chronic care management services. Both chronic care and complex chronic care management address, as needed, all medical conditions, psychosocial needs, and activities of daily living. Principal care management services are disease-specific management services. A patient may have multiple chronic conditions of sufficient severity to warrant complex chronic care management but may receive principal care management if the reporting physician or other QHP is providing single disease rather than comprehensive care management.

Care Planning

A plan of care for health problems is based on a physical, mental, cognitive, social, functional, and environmental evaluation. It is intended to provide a simple and concise overview of the patient and his or her medical condition(s) and be a useful resource for patients, caregivers, health care professionals, and others, as necessary.

The care management office/practice must have the following capabilities:

1. Provide 24/7 access to physicians or other QHPs or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of the week;
2. Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
3. Provide timely access and management for follow-up after an emergency department visit or facility discharge;
4. Utilize an electronic health record system for timely access to clinical information;
5. Be able to engage and educate patients and caregivers as well as coordinate and integrate care among all professionals, as appropriate for each patient;
6. Reporting physician or other QHP overseas activities of the care team;
7. All care team members providing services are clinically integrated.

- **Chronic Care Management (CCM) Services: 99490, 99491, 99437, and 99439**

CCM services are management and support services provided by clinical staff, under the direction of a physician or other QHP or may be provided personally by a physician or other QHP to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure

timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

Care management activities performed by clinical staff, or personally by the physician or other QHP, typically include includes:

1. Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. Communication with home health agencies and other community services utilized by the patient;
3. Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family;
7. Management of care transitions not reported as part of transitional care management (99495, 99496)
8. Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above;
9. Development, communication, and maintenance of a comprehensive care or disease specific (as applicable) care plan;
10. Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
11. A copy of the plan of care must be given to the patient and/or caregiver

◆ **Complex Chronic Care Management (CCM) Services: 99487, 99489**

99487: Complex chronic care management services, with the following required elements:

- Multiple (2+) 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 a comprehensive care plan
- Moderate or high complexity medical decision making
- First 60 minutes of clinical staff time directed by a physician or other QHP, *per calendar month*

Note: Complex chronic care management services require moderate or high medical decision making as defined in the Evaluation and Management (E/M) guidelines.

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes, in a calendar month, are *not* reported separately.

Complex Chronic Care Management

Total Duration of Staff Care Management Services	Complex Chronic Care Management
less than 60 minutes	Not separately reported
30 - 89 minutes (1 hour - 1 hr. 29 minutes)	99487 x 1
90 - 119 minutes (1 hr. 30 min - 1 hr. 59 minutes)	99487 x 1 and 99489 x 1
120 minutes or more (2 hours or more)	99487 x 1 and 99489 x 2 and 99489 for each additional 30 minutes

99490: Chronic care management services, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, *per calendar month*, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99439: Chronic care management services; 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)

- Elements for 99490 apply
- Report code 99439 in conjunction with 99490
- Do not report 99439 more than twice per calendar month

Note: Do not report 99439, 99490 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99437, 99487, 99489, 99491, 99605, 99606, 99607.

Note: Do not report 99439, 99490 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

99491: Chronic care management services, provided personally by a physician or other qualified health care professional, first 30 minutes of physician or other qualified health care professional time, *per calendar month*, 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

99437: Chronic care management services; each additional 30 minutes of clinical staff time directed by a physician or other QHP, *per calendar month* (list separately in addition to code for primary procedure)

- Elements for 99491 apply
- Report code 99437 in conjunction with 99491

Note: Do not report 99437, 99491 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99439, 99487, 99489, 99490, 99605, 99606, 99607.

Note: Do not report 99437, 99491 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99495, 99496, 99605, 99606, 99607.

CCM Documentation Requirements:

- The eligible practitioner can only bill **one CCM code per month per qualifying patient**.
- The initiation of CCM services **must occur during a face-to-face visit** with the billing practitioner.
- Obtaining **advance consent from the patient is required**. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:
  1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
  2. As the central coordinator of the patient's care plan the billing CCM codes is intended for PCP use. However, other specialties may bill CCM codes if they are the *primary* coordinator of the patient's continuing care (e.g., Oncology) Only a **single practitioner can furnish and be paid for CCM services once per calendar month per patient**.
  3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.
- **Documentation of a Comprehensive Care Plan is required**. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
  1. Problem list
  2. Expected outcomes and prognosis
  3. Measurable treatment goals
  4. Cognitive and Functional assessments
  5. Planned interventions and identification of the individuals responsible for each intervention
  6. Medication and symptom management
  7. Environmental evaluation
  8. Caregiver assessment
  9. Interaction and coordination with resources and health care professionals and others outside the practice, as necessary, with description of how outside services will be directed
  10. Schedule for periodic review and when required, revision of the care plan

- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.
- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the practitioner may choose that date as the date of service and need not hold the claim until the end of the month. For complex CCM (99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

◆ Principal Care Management Services (PCM): 99424, 99425, 99426, 99427

PCM closely mimics Chronic Care Management (CCM) requirements, and may not be billed concurrently with CCM, behavioral health integration services. Like CCM, a verbal consent is required and must be documented in the patient's chart.

99424: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation /decompen-sation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other QHP, *per calendar month*.

99425: Each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

- Elements for 99424 apply
- Report code 99424 in conjunction with 99425

Note: Do not report 99424, 99425 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491, 99605, 99606, 99607.

Note: Do not report 99424, 99425 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

99426: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation /decompen-sation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

- Ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other QHP, *per calendar month*.

99427: Each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

- Elements for 99426 apply
- Report code 99426 in conjunction with 99427

Note: Do not report 99426, 99427 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99437, 99439, 99487, 99489, 99490, 99491, 99605, 99606, 99607.

Note: Do not report 99426, 99427 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

Table for Reporting Principal Care Management Services

Total Duration Principal CM Services	Staff Type	Principal Care Management
less than 30 minutes	Not separately reported	Not separately reported
30 - 59 minutes	Physician or other QHP	99424 x 1
	Clinical Staff	99426 x 1
60 - 89 minutes	Physician or other QHP	99424 x 1 and 99425 x 1
	Clinical Staff	99426 x 1 and 99427 x 1
90 - 119 minutes	Physician or other QHP	99424 x 1 and 99425 x 2
	Clinical Staff	99426 x 1 and 99427 x 2
120 minutes or more	Physician or other QHP	99424 x 1 and 99425 x 3, as appropriate see illustrated reporting examples above
	Clinical Staff	99426 x 1 and 99427 x 2

Table for Reporting Care Management Services

Code	Service	Staff Type	Total Duration (Time Span)	Unit Max Per Month
99490	Chronic CM	Clinical Staff	20 minutes (20 - 39 minutes)	1
+99439	Chronic CM	Clinical Staff	40 - 59 minutes x 1 (60+ x 2)	2
99491	Chronic CM	Physician or other QHP	30 minutes (30 - 59 minutes)	1
+99437	Chronic CM	Physician or other QHP	30 minutes (60 minutes or more)	No limit
99487	Complex CCM	Clinical Staff	60 minutes (60 - 89 minutes)	1
+99489	Complex CCM	Clinical Staff	30 minutes (less than 90 minutes x 1) (less than 120 minutes x 2, etc.)	No limit
99424	Principal CM	Physician or other QHP	30 minutes (30 - 59 minutes)	1
+99425	Principal CM	Physician or other QHP	30 minutes (60 minutes or more)	No limit
99426	Principal CM	Clinical Staff	30 minutes (30 - 59 minutes)	1
+99427	Principal CM	Clinical Staff	30 minutes (60 minutes or more)	2+

Note: If the treating physician or other QHP personally performs any of the care management services and those activities are not used to meet the criteria for a separately reported code (99424, 99491), then his or her time may be counted toward the required clinical staff time to meet the elements of 99426, 99487, 99490 as applicable.

◆ Transitional Care Management (TCM) Services: 99495, 99496

Codes 99495 and 99496 are used to report TCM. These services are for a new or established patient who's medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other QHP and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan.

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other QHP may include:

1. Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. Communication with agencies and other community services utilized by the patient;
3. Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other QHP may include:

1. Obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);

2. Reviewing need for or follow-up on pending diagnostic tests and treatments;
3. Interaction with other QHPs who will assume or reassume care of the patient's system-specific problems;
4. Education of patient, family, guardian, and/or caregiver;
5. Establishment or reestablishment of referrals and arranging for needed community resources;
6. Assistance in scheduling any required follow-up with community providers and services.

Transitional Care Management Services

Type of Medical Decision Making	Face-to-Face Visit Within 7 Days	Face-to-Face Visit Within 14 Days
Moderate Complexity	Use code 99495	Use code 99495
High Complexity	Use code 99496	Use code 99495

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services IF they have primary responsibility for post-discharge care coordination – secondary consulting specialists or other secondary practitioners are not eligible for separate reimbursement.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day in which the discharge day management services are reported.
- You may not bill TCM services that are within a post-operative global period (TCM services will not be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner).
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).
- The place of service should correspond to the place of service of the required face-to-face visit.
- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.
- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Evidence of the patient's consent to participate in TCM services and an acknowledgement service may be subject to additional cost share responsibilities.
- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision-making actions and the level of complexity (moderate or high).

◆ Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a PCP physician or other qualified PCP health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion along with beginning and ending times.
- Patient/surrogate/family "given opportunity to decline;"
- Details of discussion (e.g., Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of ACP services, the patient must provide consent and consent must be documented in the medical record in addition to an acknowledgement service may be subject to additional cost share responsibilities.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.

- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- **Reimbursement for 99497 and 99498 are limited to the following specialties: PCP specialties (NP's and PA's)**
- 99498 must be reported in conjunction with 99497

◆ **Psychiatric Collaborative Care Management Services (PCCM): 99492, 99493, 99494, G2214**

PCCM services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99492: Initial psychiatric collaborative care management, first 70 minutes in the *first calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other QHP;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

99493: Subsequent psychiatric collaborative care management, first 60 minutes in a *subsequent month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a *calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP. (List separately in addition to code for primary procedure)

- Use 99494 in conjunction with 99492, 99493
- Elements of 99492 and/or 99493 apply

Note: If the treating physician or other QHP personally performs BH care manager activities and those activities are not used to meet criteria for separately reported code, his or her time may be counted toward the required BH care manager time to meet the elements of 99492, 99493, 99494.

Collaborative Care Management

Type of Service	Total Duration of Collaborative Care Management Over Calendar Month	Codes
Initial - 70 minutes	less than 36 minutes	Not separately reported
	36 - 85 minutes (36 minutes - 1 hr. 25 minutes)	99492 x 1
Initial plus each additional increment up to 30 minutes	86 - 115 minutes (1 hr. 26 min. - 1 hr. 55 minutes)	99492 x 1 *and* 99494 x 1
Subsequent - 60 minutes	less than 31 minutes	Not separately reported
	31 - 75 minutes (31 minutes - 1 hr. 15 minutes)	99493 x 1
Subsequent plus each additional increment up to 30 minutes	76 - 105 minutes (1 hr. 16 min. - 1 hr. 45 minutes)	99493 x 1 *and* 99494 x 1

G2214: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

PCCM Service Requirements:

- An initiating visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric services. This can be an Evaluation and Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE).
- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:
  1. Information on the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during calendar month.
  3. That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. The patient is giving permission to consult with relevant specialists.
- At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric services, furnished;
  a) Under the direction of the physician, NP, PA, or CNM, and;
  b) By a practitioner or Behavioral Health Care Manager under general supervision.

Patient must have a behavioral health or psychiatric condition that is being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants psychiatric services. PCCM Services require a team that includes the following:

- Practitioner (physician, NP, PA, or CNM) who:
  1. Directs the behavioral health care manager or clinical staff.
  2. Oversees; the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.
  3. Remains involved through ongoing management, collaboration and reassessment.
- Behavioral Health Care Manager who:
  1. Provides assessment and CM services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant.
  2. Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the care team.
  3. Is available to contact the patient outside of regular hours as necessary to conduct the behavioral health care manager's duties.
- Psychiatric Consultant who:
  1. Participates in regular reviews of the clinical status of patients receiving services;
  2. Advises the practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments.
  3. Facilitate referral for direct provision of psychiatric care when clinically indicated.

◆ **General Behavioral Health Integration Care Management (BHI): 99484**

BHI services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other QHP time, *per calendar month*, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Note: Clinical staff time spent coordinating care with the emergency department may be reported using 99484, but time spent while the patient is inpatient or admitted to observation status may not be reported using 99484. Do not report 99484 in conjunction with 99492, 99493, 99494 in the same calendar month.

Note: E/M services, including care management services (99424, 99425, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491, 99495, 99496), and psychiatric services (90785-90899) may be reported separately by the same physician or other QHP on the same day or during the same calendar month, but time and activities used to meet criteria for another reported service do not count toward meeting criteria for 99484.

Note: Do not report G0323 for Commercial products, instead report 99484.

General BHI Care Management Service Requirements:

- An initiating Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services.
- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by the practitioner or clinical staff;
  can be written or verbal, must be documented in the medical record and includes information:
  1. On the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during a calendar month.
  3. On the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. Permission to consult with relevant specialist.
- At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the physician, NP, PA, or CNM, and b) by a practitioner, or by clinical personnel under general supervision.
- Patient must have one of the following two options:
  a) Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, or;
  b) Any behavioral health or psychiatric condition being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants BHI services.
- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:
  1. Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.
  2. 24/7 access to physicians or other QHPs or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
  3. Comprehensive CM including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all prescribed preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
  4. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental

(re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.

5. Care plan information made available electronically (including fax) in a timely manner as appropriate and a copy of the plan of care given to the patient and/or caregiver.
6. Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
7. Coordination with home and community-based clinical service providers, and documentation of communication to and from home and community-based providers regarding the patient's psychosocial needs and functional deficits in the medical record.
8. Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

1. Initial assessment/follow-up monitoring, including use of applicable validated rating scales
2. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
3. Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)
4. Continuity of care with a designated member of the care team

Additional BHI Documentation Requirements:

- Beginning and ending times, along with total minutes, must be documented in the patient's medical record and made available for audit review as required.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows published CMS guidelines for Care Coordination services. See the reference section below for sources. This is representative of some guidelines and not an all-inclusive list.

REFERENCES:

- Chronic Care Management Services; Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- Delaware PCP and Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743

- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs

- Cognitive Assessment and Care Planning Services
  https://www.alz.org/careplanning/downloads/cms-consensus.pdf

- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section. *Current Procedure Terminology Manual* (CPT®) is copyright American Medical Association. All rights Reserved. The AMA assumes no liability for the data contained in this policy.

- AAP News and Journals Gateway
  https://www.aappublications.org/news/2017/11/02/Coding110217

- Behavioral Health Integration Services; Department of Health and Human Services Centers for Medicare & Medicaid Services, MLN Matters Booklet
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs); Centers for Medicare & Medicaid Services, MM10175.
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

- Advanced Care Planning; Centers for Medicare & Medicaid Services, MLN Fact Sheet.
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

- Behavioral Health Integration Services; Centers for Medicare & Medicaid Services, MLN Booklet.
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Transitional Care Management Services; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

POLICY UPDATE HISTORY INFORMATION:

1 / 2019	Implementation
5 / 2019	Clarified that TCM services during global period cannot be billed by the same practitioner
1 / 2020	Added codes G2058, G2064 and G2065
4 / 2020	Added codes 99484, 99492, 99493 and 99494 eligible for all regions. Added 99487, 99489, 99490 and 99491 eligible for WV and PA
3 / 2021	Removed code G2058. Added codes 99439 and G2214.
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy. Added code 99424, 99425, 99426, 99427 and 99437. Added and edited information throughout the policy.

6 / 2022	Removed codes G2065 and G2064 and advisory reference guide link.
1 / 2023	Added note for G0323

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	July 18, 2022	**Revised Date:**	June 2022
Date Reviewed:	June 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Care management is the range of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions. This policy is intended to provide the Plan's reimbursement direction for these services.

DEFINITIONS:

Transitional Care Management (TCM): Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of twenty-nine (29) days.

Advance Care Planning (ACP): A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

Chronic Care Management (CCM): Services encompassing the oversight and education activities by health care professionals to help patients with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.

Principal Care Management Services (PCM): Principal care management represents services that focus on the medical and/or psychological needs manifested by a single, complex chronic condition expected to last at least three (3) months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease.

Psychiatric Collaborative Care Management (PCCM): Behavioral health services delivered via a specific evidence-based model. Care is managed by a behavioral health care manager (BHCM), who has master's/doctoral-level education or specialized training in behavioral health, under direction of a treating physician or qualified health care professional (QHP) in consultation with a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications.

General Behavioral Health Integration Care Management (BHI): The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Care Coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

Primary Care: Health care provided by a physician or an individual license to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes internal medicine, family practice, general practice, pediatrics, CRNP PCP, geriatric medicine, and multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, pediatrics, CRNP PCP, PA PCP, or geriatric medicine).

Comprehensive Care: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

Qualified Healthcare Professional (QHP): An individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. QHPs are distinct from clinical staff.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Care Management Services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional (QHP) or may be provided personally by a physician or other QHP to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. Care management services improve care coordination, reduce avoidable hospital services, improve patient engagement, and decrease care fragmentation. The physician or other QHP provides or overseas the management and/or coordination of care management services, which include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

There are three (3) general categories of care management services: chronic care management, complex chronic care management, and principal care management. Complex chronic care management addresses all of the patient's medical conditions, and principal care management services addresses a single condition. Each of the three (3) categories is further subdivided into those services that are personally performed by the physician or other QHP.

Code selection for these services is based on time in a calendar month, and time used in reporting these services may not represent time spent in another reported service. Chronic care management services do not require moderate to high-level medical decision making and may be reported for a shorter time threshold than complex chronic care management services. Both chronic care and complex chronic care management address, as needed, all medical conditions, psychosocial needs, and activities of daily living. Principal care management services are disease-specific management services. A patient may have multiple chronic conditions of sufficient severity to warrant complex chronic care management but may receive principal care management if the reporting physician or other QHP is providing single disease rather than comprehensive care management.

Care Planning

A plan of care for health problems is based on a physical, mental, cognitive, social, functional, and environmental evaluation. It is intended to provide a simple and concise overview of the patient and his or her medical condition(s) and be a useful resource for patients, caregivers, health care professionals, and others, as necessary.

The care management office/practice must have the following capabilities:

1. Provide 24/7 access to physicians or other QHPs or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of the week;
2. Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
3. Provide timely access and management for follow-up after an emergency department visit or facility discharge;
4. Utilize an electronic health record system for timely access to clinical information;
5. Be able to engage and educate patients and caregivers as well as coordinate and integrate care among all professionals, as appropriate for each patient;
6. Reporting physician or other QHP overseas activities of the care team;
7. All care team members providing services are clinically integrated.

◆ **Chronic Care Management (CCM) Services: 99490, 99491, 99437, and 99439**

CCM services are management and support services provided by clinical staff, under the direction of a physician or other QHP or may be provided personally by a physician or other QHP to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure

timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

Care management activities performed by clinical staff, or personally by the physician or other QHP, typically include includes:

1. Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. Communication with home health agencies and other community services utilized by the patient;
3. Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family;
7. Management of care transitions not reported as part of transitional care management (99495, 99496)
8. Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above;
9. Development, communication, and maintenance of a comprehensive care or disease specific (as applicable) care plan;
10. Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
11. A copy of the plan of care must be given to the patient and/or caregiver

◆ **Complex Chronic Care Management (CCM) Services: 99487, 99489**

99487: Complex chronic care management services, with the following required elements:

- Multiple (2+) 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 a comprehensive care plan
- Moderate or high complexity medical decision making
- First 60 minutes of clinical staff time directed by a physician or other QHP, *per calendar month*

Note: Complex chronic care management services require moderate or high medical decision making as defined in the Evaluation and Management (E/M) guidelines.

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes, in a calendar month, are *not* reported separately.

Complex Chronic Care Management

Total Duration of Staff Care Management Services	Complex Chronic Care Management
less than 60 minutes	Not separately reported
30 - 89 minutes (1 hour - 1 hr. 29 minutes)	99487 x 1
90 - 119 minutes (1 hr. 30 min - 1 hr. 59 minutes)	99487 x 1 and 99489 x 1
120 minutes or more (2 hours or more)	99487 x 1 and 99489 x 2 and 99489 for each additional 30 minutes

99490: Chronic care management services, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, *per calendar month*, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99439: Chronic care management services; 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)

- Elements for 99490 apply
- Report code 99439 in conjunction with 99490
- Do not report 99439 more than twice per calendar month

Note: Do not report 99439, 99490 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99437, 99487, 99489, 99491, 99605, 99606, 99607.

Note: Do not report 99439, 99490 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

99491: Chronic care management services, provided personally by a physician or other qualified health care professional, first 30 minutes of physician or other qualified health care professional time, *per calendar month*, 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

99437: Chronic care management services; each additional 30 minutes of clinical staff time directed by a physician or other QHP, *per calendar month* (list separately in addition to code for primary procedure)

- Elements for 99491 apply
- Report code 99437 in conjunction with 99491

Note: Do not report 99437, 99491 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99439, 99487, 99489, 99490, 99605, 99606, 99607.

Note: Do not report 99437, 99491 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99495, 99496, 99605, 99606, 99607.

CCM Documentation Requirements:

- The eligible practitioner can only bill **one CCM code per month per qualifying patient**.
- The initiation of CCM services **must occur during a face-to-face visit** with the billing practitioner.
- Obtaining **advance consent from the patient is required**. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:
  1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
  2. As the central coordinator of the patient's care plan the billing CCM codes is intended for PCP use. However, other specialties may bill CCM codes if they are the *primary* coordinator of the patient's continuing care (e.g., Oncology) Only a **single practitioner can furnish and be paid for CCM services once per calendar month per patient**.
  3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.
- **Documentation of a Comprehensive Care Plan is required**. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
  1. Problem list
  2. Expected outcomes and prognosis
  3. Measurable treatment goals
  4. Cognitive and Functional assessments
  5. Planned interventions and identification of the individuals responsible for each intervention
  6. Medication and symptom management
  7. Environmental evaluation
  8. Caregiver assessment
  9. Interaction and coordination with resources and health care professionals and others outside the practice, as necessary, with description of how outside services will be directed
  10. Schedule for periodic review and when required, revision of the care plan

- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.
- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the practitioner may choose that date as the date of service and need not hold the claim until the end of the month. For complex CCM (99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

◆ Principal Care Management Services (PCM): 99424, 99425, 99426, 99427

PCM closely mimics Chronic Care Management (CCM) requirements, and may not be billed concurrently with CCM, behavioral health integration services. Like CCM, a verbal consent is required and must be documented in the patient's chart.

99424: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation /decompen-sation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other QHP, *per calendar month*.

99425: Each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

- Elements for 99424 apply
- Report code 99424 in conjunction with 99425

Note: Do not report 99424, 99425 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491, 99605, 99606, 99607.

Note: Do not report 99424, 99425 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

99426: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation /decompen-sation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

- Ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other QHP, *per calendar month*.

99427: Each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

- Elements for 99426 apply
- Report code 99426 in conjunction with 99427

Note: Do not report 99426, 99427 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99437, 99439, 99487, 99489, 99490, 99491, 99605, 99606, 99607.

Note: Do not report 99426, 99427 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

Table for Reporting Principal Care Management Services

Total Duration Principal CM Services	Staff Type	Principal Care Management
less than 30 minutes	Not separately reported	Not separately reported
30 - 59 minutes	Physician or other QHP	99424 x 1
	Clinical Staff	99426 x 1
60 - 89 minutes	Physician or other QHP	99424 x 1 and 99425 x 1
	Clinical Staff	99426 x 1 and 99427 x 1
90 - 119 minutes	Physician or other QHP	99424 x 1 and 99425 x 2
	Clinical Staff	99426 x 1 and 99427 x 2
120 minutes or more	Physician or other QHP	99424 x 1 and 99425 x 3, as appropriate see illustrated reporting examples above
	Clinical Staff	99426 x 1 and 99427 x 2

Table for Reporting Care Management Services

Code	Service	Staff Type	Total Duration (Time Span)	Unit Max Per Month
99490	Chronic CM	Clinical Staff	20 minutes (20 - 39 minutes)	1
+99439	Chronic CM	Clinical Staff	40 - 59 minutes x 1 (60+ x 2)	2
99491	Chronic CM	Physician or other QHP	30 minutes (30 - 59 minutes)	1
+99437	Chronic CM	Physician or other QHP	30 minutes (60 minutes or more)	No limit
99487	Complex CCM	Clinical Staff	60 minutes (60 - 89 minutes)	1
+99489	Complex CCM	Clinical Staff	30 minutes (less than 90 minutes x 1) (less than 120 minutes x 2, etc.)	No limit
99424	Principal CM	Physician or other QHP	30 minutes (30 - 59 minutes)	1
+99425	Principal CM	Physician or other QHP	30 minutes (60 minutes or more)	No limit
99426	Principal CM	Clinical Staff	30 minutes (30 - 59 minutes)	1
+99427	Principal CM	Clinical Staff	30 minutes (60 minutes or more)	2+

Note: If the treating physician or other QHP personally performs any of the care management services and those activities are not used to meet the criteria for a separately reported code (99424, 99491), then his or her time may be counted toward the required clinical staff time to meet the elements of 99426, 99487, 99490 as applicable.

◆ Transitional Care Management (TCM) Services: 99495, 99496

Codes 99495 and 99496 are used to report TCM. These services are for a new or established patient who's medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other QHP and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan.

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other QHP may include:

1. Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. Communication with agencies and other community services utilized by the patient;
3. Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other QHP may include:

1. Obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);

2. Reviewing need for or follow-up on pending diagnostic tests and treatments;
3. Interaction with other QHPs who will assume or reassume care of the patient's system-specific problems;
4. Education of patient, family, guardian, and/or caregiver;
5. Establishment or reestablishment of referrals and arranging for needed community resources;
6. Assistance in scheduling any required follow-up with community providers and services.

Transitional Care Management Services

Type of Medical Decision Making	Face-to-Face Visit Within 7 Days	Face-to-Face Visit Within 14 Days
Moderate Complexity	Use code 99495	Use code 99495
High Complexity	Use code 99496	Use code 99495

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services IF they have primary responsibility for post-discharge care coordination – secondary consulting specialists or other secondary practitioners are not eligible for separate reimbursement.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day in which the discharge day management services are reported.
- You may not bill TCM services that are within a post-operative global period (TCM services will not be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner).
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).
- The place of service should correspond to the place of service of the required face-to-face visit.
- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.
- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Evidence of the patient's consent to participate in TCM services and an acknowledgement service may be subject to additional cost share responsibilities.
- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision-making actions and the level of complexity (moderate or high).

◆ Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a PCP physician or other qualified PCP health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion along with beginning and ending times.
- Patient/surrogate/family "given opportunity to decline;"
- Details of discussion (e.g., Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of ACP services, the patient must provide consent and consent must be documented in the medical record in addition to an acknowledgement service may be subject to additional cost share responsibilities.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.

- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- **Reimbursement for 99497 and 99498 are limited to the following specialties: PCP specialties (NP's and PA's)**
- 99498 must be reported in conjunction with 99497

◆ **Psychiatric Collaborative Care Management Services (PCCM): 99492, 99493, 99494, G2214**

PCCM services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99492: Initial psychiatric collaborative care management, first 70 minutes in the *first calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other QHP;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

99493: Subsequent psychiatric collaborative care management, first 60 minutes in a *subsequent month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a *calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP. (List separately in addition to code for primary procedure)

- Use 99494 in conjunction with 99492, 99493
- Elements of 99492 and/or 99493 apply

Note: If the treating physician or other QHP personally performs BH care manager activities and those activities are not used to meet criteria for separately reported code, his or her time may be counted toward the required BH care manager time to meet the elements of 99492, 99493, 99494.

Collaborative Care Management

Type of Service	Total Duration of Collaborative Care Management Over Calendar Month	Codes
Initial - 70 minutes	less than 36 minutes	Not separately reported
	36 - 85 minutes (36 minutes - 1 hr. 25 minutes)	99492 x 1
Initial plus each additional increment up to 30 minutes	86 - 115 minutes (1 hr. 26 min. - 1 hr. 55 minutes)	99492 x 1 *and* 99494 x 1
Subsequent - 60 minutes	less than 31 minutes	Not separately reported
	31 - 75 minutes (31 minutes - 1 hr. 15 minutes)	99493 x 1
Subsequent plus each additional increment up to 30 minutes	76 - 105 minutes (1 hr. 16 min. - 1 hr. 45 minutes)	99493 x 1 *and* 99494 x 1

G2214: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

PCCM Service Requirements:

- An initiating visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric services. This can be an Evaluation and Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE).
- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:
  1. Information on the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during calendar month.
  3. That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. The patient is giving permission to consult with relevant specialists.
- At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric services, furnished;
  a) Under the direction of the physician, NP, PA, or CNM, and;
  b) By a practitioner or Behavioral Health Care Manager under general supervision.

Patient must have a behavioral health or psychiatric condition that is being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants psychiatric services. PCCM Services require a team that includes the following:

- Practitioner (physician, NP, PA, or CNM) who:
  1. Directs the behavioral health care manager or clinical staff.
  2. Oversees; the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.
  3. Remains involved through ongoing management, collaboration and reassessment.
- Behavioral Health Care Manager who:
  1. Provides assessment and CM services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant.
  2. Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the care team.
  3. Is available to contact the patient outside of regular hours as necessary to conduct the behavioral health care manager's duties.
- Psychiatric Consultant who:
  1. Participates in regular reviews of the clinical status of patients receiving services;
  2. Advises the practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments.
  3. Facilitate referral for direct provision of psychiatric care when clinically indicated.

◆ **General Behavioral Health Integration Care Management (BHI): 99484**

BHI services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other QHP time, *per calendar month*, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Note: Clinical staff time spent coordinating care with the emergency department may be reported using 99484, but time spent while the patient is inpatient or admitted to observation status may not be reported using 99484. Do not report 99484 in conjunction with 99492, 99493, 99494 in the same calendar month.

Note: E/M services, including care management services (99424, 99425, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491, 99495, 99496), and psychiatric services (90785-90899) may be reported separately by the same physician or other QHP on the same day or during the same calendar month, but time and activities used to meet criteria for another reported service do not count toward meeting criteria for 99484.

General BHI Care Management Service Requirements:

- An initiating Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services.
- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by the practitioner or clinical staff;
  can be written or verbal, must be documented in the medical record and includes information:
  1. On the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during a calendar month.
  3. On the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. Permission to consult with relevant specialist.
- At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the physician, NP, PA, or CNM, and b) by a practitioner, or by clinical personnel under general supervision.
- Patient must have one of the following two options:
  a) Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, or;
  b) Any behavioral health or psychiatric condition being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants BHI services.
- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:
  1. Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.
  2. 24/7 access to physicians or other QHPs or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
  3. Comprehensive CM including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all prescribed preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
  4. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.

5. Care plan information made available electronically (including fax) in a timely manner as appropriate and a copy of the plan of care given to the patient and/or caregiver.
6. Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
7. Coordination with home and community-based clinical service providers, and documentation of communication to and from home and community-based providers regarding the patient's psychosocial needs and functional deficits in the medical record.
8. Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

1. Initial assessment/follow-up monitoring, including use of applicable validated rating scales
2. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
3. Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)
4. Continuity of care with a designated member of the care team

Additional BHI Documentation Requirements:

- Beginning and ending times, along with total minutes, must be documented in the patient's medical record and made available for audit review as required.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows published CMS guidelines for Care Coordination services. See the reference section below for sources. This is representative of some guidelines and not an all-inclusive list.

REFERENCES:

- Chronic Care Management Services; Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- Delaware PCP and Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743

- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs

- Cognitive Assessment and Care Planning Services
  https://www.alz.org/careplanning/downloads/cms-consensus.pdf

- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section. *Current Procedure Terminology Manual* (CPT®) is copyright American Medical Association. All rights Reserved. The AMA assumes no liability for the data contained in this policy.

- AAP News and Journals Gateway
  https://www.aappublications.org/news/2017/11/02/Coding110217

- Behavioral Health Integration Services; Department of Health and Human Services Centers for Medicare & Medicaid Services, MLN Matters Booklet
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs); Centers for Medicare & Medicaid Services, MM10175.
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

- Advanced Care Planning; Centers for Medicare & Medicaid Services, MLN Fact Sheet.
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

- Behavioral Health Integration Services; Centers for Medicare & Medicaid Services, MLN Booklet.
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Transitional Care Management Services; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

POLICY UPDATE HISTORY INFORMATION:

1 / 2019	Implementation
5 / 2019	Clarified that TCM services during global period cannot be billed by the same practitioner
1 / 2020	Added codes G2058, G2064, G2065
4 / 2020	Added codes 99484, 99492, 99493 and 99494 eligible for all regions. Added 99487, 99489, 99490 and 99491 eligible for WV and PA
3 / 2021	Removed code G2058. Added codes 99439 and G2214.
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy. Added code 99424, 99425, 99426, 99427 and 99437. Added and edited information throughout the policy.

6 / 2022	Removed Codes G2065 G2064 and information associated, Advisory Reference guide link.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	October 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Care management is the range of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions. This policy is intended to provide the Plan's reimbursement direction for these services.

DEFINITIONS:

Transitional Care Management (TCM): Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of twenty-nine (29) days.

Advance Care Planning (ACP): A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

Chronic Care Management (CCM): Services encompassing the oversight and education activities by health care professionals to help patients with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.

Principal Care Management Services (PCM): Principal care management represents services that focus on the medical and/or psychological needs manifested by a single, complex chronic condition expected to last at least three (3) months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease.

Psychiatric Collaborative Care Management (PCCM): Behavioral health services delivered via a specific evidence-based model. Care is managed by a behavioral health care manager (BHCM), who has master's/doctoral-level education or specialized training in behavioral health, under direction of a treating physician or qualified health care professional (QHP) in consultation with a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications.

General Behavioral Health Integration Care Management (BHI): The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Care Coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

Primary Care: Health care provided by a physician or an individual license to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes internal medicine, family practice, general practice, pediatrics, CRNP PCP, geriatric medicine, and multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, pediatrics, CRNP PCP, PA PCP, or geriatric medicine).

Comprehensive Care: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

Qualified Healthcare Professional (QHP): An individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. QHPs are distinct from clinical staff.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Care Management Services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional (QHP) or may be provided personally by a physician or other QHP to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. Care management services improve care coordination, reduce avoidable hospital services, improve patient engagement, and decrease care fragmentation. The physician or other QHP provides or overseas the management and/or coordination of care management services, which include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

There are three (3) general categories of care management services: chronic care management, complex chronic care management, and principal care management. Complex chronic care management addresses all of the patient's medical conditions, and principal care management services addresses a single condition. Each of the three (3) categories is further subdivided into those services that are personally performed by the physician or other QHP.

Code selection for these services is based on time in a calendar month, and time used in reporting these services may not represent time spent in another reported service. Chronic care management services do not require moderate to high-level medical decision making and may be reported for a shorter time threshold than complex chronic care management services. Both chronic care and complex chronic care management address, as needed, all medical conditions, psychosocial needs, and activities of daily living. Principal care management services are disease-specific management services. A patient may have multiple chronic conditions of sufficient severity to warrant complex chronic care management but may receive principal care management if the reporting physician or other QHP is providing single disease rather than comprehensive care management.

Care Planning

A plan of care for health problems is based on a physical, mental, cognitive, social, functional, and environmental evaluation. It is intended to provide a simple and concise overview of the patient and his or her medical condition(s) and be a useful resource for patients, caregivers, health care professionals, and others, as necessary.

The care management office/practice must have the following capabilities:

1. Provide 24/7 access to physicians or other QHPs or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of the week;
2. Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
3. Provide timely access and management for follow-up after an emergency department visit or facility discharge;
4. Utilize an electronic health record system for timely access to clinical information;
5. Be able to engage and educate patients and caregivers as well as coordinate and integrate care among all professionals, as appropriate for each patient;
6. Reporting physician or other QHP overseas activities of the care team;
7. All care team members providing services are clinically integrated.

◆ **Chronic Care Management (CCM) Services: 99490, 99491, 99437, and 99439**

CCM services are management and support services provided by clinical staff, under the direction of a physician or other QHP or may be provided personally by a physician or other QHP to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure

timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

Care management activities performed by clinical staff, or personally by the physician or other QHP, typically include includes:

1. Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. Communication with home health agencies and other community services utilized by the patient;
3. Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family;
7. Management of care transitions not reported as part of transitional care management (99495, 99496)
8. Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service, noted above;
9. Development, communication, and maintenance of a comprehensive care or disease specific (as applicable) care plan;
10. Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
11. A copy of the plan of care must be given to the patient and/or caregiver

◆ **Complex Chronic Care Management (CCM) Services: 99487, 99489**

99487: Complex chronic care management services, with the following required elements:

- Multiple (2+) 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 a comprehensive care plan
- Moderate or high complexity medical decision making
- First 60 minutes of clinical staff time directed by a physician or other QHP, *per calendar month*

Note: Complex chronic care management services require moderate or high medical decision making as defined in the Evaluation and Management (E/M) guidelines.

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes, in a calendar month, are *not* reported separately.

Complex Chronic Care Management

Total Duration of Staff Care Management Services	Complex Chronic Care Management
less than 60 minutes	Not separately reported
30 - 89 minutes (1 hour - 1 hr. 29 minutes)	99487 x 1
90 - 119 minutes (1 hr. 30 min - 1 hr. 59 minutes)	99487 x 1 and 99489 x 1
120 minutes or more (2 hours or more)	99487 x 1 and 99489 x 2 and 99489 for each additional 30 minutes

99490: Chronic care management services, first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, *per calendar month*, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99439: Chronic care management services; 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)

- Elements for 99490 apply
- Report code 99439 in conjunction with 99490
- Do not report 99439 more than twice per calendar month

Note: Do not report 99439, 99490 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99437, 99487, 99489, 99491, 99605, 99606, 99607.

Note: Do not report 99439, 99490 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

99491: Chronic care management services, provided personally by a physician or other qualified health care professional, first 30 minutes of physician or other qualified health care professional time, *per calendar month*, 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

99437: Chronic care management services; each additional 30 minutes of clinical staff time directed by a physician or other QHP, *per calendar month* (list separately in addition to code for primary procedure)

- Elements for 99491 apply
- Report code 99437 in conjunction with 99491

Note: Do not report 99437, 99491 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99439, 99487, 99489, 99490, 99605, 99606, 99607.

Note: Do not report 99437, 99491 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99495, 99496, 99605, 99606, 99607.

◆ **Comprehensive Care Management Services: G2064, G2065**

G2064: Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

G2065: Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

CCM Documentation Requirements:

- The eligible practitioner can only bill **one CCM code per month per qualifying patient**.
- The initiation of CCM services **must occur during a face-to-face visit** with the billing practitioner.

- Obtaining **advance consent from the patient is required**. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:
  1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
  2. As the central coordinator of the patient's care plan the billing CCM codes is intended for PCP use. However, other specialties may bill CCM codes if they are the *primary* coordinator of the patient's continuing care (e.g., Oncology) Only a **single practitioner can furnish and be paid for CCM services once per calendar month per patient**.
  3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.
- **Documentation of a Comprehensive Care Plan is required**. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
  1. Problem list
  2. Expected outcomes and prognosis
  3. Measurable treatment goals
  4. Cognitive and Functional assessments
  5. Planned interventions and identification of the individuals responsible for each intervention
  6. Medication and symptom management
  7. Environmental evaluation
  8. Caregiver assessment
  9. Interaction and coordination with resources and health care professionals and others outside the practice, as necessary, with description of how outside services will be directed
  10. Schedule for periodic review and when required, revision of the care plan
- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.
- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the practitioner may choose that date as the date of service and need not hold the claim until the end of the month. For complex CCM (99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

◆ Principal Care Management Services (PCM): 99424, 99425, 99426, 99427

PCM closely mimics Chronic Care Management (CCM) requirements, and may not be billed concurrently with CCM, behavioral health integration services. Like CCM, a verbal consent is required and must be documented in the patient's chart.

99424: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation /decompen-sation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan

- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other QHP, *per calendar month*.

99425: Each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

- Elements for 99424 apply
- Report code 99424 in conjunction with 99425

Note: Do not report 99424, 99425 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491, 99605, 99606, 99607.

Note: Do not report 99424, 99425 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

99426: Principal care management services, for a single high-risk disease, with the following required elements:

- One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation /decompen-sation, functional decline, or death
- The condition requires development, monitoring, or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities
- Ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other QHP, *per calendar month*.

99427: Each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

- Elements for 99426 apply
- Report code 99426 in conjunction with 99427

Note: Do not report 99426, 99427 in the same **calendar month** with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99437, 99439, 99487, 99489, 99490, 99491, 99605, 99606, 99607.

Note: Do not report 99426, 99427 **for service time reported with** 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607.

Table for Reporting Principal Care Management Services

Total Duration Principal CM Services	Staff Type	Principal Care Management
less than 30 minutes	Not separately reported	Not separately reported
30 - 59 minutes	Physician or other QHP	99424 x 1

	Clinical Staff	99426 x 1
60 - 89 minutes	Physician or other QHP	99424 x 1 and 99425 x 1
	Clinical Staff	99426 x 1 and 99427 x 1
90 - 119 minutes	Physician or other QHP	99424 x 1 and 99425 x 2
	Clinical Staff	99426 x 1 and 99427 x 2
120 minutes or more	Physician or other QHP	99424 x 1 and 99425 x 3, as appropriate see illustrated reporting examples above
	Clinical Staff	99426 x 1 and 99427 x 2

Table for Reporting Care Management Services

Code	Service	Staff Type	Total Duration (Time Span)	Unit Max Per Month
99490	Chronic CM	Clinical Staff	20 minutes (20 - 39 minutes)	1
+99439	Chronic CM	Clinical Staff	40 - 59 minutes x 1 (60+ x 2)	2
99491	Chronic CM	Physician or other QHP	30 minutes (30 - 59 minutes)	1
+99437	Chronic CM	Physician or other QHP	30 minutes (60 minutes or more)	No limit
99487	Complex CCM	Clinical Staff	60 minutes (60 - 89 minutes)	1
+99489	Complex CCM	Clinical Staff	30 minutes (less than 90 minutes x 1) (less than 120 minutes x 2, etc.)	No limit
99424	Principal CM	Physician or other QHP	30 minutes (30 - 59 minutes)	1
+99425	Principal CM	Physician or other QHP	30 minutes (60 minutes or more)	No limit
99426	Principal CM	Clinical Staff	30 minutes (30 - 59 minutes)	1
+99427	Principal CM	Clinical Staff	30 minutes (60 minutes or more)	2+

Note: If the treating physician or other QHP personally performs any of the care management services and those activities are not used to meet the criteria for a separately reported code (99424, 99491), then his or her time may be counted toward the required clinical staff time to meet the elements of 99426, 99487, 99490 as applicable.

- **Transitional Care Management (TCM) Services: 99495, 99496**

Codes 99495 and 99496 are used to report TCM. These services are for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other QHP and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan.

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other QHP may include:

1. Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. Communication with agencies and other community services utilized by the patient;
3. Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other QHP may include:

1. Obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);
2. Reviewing need for or follow-up on pending diagnostic tests and treatments;
3. Interaction with other QHPs who will assume or reassume care of the patient's system-specific problems;
4. Education of patient, family, guardian, and/or caregiver;
5. Establishment or reestablishment of referrals and arranging for needed community resources;
6. Assistance in scheduling any required follow-up with community providers and services.

Transitional Care Management Services

Type of Medical Decision Making	Face-to-Face Visit Within 7 Days	Face-to-Face Visit Within 14 Days
Moderate Complexity	Use code 99495	Use code 99495
High Complexity	Use code 99496	Use code 99495

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services IF they have primary responsibility for post-discharge care coordination – secondary consulting specialists or other secondary practitioners are not eligible for separate reimbursement.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.

- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day in which the discharge day management services are reported.
- You may not bill TCM services that are within a post-operative global period (TCM services will not be paid if any of the 30-day TCM period falls within a global period for a procedure code billed by the same practitioner).
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).
- The place of service should correspond to the place of service of the required face-to-face visit.
- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.
- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Evidence of the patient's consent to participate in TCM services and an acknowledgement service may be subject to additional cost share responsibilities.
- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision-making actions and the level of complexity (moderate or high).

◆ Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a PCP physician or other qualified PCP health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion along with beginning and ending times.
- Patient/surrogate/family "given opportunity to decline;"
- Details of discussion (e.g., Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of ACP services, the patient must provide consent and consent must be documented in the medical record in addition to an acknowledgement service may be subject to additional cost share responsibilities.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.
- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- **Reimbursement for 99497 and 99498 are limited to the following specialties: PCP specialties (NP's and PA's)**
- 99498 must be reported in conjunction with 99497

◆ **Psychiatric Collaborative Care Management Services (PCCM): 99492, 99493, 99494, G2214**

PCCM services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99492: Initial psychiatric collaborative care management, first 70 minutes in the *first calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other QHP;

- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

99493: Subsequent psychiatric collaborative care management, first 60 minutes in a *subsequent month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a *calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP. (List separately in addition to code for primary procedure)

- Use 99494 in conjunction with 99492, 99493
- Elements of 99492 and/or 99493 apply

Note: If the treating physician or other QHP personally performs BH care manager activities and those activities are not used to meet criteria for separately reported code, his or her time may be counted toward the required BH care manager time to meet the elements of 99492, 99493, 99494.

Collaborative Care Management

Type of Service	Total Duration of Collaborative Care Management Over Calendar Month	Codes
Initial - 70 minutes	less than 36 minutes	Not separately reported
	36 - 85 minutes (36 minutes - 1 hr. 25 minutes)	99492 x 1
Initial plus each additional increment up to 30 minutes	86 - 115 minutes (1 hr. 26 min. - 1 hr. 55 minutes)	99492 x 1 *and* 99494 x 1
Subsequent - 60 minutes	less than 31 minutes	Not separately reported
	31 - 75 minutes (31 minutes - 1 hr. 15 minutes)	99493 x 1

Subsequent plus each additional increment up to 30 minutes	76 - 105 minutes (1 hr. 16 min. - 1 hr. 45 minutes)	99493 x 1 *and* 99494 x 1

G2214: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

PCCM Service Requirements:

- An initiating visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric services. This can be an Evaluation and Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE).
- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:
  1. Information on the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during calendar month.
  3. That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. The patient is giving permission to consult with relevant specialists.
- At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric services, furnished;
  a) Under the direction of the physician, NP, PA, or CNM, and;
  b) By a practitioner or Behavioral Health Care Manager under general supervision.

Patient must have a behavioral health or psychiatric condition that is being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants psychiatric services. PCCM Services require a team that includes the following:

- Practitioner (physician, NP, PA, or CNM) who:
  1. Directs the behavioral health care manager or clinical staff.
  2. Oversees; the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.
  3. Remains involved through ongoing management, collaboration and reassessment.
- Behavioral Health Care Manager who:
  1. Provides assessment and CM services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant.
  2. Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the care team.
  3. Is available to contact the patient outside of regular hours as necessary to conduct the behavioral health care manager's duties.
- Psychiatric Consultant who:
  1. Participates in regular reviews of the clinical status of patients receiving services;
  2. Advises the practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health

treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments.

3. Facilitate referral for direct provision of psychiatric care when clinically indicated.

◆ **General Behavioral Health Integration Care Management (BHI): 99484**

BHI services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other QHP time, *per calendar month*, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Note: Clinical staff time spent coordinating care with the emergency department may be reported using 99484, but time spent while the patient is inpatient or admitted to observation status may not be reported using 99484. Do not report 99484 in conjunction with 99492, 99493, 99494 in the same calendar month.

Note: E/M services, including care management services (99424, 99425, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491, 99495, 99496), and psychiatric services (90785-90899) may be reported separately by the same physician or other QHP on the same day or during the same calendar month, but time and activities used to meet criteria for another reported service do not count toward meeting criteria for 99484.

General BHI Care Management Service Requirements:

- An initiating Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services.
- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by the practitioner or clinical staff;
  can be written or verbal, must be documented in the medical record and includes information:
  1. On the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during a calendar month.
  3. On the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. Permission to consult with relevant specialist.

- At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the physician, NP, PA, or CNM, and b) by a practitioner, or by clinical personnel under general supervision.
- Patient must have one of the following two options:
    a) Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, or;
    b) Any behavioral health or psychiatric condition being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants BHI services.
- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

1. Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.
2. 24/7 access to physicians or other QHPs or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
3. Comprehensive CM including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all prescribed preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
4. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.
5. Care plan information made available electronically (including fax) in a timely manner as appropriate and a copy of the plan of care given to the patient and/or caregiver.
6. Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
7. Coordination with home and community-based clinical service providers, and documentation of communication to and from home and community-based providers regarding the patient's psychosocial needs and functional deficits in the medical record.
8. Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

1. Initial assessment/follow-up monitoring, including use of applicable validated rating scales
2. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
3. Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)
4. Continuity of care with a designated member of the care team

Additional BHI Documentation Requirements:

- Beginning and ending times, along with total minutes, must be documented in the patient's medical record and made available for audit review as required.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows published CMS guidelines for Care Coordination services. See the reference section below for sources. This is representative of some guidelines and not an all-inclusive list.

REFERENCES:

- Chronic Care Management Services; Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf
- Delaware PCP and Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743
- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs
- Summary of CCM Service Requirements, Advisory https://www.advisory.com/-/media/Advisory-com/Research/PPR/Resources/2017/Summary-of-CCM-Service-Requirements.pdf
- Cognitive Assessment and Care Planning Services https://www.alz.org/careplanning/downloads/cms-consensus.pdf
- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section. *Current Procedure Terminology Manual* (CPT®) is copyright American Medical Association. All rights Reserved. The AMA assumes no liability for the data contained in this policy.
- AAP News and Journals Gateway https://www.aappublications.org/news/2017/11/02/Coding110217
- Behavioral Health Integration Services; Department of Health and Human Services Centers for Medicare & Medicaid Services, MLN Matters Booklet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf
- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs); Centers for Medicare & Medicaid Services, MM10175.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

- Advanced Care Planning; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

- Behavioral Health Integration Services; Centers for Medicare & Medicaid Services, MLN Booklet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Transitional Care Management Services; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

POLICY UPDATE HISTORY INFORMATION:

1 / 2019	Implementation
5 / 2019	Clarified that TCM services during global period cannot be billed by the same practitioner
1 / 2020	Added codes G2058, G2064, G2065
4 / 2020	Added codes 99484, 99492, 99493 and 99494 eligible for all regions. Added 99487, 99489, 99490 and 99491 eligible for WV and PA
3 / 2021	Removed code G2058. Added codes 99439 and G2214.
11 / 2021	Added NY region applicable to the policy
1 /2022	Added Delaware Medicare Advantage applicable to the policy. Added code 99424, 99425, 99426, 99427 and 99437. Added and edited information throughout the policy.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	October 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

Care management is the range of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions. This policy is intended to provide the Plan's reimbursement direction for these services.

DEFINITIONS:

Transitional Care Management (TCM): Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of 29 days.

Advance Care Planning (ACP): A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

Chronic Care Management (CCM): Services encompassing the oversight and education activities by health care professionals to help patients with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.

Psychiatric Collaborative Care Management (PCCM): Behavioral health services delivered via a specific evidence-based model. Care is managed by a behavioral health care manager (BHCM), who has master's/doctoral-level education or specialized training in behavioral health, under direction of a treating physician or qualified health care professional (QHP) in consultation with a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications.

General Behavioral Health Integration Care Management (BHI): The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Care Coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Primary Care: Health care provided by a physician or an individual license to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes internal medicine, family practice, general practice, pediatrics, CRNP PCP, geriatric medicine, and multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, pediatrics, CRNP PCP, PA PCP, or geriatric medicine).

Comprehensive Care: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Transitional Care Management (TCM) Services: 99495, 99496

Codes 99495 and 99496 are used to report TCM. These services are for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional (QHP) and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan.

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional may include:

1. Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. Communication with agencies and other community services utilized by the patient;
3. Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

1. Obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);
2. Reviewing need for or follow-up on pending diagnostic tests and treatments;
3. Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
4. Education of patient, family, guardian, and/or caregiver;
5. Establishment or reestablishment of referrals and arranging for needed community resources;
6. Assistance in scheduling any required follow-up with community providers and services.

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services IF they have primary responsibility for post-discharge care coordination – secondary consulting specialists or other secondary practitioners are not eligible for separate reimbursement.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day in which the discharge day management services are reported.
- You may not bill TCM services that are within a post-operative global period (TCM services will not be paid if any of the 30 day TCM period falls within a global period for a procedure code billed by the same practitioner).
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).

- The place of service should correspond to the place of service of the required face-to-face visit.
- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.
- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Evidence of the patient's consent to participate in TCM services and an acknowledgement services may be subject to additional cost share responsibilities.
- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision making actions and the level of complexity (moderate or high).

Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a PCP physician or other qualified PCP health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure 99497).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion along with beginning and ending times.
- Patient/surrogate/family "given opportunity to decline;"

- Details of discussion (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of ACP services, the patient must provide consent and consent must be documented in the medical record in addition to an acknowledgement services may be subject to additional cost share responsibilities.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.
- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- **Reimbursement for 99497 and 99498 are limited to the following specialties: PCP specialties (NP's and PA's)**
- 99498 must be reported in conjunction with 99497

Chronic Care Management (CCM) Services: 99487, 99489, 99490, 99491 and 99439

CCM services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services many include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

CCM activities performed by clinical staff includes the following activities and any other activities designated as CCM by CMS:

1. Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. Communication with home health agencies and other community services utilized by the patient;
3. Collection of health outcomes data and registry documentation;
4. Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
5. Assessment and support for treatment regimen adherence and medication management;
6. Identification of available community and health resources;
7. Facilitating access to care and services needed by the patient and/or family;
8. Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service;

9. Development, communication, and maintenance of a comprehensive care plan;
10. Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
11. A copy of the plan of care must be given to the patient and/or caregiver

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 a comprehensive care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health professional, *per calendar month*

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes in duration, in a calendar month, are *not* reported separately.

99490: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, *per calendar month*, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99491: Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, *per calendar month*, 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

99439: Chronic care management services; 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)

Note: Do not report 99439 for care management services less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month. You can report this add-on code to CPT code 99490 a maximum of twice per service period. When you report 99439, CPT code 99490 will represent the first 20 minutes of non-complex CCM services, with 99439 reporting additional 20-minute increments of service time (maximum of 60 minutes total). Use 99439 in conjunction with 99490. Do not report 99490 and 99439 in the same calendar month as 99487, 99489 or 99491. See the Chronic Care Management section of the AMA CPT Manual for additional rules and proper billing instructions for these services.

Chronic Care Management		
Total Time (in minutes)	**Code(s) to bill**	**Quantity**
less than 20	Not reported separately	N/A
20 - 39	99490	1
40 - 59	99490 + 99439	1 1
60 - 79	99490 + 99439	1 2

Complex Chronic Care Management		
Total Time (in minutes)	**Code(s) to bill**	**Quantity**
less than 60	Not reported separately	N/A
60 - 89	99487	1
90 - 119	99487 + 99489	1 1
120 - 149	99487 + 99489	1 2
150 - 179	99487 + 99489	1 3
180 - 219	99487 + 99489	1 4

Comprehensive Care Management Services: G2064, G2065

G2064: Comprehensive care management services for a single high-risk disease, e.g. principle care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

G2065: Comprehensive care management services for a single high-risk disease, e.g. principle care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

CCM Documentation Requirements:

- The eligible practitioner can only bill **one CCM code per month per qualifying patient**.
- The initiation of CCM services **must occur during a face-to-face visit** with the billing practitioner.
- Obtaining **advance consent from the patient is required**. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:
    1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
    2. As the central coordinator of the patient's care plan the billing CCM codes is intended for PCP use. However, other specialties may bill CCM codes if they are the *primary* coordinator of the patient's continuing care (e.g. Oncology) Only a **single practitioner can furnish and be paid for CCM services once per calendar month per patient**.
    3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.
- **Documentation of a Comprehensive Care Plan is required**. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
    1. Problem list
    2. Expected outcomes and prognosis
    3. Measurable treatment goals
    4. Symptom management
    5. Planned interventions and identification of the individuals responsible for each intervention
    6. Medication management
    7. Environmental evaluation
    8. Caregiver assessment
    9. Community and Social services ordered
    10. A description of how services and specialists outside of the practice will be directed/coordinated.
    11. Schedule for periodic review and when required, revision of the care plan.
- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.
- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the

practitioner may choose that date as the date of service, and need not hold the claim until the end of the month. For complex CCM (CPT 99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

Psychiatric Collaborative Care Management Services (PCCM): 99492, 99493, 99494, G2214

PCCM services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99492: Initial psychiatric collaborative care management, first 70 minutes in the *first calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other QHP;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

99493: Subsequent psychiatric collaborative care management, first 60 minutes in a *subsequent month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a *calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP.

Note: List 99494 separately in addition to code for primary procedure. Use 99494 in conjunction with 99492, 99493.

Initial month and time of service	Code(s) to bill	Subsequent month and time of service	Code(s) to bill
Initial <36 mins	Not separately reported	Subsequent <36 mins	Not separately reported
Initial 36-85 mins	99492	Subsequent 36-85 mins	99493
Initial 86-115 mins	99492 and 99494	Subsequent 86-115 mins	99493 and 99494
Initial 116-145 mins	99492 and 99494 (x2)	Subsequent 116-144 mins	9492 and 99494 (x2)

G2214: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

PCCM Service Requirements:

- An initiating visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric services. This can be an Evaluation and Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE).

- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:

    1. Information on the availability of care coordination services and applicable cost-sharing.
    2. That only one practitioner can furnish and be paid for care coordination services during calendar month.
    3. That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month).
    4. The patient is giving permission to consult with relevant specialists.

- At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric services, furnished;
  a) Under the direction of the physician, NP, PA, or CNM, and;
  b) By a practitioner or Behavioral Health Care Manager under general supervision.

Patient must have a behavioral health or psychiatric condition that is being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants psychiatric services.

PCCM Services require a team that includes the following:

- Practitioner (physician, NP, PA, or CNM) who:

    1. Directs the behavioral health care manager or clinical staff.
    2. Oversees; the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.

3. Remains involved through ongoing oversight, management, collaboration and reassessment.

- Behavioral Health Care Manager who:

1. Provides assessment and care management services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant.
2. Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team.
3. Is available to contact the patient outside of regular hours as necessary to conduct the behavioral health care manager's duties.

- Psychiatric Consultant who:

1. Participates in regular reviews of the clinical status of patients receiving services;
2. Advises the practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments.
3. Facilitate referral for direct provision of psychiatric care when clinically indicated.

General Behavioral Health Integration Care Management (BHI): 99484

BHI services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, *per calendar month*, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Note: Clinical staff time spent coordinating care with the emergency department may be reported using 99484, but time spent while the patient is inpatient or admitted to observation status may not be reported using 99484.

General BHI Care Management Service Requirements:

- An initiating Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services.

- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by the practitioner or clinical staff;
  can be written or verbal, must be documented in the medical record and includes information:

  1. On the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during a calendar month.
  3. On the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. Permission to consult with relevant specialist.

- At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the physician, NP, PA, or CNM, and b) by a practitioner, or by clinical personnel under general supervision.

- Patient must have one of the following two options:

  a) Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, or;
  b) Any behavioral health or psychiatric condition being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants BHI services.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

  1. Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.
  2. 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
  3. Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
  4. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and

environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.

5. Care plan information made available electronically (including fax) in a timely manner as appropriate and a copy of the plan of care given to the patient and/or caregiver.
6. Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
7. Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record.
8. Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

1. Initial assessment or follow-up monitoring, including the use of applicable validated rating scales
2. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
3. Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)
4. Continuity of care with a designated member of the care team

Additional BHI Documentation Requirements:

- Beginning and ending times, along with total minutes, must be documented in the patient's medical record and made available for audit review as required.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows published CMS guidelines for Care Coordination services. See the reference section below for sources. This is representative of some guidelines and not an all-inclusive list.

REFERENCES:

- Chronic Care Management Services; Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- Delaware PCP and Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743

- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs

- Summary of CCM Service Requirements, Advisory https://www.advisory.com/-/media/Advisory-com/Research/PPR/Resources/2017/Summary-of-CCM-Service-Requirements.pdf

- Cognitive Assessment and Care Planning Services https://www.alz.org/careplanning/downloads/cms-consensus.pdf

- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section. *Current Procedure Terminology Manual* (CPT®) is copyright American Medical Association. All rights Reserved. The AMA assumes no liability for the data contained in this policy.

- AAP News and Journals Gateway https://www.aappublications.org/news/2017/11/02/Coding110217

- Behavioral Health Integration Services; Department of Health and Human Services Centers for Medicare & Medicaid Services, MLN Matters Booklet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs); Centers for Medicare & Medicaid Services, MM10175. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

- Advanced Care Planning; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

- Behavioral Health Integration Services; Centers for Medicare & Medicaid Services, MLN Booklet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Transitional Care Management Services; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

POLICY UPDATE HISTORY INFORMATION:

1 / 2019	Implementation
5 / 2019	Clarified that TCM services during global period cannot be billed by the same practitioner
1 / 2020	Added codes G2058, G2064, G2065
4 / 2020	Added codes 99484, 99492, 99493 and 99494 eligible for all regions. Added 99487, 99489, 99490 and 99491 eligible for WV and PA
3 / 2021	Removed code G2058. Added codes 99439 and G2214.
11 / 2021	Added NY region applicable to the policy
1 /2022	Added Delaware Medicare Advantage applicable to the policy

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☐	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

Care management is the range of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions. This policy is intended to provide the Plan's reimbursement direction for these services.

DEFINITIONS:

Transitional Care Management (TCM): Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of 29 days.

Advance Care Planning (ACP): A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

Chronic Care Management (CCM): Services encompassing the oversight and education activities by health care professionals to help patients with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.

Psychiatric Collaborative Care Management (PCCM): Behavioral health services delivered via a specific evidence-based model. Care is managed by a behavioral health care manager (BHCM), who has master's/doctoral-level education or specialized training in behavioral health, under direction of a treating physician or qualified health care professional (QHP) in consultation with a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications.

General Behavioral Health Integration Care Management (BHI): The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Care Coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Primary Care: Health care provided by a physician or an individual license to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes internal medicine, family practice, general practice, pediatrics, CRNP PCP, geriatric medicine, and multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, pediatrics, CRNP PCP, PA PCP, or geriatric medicine).

Comprehensive Care: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Transitional Care Management (TCM) Services: 99495, 99496

Codes 99495 and 99496 are used to report TCM. These services are for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional (QHP) and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan.

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional may include:

1. Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. Communication with agencies and other community services utilized by the patient;
3. Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

1. Obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);
2. Reviewing need for or follow-up on pending diagnostic tests and treatments;
3. Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
4. Education of patient, family, guardian, and/or caregiver;
5. Establishment or reestablishment of referrals and arranging for needed community resources;
6. Assistance in scheduling any required follow-up with community providers and services.

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services IF they have primary responsibility for post-discharge care coordination – secondary consulting specialists or other secondary practitioners are not eligible for separate reimbursement.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day in which the discharge day management services are reported.
- You may not bill TCM services that are within a post-operative global period (TCM services will not be paid if any of the 30 day TCM period falls within a global period for a procedure code billed by the same practitioner).
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).
- The place of service should correspond to the place of service of the required face-to-face visit.

- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.
- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Evidence of the patient's consent to participate in TCM services and an acknowledgement services may be subject to additional cost share responsibilities.
- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision making actions and the level of complexity (moderate or high).

Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a PCP physician or other qualified PCP health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure 99497).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion along with beginning and ending times.
- Patient/surrogate/family "given opportunity to decline;"

- Details of discussion (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of ACP services, the patient must provide consent and consent must be documented in the medical record in addition to an acknowledgement services may be subject to additional cost share responsibilities.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.
- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- **Reimbursement for 99497 and 99498 are limited to the following specialties: PCP specialties (NP's and PA's)**
- 99498 must be reported in conjunction with 99497

Chronic Care Management (CCM) Services: 99487, 99489, 99490, 99491 and 99439

CCM services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services many include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

CCM activities performed by clinical staff includes the following activities and any other activities designated as CCM by CMS:

1. Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. Communication with home health agencies and other community services utilized by the patient;
3. Collection of health outcomes data and registry documentation;
4. Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
5. Assessment and support for treatment regimen adherence and medication management;
6. Identification of available community and health resources;
7. Facilitating access to care and services needed by the patient and/or family;
8. Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service;

9. Development, communication, and maintenance of a comprehensive care plan;
10. Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
11. A copy of the plan of care must be given to the patient and/or caregiver

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 a comprehensive care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health professional, *per calendar month*

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes in duration, in a calendar month, are *not* reported separately.

99490: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, *per calendar month*, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99491: Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, *per calendar month*, 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

99439: Chronic care management services; 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)

Note: Do not report 99439 for care management services less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month. You can report this add-on code to CPT code 99490 a maximum of twice per service period. When you report 99439, CPT code 99490 will represent the first 20 minutes of non-complex CCM services, with 99439 reporting additional 20-minute increments of service time (maximum of 60 minutes total). Use 99439 in conjunction with 99490. Do not report 99490 and 99439 in the same calendar month as 99487, 99489 or 99491. See the Chronic Care Management section of the AMA CPT Manual for additional rules and proper billing instructions for these services.

Chronic Care Management		
Total Time (in minutes)	**Code(s) to bill**	**Quantity**
less than 20	Not reported separately	N/A
20 - 39	99490	1
40 - 59	99490 + 99439	1 1
60 - 79	99490 + 99439	1 2

Complex Chronic Care Management		
Total Time (in minutes)	**Code(s) to bill**	**Quantity**
less than 60	Not reported separately	N/A
60 - 89	99487	1
90 - 119	99487 + 99489	1 1
120 - 149	99487 + 99489	1 2
150 - 179	99487 + 99489	1 3
180 - 219	99487 + 99489	1 4

Comprehensive Care Management Services: G2064, G2065

G2064: Comprehensive care management services for a single high-risk disease, e.g. principle care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

G2065: Comprehensive care management services for a single high-risk disease, e.g. principle care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

CCM Documentation Requirements:

- The eligible practitioner can only bill **one CCM code per month per qualifying patient**.
- The initiation of CCM services **must occur during a face-to-face visit** with the billing practitioner.
- Obtaining **advance consent from the patient is required**. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:
    1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
    2. As the central coordinator of the patient's care plan the billing CCM codes is intended for PCP use. However, other specialties may bill CCM codes if they are the *primary* coordinator of the patient's continuing care (e.g. Oncology) Only a **single practitioner can furnish and be paid for CCM services once per calendar month per patient**.
    3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.
- **Documentation of a Comprehensive Care Plan is required**. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
    1. Problem list
    2. Expected outcomes and prognosis
    3. Measurable treatment goals
    4. Symptom management
    5. Planned interventions and identification of the individuals responsible for each intervention
    6. Medication management
    7. Environmental evaluation
    8. Caregiver assessment
    9. Community and Social services ordered
    10. A description of how services and specialists outside of the practice will be directed/coordinated.
    11. Schedule for periodic review and when required, revision of the care plan.
- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.
- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the

practitioner may choose that date as the date of service, and need not hold the claim until the end of the month. For complex CCM (CPT 99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

Psychiatric Collaborative Care Management Services (PCCM): 99492, 99493, 99494, G2214

PCCM services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99492: Initial psychiatric collaborative care management, first 70 minutes in the *first calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other QHP;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

99493: Subsequent psychiatric collaborative care management, first 60 minutes in a *subsequent month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a *calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP.

Note: List 99494 separately in addition to code for primary procedure. Use 99494 in conjunction with 99492, 99493.

Initial month and time of service	Code(s) to bill	Subsequent month and time of service	Code(s) to bill
Initial <36 mins	Not separately reported	Subsequent <36 mins	Not separately reported
Initial 36-85 mins	99492	Subsequent 36-85 mins	99493
Initial 86-115 mins	99492 and 99494	Subsequent 86-115 mins	99493 and 99494
Initial 116-145 mins	99492 and 99494 (x2)	Subsequent 116-144 mins	9492 and 99494 (x2)

G2214: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

PCCM Service Requirements:

- An initiating visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric services. This can be an Evaluation and Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE).

- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:

    1. Information on the availability of care coordination services and applicable cost-sharing.
    2. That only one practitioner can furnish and be paid for care coordination services during calendar month.
    3. That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month).
    4. The patient is giving permission to consult with relevant specialists.

- At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric services, furnished;
  a) Under the direction of the physician, NP, PA, or CNM, and;
  b) By a practitioner or Behavioral Health Care Manager under general supervision.

Patient must have a behavioral health or psychiatric condition that is being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants psychiatric services.

PCCM Services require a team that includes the following:

- Practitioner (physician, NP, PA, or CNM) who:

    1. Directs the behavioral health care manager or clinical staff.
    2. Oversees; the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.

3. Remains involved through ongoing oversight, management, collaboration and reassessment.

- Behavioral Health Care Manager who:

1. Provides assessment and care management services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant.
2. Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team.
3. Is available to contact the patient outside of regular hours as necessary to conduct the behavioral health care manager's duties.

- Psychiatric Consultant who:

1. Participates in regular reviews of the clinical status of patients receiving services;
2. Advises the practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments.
3. Facilitate referral for direct provision of psychiatric care when clinically indicated.

General Behavioral Health Integration Care Management (BHI): 99484

BHI services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, *per calendar month*, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Note: Clinical staff time spent coordinating care with the emergency department may be reported using 99484, but time spent while the patient is inpatient or admitted to observation status may not be reported using 99484.

General BHI Care Management Service Requirements:

- An initiating Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services.

- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by the practitioner or clinical staff;
  can be written or verbal, must be documented in the medical record and includes information:

  1. On the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during a calendar month.
  3. On the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. Permission to consult with relevant specialist.

- At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the physician, NP, PA, or CNM, and b) by a practitioner, or by clinical personnel under general supervision.

- Patient must have one of the following two options:

  a) Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, or;
  b) Any behavioral health or psychiatric condition being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants BHI services.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

  1. Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.
  2. 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
  3. Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
  4. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and

environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.

5. Care plan information made available electronically (including fax) in a timely manner as appropriate and a copy of the plan of care given to the patient and/or caregiver.
6. Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
7. Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record.
8. Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

1. Initial assessment or follow-up monitoring, including the use of applicable validated rating scales
2. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
3. Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)
4. Continuity of care with a designated member of the care team

Additional BHI Documentation Requirements:

- Beginning and ending times, along with total minutes, must be documented in the patient's medical record and made available for audit review as required.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows published CMS guidelines for Care Coordination services. See the reference section below for sources. This is representative of some guidelines and not an all-inclusive list.

REFERENCES:

- Chronic Care Management Services; Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- Delaware PCP and Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743

- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs

- Summary of CCM Service Requirements, Advisory https://www.advisory.com/-/media/Advisory-com/Research/PPR/Resources/2017/Summary-of-CCM-Service-Requirements.pdf

- Cognitive Assessment and Care Planning Services https://www.alz.org/careplanning/downloads/cms-consensus.pdf

- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section. *Current Procedure Terminology Manual* (CPT®) is copyright American Medical Association. All rights Reserved. The AMA assumes no liability for the data contained in this policy.

- AAP News and Journals Gateway https://www.aappublications.org/news/2017/11/02/Coding110217

- Behavioral Health Integration Services; Department of Health and Human Services Centers for Medicare & Medicaid Services, MLN Matters Booklet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs); Centers for Medicare & Medicaid Services, MM10175. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

- Advanced Care Planning; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

- Behavioral Health Integration Services; Centers for Medicare & Medicaid Services, MLN Booklet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Transitional Care Management Services; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

POLICY UPDATE HISTORY INFORMATION:

1 / 2019	Implementation
5 / 2019	Clarified that TCM services during global period cannot be billed by the same practitioner
1 / 2020	Added codes G2058, G2064, G2065
4 / 2020	Added codes 99484, 99492, 99493 and 99494 eligible for all regions. Added 99487, 99489, 99490 and 99491 eligible for WV and PA
3 / 2021	Removed code G2058. Added codes 99439 and G2214.
11 / 2021	Added NY region applicable to the policy

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSIONS

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	March 15, 2021	**Revised Date:**	March 2021
Date Reviewed:	January 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

Care management is the range of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions. This policy is intended to provide the Plan's reimbursement direction for these services.

DEFINITIONS:

Transitional Care Management (TCM): Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of 29 days.

Advance Care Planning (ACP): A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

Chronic Care Management (CCM): Services encompassing the oversight and education activities by health care professionals to help patients with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.

Psychiatric Collaborative Care Management (PCCM): Behavioral health services delivered via a specific evidence-based model. Care is managed by a behavioral health care manager (BHCM), who has master's/doctoral-level education or specialized training in behavioral health, under direction of a treating physician or qualified health care professional (QHP) in consultation with a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications.

General Behavioral Health Integration Care Management (BHI): The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Care Coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Primary Care: Health care provided by a physician or an individual license to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes internal medicine, family practice, general practice, pediatrics, CRNP PCP, geriatric medicine, and multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, pediatrics, CRNP PCP, PA PCP, or geriatric medicine).

Comprehensive Care: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Transitional Care Management (TCM) Services: 99495, 99496

Codes 99495 and 99496 are used to report TCM. These services are for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional (QHP) and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan.

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge

- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional may include:

1. Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. Communication with agencies and other community services utilized by the patient;
3. Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

1. Obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);
2. Reviewing need for or follow-up on pending diagnostic tests and treatments;
3. Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
4. Education of patient, family, guardian, and/or caregiver;
5. Establishment or reestablishment of referrals and arranging for needed community resources;
6. Assistance in scheduling any required follow-up with community providers and services.

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services IF they have primary responsibility for post-discharge care coordination – secondary consulting specialists or other secondary practitioners are not eligible for separate reimbursement.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day in which the discharge day management services are reported.
- You may not bill TCM services that are within a post-operative global period (TCM services will not be paid if any of the 30 day TCM period falls within a global period for a procedure code billed by the same practitioner).
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).
- The place of service should correspond to the place of service of the required face-to-face visit.
- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.

- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Evidence of the patient's consent to participate in TCM services and an acknowledgement services may be subject to additional cost share responsibilities.
- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision making actions and the level of complexity (moderate or high).

Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a PCP physician or other qualified PCP health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure 99497).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion along with beginning and ending times.
- Patient/surrogate/family "given opportunity to decline;"
- Details of discussion (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of ACP services, the patient must provide consent and consent must be documented in the medical record in addition to an acknowledgement services may be subject to additional cost share responsibilities.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.
- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- **Reimbursement for 99497 and 99498 are limited to the following specialties: PCP specialties (NP's and PA's)**
- 99498 must be reported in conjunction with 99497

Chronic Care Management (CCM) Services: 99487, 99489, 99490, 99491 and 99439

CCM services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services many include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

CCM activities performed by clinical staff includes the following activities and any other activities designated as CCM by CMS:

1. Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. Communication with home health agencies and other community services utilized by the patient;
3. Collection of health outcomes data and registry documentation;
4. Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
5. Assessment and support for treatment regimen adherence and medication management;
6. Identification of available community and health resources;
7. Facilitating access to care and services needed by the patient and/or family;
8. Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service;
9. Development, communication, and maintenance of a comprehensive care plan;
10. Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
11. A copy of the plan of care must be given to the patient and/or caregiver

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 a comprehensive care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health professional, *per calendar month*

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes in duration, in a calendar month, are *not* reported separately.

99490: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, *per calendar month*, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99491: Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, *per calendar month*, 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

99439: Chronic care management services; 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)

Note: Do not report 99439 for care management services less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month. You can report this add-on code to CPT code 99490 a maximum of twice per service period. When you report 99439, CPT code 99490 will represent the first 20 minutes of non-complex CCM services, with 99439 reporting additional 20-minute increments of service time (maximum of 60 minutes total). Use 99439 in conjunction with 99490. Do not report 99490 and 99439 in the same calendar month as 99487, 99489 or 99491. See the Chronic Care Management section of the AMA CPT Manual for additional rules and proper billing instructions for these services.

Chronic Care Management		
Total Time (in minutes)	**Code(s) to bill**	**Quantity**
less than 20	Not reported separately	N/A
20 - 39	99490	1
40 - 59	99490 + 99439	1 1
60 - 79	99490 + 99439	1 2

Complex Chronic Care Management		
Total Time (in minutes)	**Code(s) to bill**	**Quantity**
less than 60	Not reported separately	N/A
60 - 89	99487	1
90 - 119	99487 + 99489	1 1
120 - 149	99487 + 99489	1 2
150 - 179	99487 + 99489	1 3
180 - 219	99487 + 99489	1 4

Comprehensive Care Management Services: G2064, G2065

G2064: Comprehensive care management services for a single high-risk disease, e.g. principle care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

G2065: Comprehensive care management services for a single high-risk disease, e.g. principle care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

CCM Documentation Requirements:

- The eligible practitioner can only bill **one CCM code per month per qualifying patient**.
- The initiation of CCM services **must occur during a face-to-face visit** with the billing practitioner.
- Obtaining **advance consent from the patient is required**. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:
    1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
    2. As the central coordinator of the patient's care plan the billing CCM codes is intended for PCP use. However, other specialties may bill CCM codes if they are the *primary* coordinator of the patient's continuing care (e.g. Oncology) Only a **single practitioner can furnish and be paid for CCM services once per calendar month per patient**.
    3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.
- **Documentation of a Comprehensive Care Plan is required**. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
    1. Problem list
    2. Expected outcomes and prognosis
    3. Measurable treatment goals
    4. Symptom management
    5. Planned interventions and identification of the individuals responsible for each intervention
    6. Medication management
    7. Environmental evaluation
    8. Caregiver assessment
    9. Community and Social services ordered
    10. A description of how services and specialists outside of the practice will be directed/coordinated.
    11. Schedule for periodic review and when required, revision of the care plan.
- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.
- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month. For complex CCM (CPT 99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

Psychiatric Collaborative Care Management Services (PCCM): 99492, 99493, 99494, G2214

PCCM services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99492: Initial psychiatric collaborative care management, first 70 minutes in the *first calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other QHP;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

99493: Subsequent psychiatric collaborative care management, first 60 minutes in a *subsequent month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a *calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP.

Note: List 99494 separately in addition to code for primary procedure. Use 99494 in conjunction with 99492, 99493.

Initial month and time of service	Code(s) to bill	Subsequent month and time of service	Code(s) to bill
Initial <36 mins	Not separately reported	Subsequent <36 mins	Not separately reported
Initial 36-85 mins	99492	Subsequent 36-85 mins	99493
Initial 86-115 mins	99492 and 99494	Subsequent 86-115 mins	99493 and 99494
Initial 116-145 mins	99492 and 99494 (x2)	Subsequent 116-144 mins	9492 and 99494 (x2)

G2214: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

PCCM Service Requirements:

- An initiating visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric services. This can be an Evaluation and Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE).

- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:

    1. Information on the availability of care coordination services and applicable cost-sharing.
    2. That only one practitioner can furnish and be paid for care coordination services during calendar month.
    3. That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month).
    4. The patient is giving permission to consult with relevant specialists.

- At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric services, furnished;
    a) Under the direction of the physician, NP, PA, or CNM, and;
    b) By a practitioner or Behavioral Health Care Manager under general supervision.

Patient must have a behavioral health or psychiatric condition that is being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants psychiatric services.

PCCM Services require a team that includes the following:

- Practitioner (physician, NP, PA, or CNM) who:

    1. Directs the behavioral health care manager or clinical staff.
    2. Oversees; the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.
    3. Remains involved through ongoing oversight, management, collaboration and reassessment.

- Behavioral Health Care Manager who:

    1. Provides assessment and care management services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant.
    2. Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team.
    3. Is available to contact the patient outside of regular hours as necessary to conduct the behavioral health care manager's duties.

- Psychiatric Consultant who:

1. Participates in regular reviews of the clinical status of patients receiving services;
2. Advises the practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments.
3. Facilitate referral for direct provision of psychiatric care when clinically indicated.

General Behavioral Health Integration Care Management (BHI): 99484

BHI services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, *per calendar month*, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Note: Clinical staff time spent coordinating care with the emergency department may be reported using 99484, but time spent while the patient is inpatient or admitted to observation status may not be reported using 99484.

General BHI Care Management Service Requirements:

- An initiating Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services.

- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by the practitioner or clinical staff;
  can be written or verbal, must be documented in the medical record and includes information:

  1. On the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during a calendar month.
  3. On the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. Permission to consult with relevant specialist.

- At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the physician, NP, PA, or CNM, and b) by a practitioner, or by clinical personnel under general supervision.

- Patient must have one of the following two options:

    a) Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, or;
    b) Any behavioral health or psychiatric condition being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants BHI services.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

    1. Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.
    2. 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
    3. Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
    4. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.
    5. Care plan information made available electronically (including fax) in a timely manner as appropriate and a copy of the plan of care given to the patient and/or caregiver.
    6. Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
    7. Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record.
    8. Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

    1. Initial assessment or follow-up monitoring, including the use of applicable validated rating scales

2. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes
3. Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)
4. Continuity of care with a designated member of the care team

Additional BHI Documentation Requirements:

- Beginning and ending times, along with total minutes, must be documented in the patient's medical record and made available for audit review as required.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows published CMS guidelines for Care Coordination services. See the reference section below for sources. This is representative of some guidelines and not an all-inclusive list.

REFERENCES:

- Chronic Care Management Services; Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- Delaware PCP and Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743

- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs

- Summary of CCM Service Requirements, Advisory https://www.advisory.com/-/media/Advisory-com/Research/PPR/Resources/2017/Summary-of-CCM-Service-Requirements.pdf

- Cognitive Assessment and Care Planning Services https://www.alz.org/careplanning/downloads/cms-consensus.pdf

- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section. *Current Procedure Terminology Manual* (CPT®) is copyright American Medical Association. All rights Reserved. The AMA assumes no liability for the data contained in this policy.

- AAP News and Journals Gateway https://www.aappublications.org/news/2017/11/02/Coding110217

- Behavioral Health Integration Services; Department of Health and Human Services Centers for Medicare & Medicaid Services, MLN Matters Booklet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs); Centers for Medicare & Medicaid Services, MM10175. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

- Advanced Care Planning; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

- Behavioral Health Integration Services; Centers for Medicare & Medicaid Services, MLN Booklet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Transitional Care Management Services; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

POLICY UPDATE HISTORY INFORMATION:

1 / 2019	Implementation
5 / 2019	Clarified that TCM services during global period cannot be billed by the same practitioner
1 / 2020	Added codes G2058, G2064, G2065
4 / 2020	Added codes 99484, 99492, 99493 and 99494 eligible for all regions. Added 99487, 99489, 99490 and 99491 eligible for WV and PA
3 / 2021	Removed code G2058. Added codes 99439 and G2214.

Highmark Reimbursement Policy Bulletin

HISTORY VERSIONS

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	April 13, 2020	**Revised Date:**	April 2020
Date Reviewed:	March 2019		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

Care management is the range of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions. This policy is intended to provide the Plan's reimbursement direction for these services.

DEFINITIONS:

Transitional Care Management (TCM): Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of 29 days.

Advance Care Planning (ACP): A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

Chronic Care Management (CCM): Services encompassing the oversight and education activities by health care professionals to help patients with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.

Psychiatric Collaborative Care Management (PCCM): Behavioral health services delivered via a specific evidence-based model. Care is managed by a behavioral health care manager (BHCM), who has master's/doctoral-level education or specialized training in behavioral health, under direction of a treating physician or qualified health care professional (QHP) in consultation with a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications.

General Behavioral Health Integration Care Management (BHI): The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Care Coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Primary Care: Health care provided by a physician or an individual license to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes internal medicine, family practice, general practice, pediatrics, CRNP PCP, geriatric medicine, and multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, pediatrics, CRNP PCP, PA PCP, or geriatric medicine).

Comprehensive Care: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

COMMERCIAL REIMBURSEMENT GUIDELINES:

Transitional Care Management (TCM) Services: 99495, 99496

Codes 99495 and 99496 are used to report TCM. These services are for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional (QHP) and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan.

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge

- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional may include:

1. Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. Communication with agencies and other community services utilized by the patient;
3. Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

1. Obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);
2. Reviewing need for or follow-up on pending diagnostic tests and treatments;
3. Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
4. Education of patient, family, guardian, and/or caregiver;
5. Establishment or reestablishment of referrals and arranging for needed community resources;
6. Assistance in scheduling any required follow-up with community providers and services.

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services IF they have primary responsibility for post-discharge care coordination – secondary consulting specialists or other secondary practitioners are not eligible for separate reimbursement.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day in which the discharge day management services are reported.
- You may not bill TCM services that are within a post-operative global period (TCM services will not be paid if any of the 30 day TCM period falls within a global period for a procedure code billed by the same practitioner).
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).
- The place of service should correspond to the place of service of the required face-to-face visit.
- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.

- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Evidence of the patient's consent to participate in TCM services and an acknowledgement services may be subject to additional cost share responsibilities.
- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision making actions and the level of complexity (moderate or high).

Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a PCP physician or other qualified PCP health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure 99497).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion along with beginning and ending times.
- Patient/surrogate/family "given opportunity to decline;"
- Details of discussion (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of ACP services, the patient must provide consent and consent must be documented in the medical record in addition to an acknowledgement services may be subject to additional cost share responsibilities.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.
- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- **Reimbursement for 99497 and 99498 are limited to the following specialties: PCP specialties (NP's and PA's)**
- 99498 must be reported in conjunction with 99497

Chronic Care Management (CCM) Services: 99487, 99489, 99490, 99491 and G2058

CCM services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services many include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

CCM activities performed by clinical staff includes the following activities and any other activities designated as CCM by CMS:

1. Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. Communication with home health agencies and other community services utilized by the patient;
3. Collection of health outcomes data and registry documentation;
4. Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
5. Assessment and support for treatment regimen adherence and medication management;
6. Identification of available community and health resources;
7. Facilitating access to care and services needed by the patient and/or family;
8. Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service;
9. Development, communication, and maintenance of a comprehensive care plan;
10. Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
11. A copy of the plan of care must be given to the patient and/or caregiver

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 a comprehensive care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health professional, *per calendar month*

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes in duration, in a calendar month, are *not* reported separately.

99490: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, *per calendar month*, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99491: Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, *per calendar month*, 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

G2058: Chronic care management services, 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).

Note: Do not report G2058 for care management services less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month. You can report this add-on code to CPT code 99490 a maximum of twice per service period. When you report G2058, CPT code 99490 will represent the first 20 minutes of non-complex CCM services, with G2058 reporting additional 20-minute increments of service time (maximum of 60 minutes total). Use G2058 in conjunction with 99490. Do not report 99490, G0258 in the same calendar month as 99487, 99489 or 99491.

Comprehensive Care Management Services: G2064, G2065

G2064: Comprehensive care management services for a single high-risk disease, e.g. principle care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

G2065: Comprehensive care management services for a single high-risk disease, e.g. principle care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

CCM Documentation Requirements:

- The eligible practitioner can only bill **one CCM code per month per qualifying patient**.
- The initiation of CCM services **must occur during a face-to-face visit** with the billing practitioner.
- Obtaining **advance consent from the patient is required**. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:
    1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
    2. As the central coordinator of the patient's care plan the billing CCM codes is intended for PCP use. However, other specialties may bill CCM codes if they are the *primary* coordinator of the patient's continuing care (e.g. Oncology) Only a **single practitioner can furnish and be paid for CCM services once per calendar month per patient**.
    3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.

- **Documentation of a Comprehensive Care Plan is required**. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
    1. Problem list
    2. Expected outcomes and prognosis
    3. Measurable treatment goals
    4. Symptom management
    5. Planned interventions and identification of the individuals responsible for each intervention
    6. Medication management
    7. Environmental evaluation
    8. Caregiver assessment
    9. Community and Social services ordered
    10. A description of how services and specialists outside of the practice will be directed/coordinated.
    11. Schedule for periodic review and when required, revision of the care plan.
- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.
- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month. For complex CCM (CPT 99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

Total Time (in minutes)	Code(s) to bill	Quantity
1-30	Cannot be billed	N/A
31-75	99487	1
76-105	99487 + 99489	1 1
106-135	99487 + 99489	1 2
136-195	99487 + 99489	1 3
196-225	99487 + 99489	1 4

Psychiatric Collaborative Care Management (PCCM) Services: 99492, 99493, 99494

PCCM services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99492: Initial psychiatric collaborative care management, first 70 minutes in the *first calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other QHP;
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;
- Review by the psychiatric consultant with modifications of the plan if recommended;
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.

99493: Subsequent psychiatric collaborative care management, first 60 minutes in a *subsequent month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a *calendar month* of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other QHP.

Note: List 99494 separately in addition to code for primary procedure. Use 99494 in conjunction with 99492, 99493.

Initial month and time of service	Code(s) to bill	Subsequent month and time of service	Code(s) to bill
Initial <36 mins	Not separately reported	Subsequent <36 mins	Not separately reported
Initial 36-85 mins	99492	Subsequent 36-85 mins	99493
Initial 86-115 mins	99492 and 99494	Subsequent 86-115 mins	99493 and 99494
Initial 116-145 mins	99492 and 99494 (x2)	Subsequent 116-144 mins	9492 and 99494 (x2)

PCCM Service Requirements:

- An initiating visit furnished by a physician, NP, PA, or CNM has occurred no more than one-year prior to commencing psychiatric services. This can be an Evaluation and Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE).

- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by practitioner or clinical staff; can be written or verbal, must be documented in the medical record and include:

    1. Information on the availability of care coordination services and applicable cost-sharing.
    2. That only one practitioner can furnish and be paid for care coordination services during calendar month.
    3. That the patient has the right to stop care coordination services at any time (effective at the end of the calendar month).
    4. The patient is giving permission to consult with relevant specialists.

- At least 70 minutes in the first calendar month, and at least 60 minutes in subsequent calendar months of psychiatric services, furnished;
  a) Under the direction of the physician, NP, PA, or CNM, and;
  b) By a practitioner or Behavioral Health Care Manager under general supervision.

Patient must have a behavioral health or psychiatric condition that is being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants psychiatric services.

PCCM Services require a team that includes the following:

- Practitioner (physician, NP, PA, or CNM) who:

    1. Directs the behavioral health care manager or clinical staff.
    2. Oversees; the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed.
    3. Remains involved through ongoing oversight, management, collaboration and reassessment.

- Behavioral Health Care Manager who:

    1. Provides assessment and care management services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the practitioner; maintenance of the registry; acting in consultation with the psychiatric consultant.
    2. Is available to provide services face-to-face with the beneficiary; has a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team.
    3. Is available to contact the patient outside of regular hours as necessary to conduct the behavioral health care manager's duties.

- Psychiatric Consultant who:

    1. Participates in regular reviews of the clinical status of patients receiving services;
    2. Advises the practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment; making adjustments to behavioral

health treatment for beneficiaries who are not progressing; managing any negative interactions between beneficiaries' behavioral health and medical treatments.
3. Facilitate referral for direct provision of psychiatric care when clinically indicated.

General Behavioral Health Integration Care Management (BHI): 99484

BHI services are intended to be billed by the patient's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

99484: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, *per calendar month*, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

Note: Clinical staff time spent coordinating care with the emergency department may be reported using 99484, but time spent while the patient is inpatient or admitted to observation status may not be reported using 99484.

General BHI Care Management Service Requirements:

- An initiating Evaluation Management (E/M), Annual Wellness Visit (AWV), or Initial Preventive Physical Examination (IPPE) visit furnished by a physician, Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse-Midwives (CNM) has occurred no more than one-year prior to commencing care coordination services.

- Beneficiary consent has been obtained during or after the initiating visit and before provision of care coordination services by the practitioner or clinical staff;
  can be written or verbal, must be documented in the medical record and includes information:

  1. On the availability of care coordination services and applicable cost-sharing.
  2. That only one practitioner can furnish and be paid for care coordination services during a calendar month.
  3. On the right to stop care coordination services at any time (effective at the end of the calendar month).
  4. Permission to consult with relevant specialist.

- At least 20 minutes of care coordination services has been furnished in the calendar month furnished a) under the direction of the physician, NP, PA, or CNM, and b) by a practitioner, or by clinical personnel under general supervision.

- Patient must have one of the following two options:

a) Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, or;
b) Any behavioral health or psychiatric condition being treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants BHI services.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

1. Structured recording of patient health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.
2. 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments.
3. Comprehensive care management including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.
4. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.
5. Care plan information made available electronically (including fax) in a timely manner as appropriate and a copy of the plan of care given to the patient and/or caregiver.
6. Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers;
7. Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the patient's psychosocial needs and functional deficits in the patient's medical record.
8. Enhanced opportunities for the patient and any caregiver to communicate with the practitioner regarding the patient's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.

- For patient meeting option A eligibility from above, the service elements must meet all of the following requirements:

1. Initial assessment or follow-up monitoring, including the use of applicable validated rating scales
2. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes

3. Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation)
4. Continuity of care with a designated member of the care team

Additional BHI Documentation Requirements:

- Beginning and ending times, along with total minutes, must be documented in the patient's medical record and made available for audit review as required.

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows published CMS guidelines for Care Coordination services. See the reference section below for sources. This is representative of some guidelines and not an all-inclusive list.

REFERENCES:

- Chronic Care Management Services; Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- Delaware PCP and Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743

- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs

- Summary of CCM Service Requirements, Advisory https://www.advisory.com/-/media/Advisory-com/Research/PPR/Resources/2017/Summary-of-CCM-Service-Requirements.pdf

- Cognitive Assessment and Care Planning Services https://www.alz.org/careplanning/downloads/cms-consensus.pdf

- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section. *Current Procedure Terminology Manual* (CPT®) is copyright American Medical Association. All rights Reserved. The AMA assumes no liability for the data contained in this policy.

- AAP News and Journals Gateway https://www.aappublications.org/news/2017/11/02/Coding110217

- Behavioral Health Integration Services; Department of Health and Human Services Centers for Medicare & Medicaid Services, MLN Matters Booklet https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs); Centers for Medicare & Medicaid Services, MM10175. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

- Advanced Care Planning; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

- Behavioral Health Integration Services; Centers for Medicare & Medicaid Services, MLN Booklet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

- Transitional Care Management Services; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

POLICY UPDATE HISTORY INFORMATION:

1 / 2019	Implementation
5 / 2019	Clarified that TCM services during global period cannot be billed by the same practitioner
1 / 2020	Added codes G2058, G2064, G2065
4 / 2020	Added codes 99484, 99492, 99493 and 99494 eligible for all regions. Added 99487, 99489, 99490 and 99491 eligible for WV and PA.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

CLICK FOR HISTORY VERSIONS

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	January 1, 2020	**Revised Date:**	January 2020
Date Reviewed:	November 2019		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

Care management is the range of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions. This policy is intended to provide the Plan's reimbursement direction for these services.

DEFINITIONS:

Transitional Care Management (TCM): Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of 29 days.

Advance Care Planning (ACP): A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

Chronic Care Management (CCM): Services encompassing the oversight and education activities by health care professionals to help patients with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.

Comprehensive Care: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

Care Coordination: The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and is often managed by the exchange of information among participants responsible for different aspects of care.

Primary care: Health care provided by a physician or an individual license to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes internal medicine, family practice, general practice, pediatrics, CRNP PCP, geriatric medicine, and multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, pediatrics, CRNP PCP, PA PCP, or geriatric medicine).

COMMERCIAL REIMBURSEMENT GUIDELINES:

Transitional Care Management (TCM) Services: 99495, 99496

Codes 99495 and 99496 are used to report transitional care management services (TCM). These services are for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional (QHP) and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan in West Virginia, Pennsylvania and Delaware.

99495: TCM Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: TCM Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional may include:

1. Communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. Communication with agencies and other community services utilized by the patient;

3. Patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. Assessment and support for treatment regimen adherence and medication management;
5. Identification of available community and health resources;
6. Facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

1. Obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);
2. Reviewing need for or follow-up on pending diagnostic tests and treatments;
3. Interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
4. Education of patient, family, guardian, and/or caregiver;
5. Establishment or reestablishment of referrals and arranging for needed community resources;
6. Assistance in scheduling any required follow-up with community providers and services.

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services IF they have primary responsibility for post-discharge care coordination – secondary consulting specialists or other secondary practitioners are not eligible for separate reimbursement.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day in which the discharge day management services are reported.
- You may not bill TCM services that are within a post-operative global period (TCM services will not be paid if any of the 30 day TCM period falls within a global period for a procedure code billed by the same practitioner).
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).
- The place of service should correspond to the place of service of the required face-to-face visit.
- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.
- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Evidence of the patient's consent to participate in TCM services and an acknowledgement services may be subject to additional cost share responsibilities.
- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision making actions and the level of complexity (moderate or high).

Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a PCP physician or other qualified PCP health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure 99497).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan in West Virginia, Pennsylvania and Delaware.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion along with beginning and ending times.
- Patient/surrogate/family "given opportunity to decline;"
- Details of discussion (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of Advanced Care Planning (ACP) services, the patient must provide consent and consent must be documented in the medical record in addition to an acknowledgement services may be subject to additional cost share responsibilities.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.
- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- **Reimbursement for 99497 and 99498 are limited to the following specialties: PCP specialties (NP's and PA's)**
- 99498 must be reported in conjunction with 99497

Chronic Care Management (CCM) Services: 99487, 99489, 99490, 99491 and G2058

These codes and services are separately reimbursed in adherence to Delaware PCP and Chronic Care Mandate Senate Bill # 227.

Chronic care management services (CCM) are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services many include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

***Note:** Coverage for CCM in Delaware is subject to the specific terms of the member's benefit plan. For West Virginia and Pennsylvania members, please reference Reimbursement Policy RP-041 Services Not Separately Reimbursed.

CCM activities performed by clinical staff includes the following activities and any other activities designated as CCM by CMS:

1. Communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. Communication with home health agencies and other community services utilized by the patient;
3. Collection of health outcomes data and registry documentation;
4. Patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
5. Assessment and support for treatment regimen adherence and medication management;
6. Identification of available community and health resources;
7. Facilitating access to care and services needed by the patient and/or family;
8. Ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service;
9. Development, communication, and maintenance of a comprehensive care plan;
10. Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;

11. A copy of the plan of care must be given to the patient and/or caregiver

99487: Complex CCM 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 a comprehensive care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health professional, *per calendar month*

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes in duration, in a calendar month, are *not* reported separately.

99490: CCM, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, *per calendar month*, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99491: CCM services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, *per calendar month*, 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

G2058: CCM, 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).

Note: Do not report G2058 for care management services less than 20 minutes additional to the first 20 minutes of CCM services during a calendar month. Use G2058 in conjunction with 99490. Do not report 99490, G0258 in the same calendar month as 99487, 99489 or 99491.

Comprehensive Care Management Services: G2064, G2065

G2064: Comprehensive Care management services for a single high-risk disease, e.g. principle care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

G2065: Comprehensive Care management services for a single high-risk disease, e.g. principle care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements:

- One complex chronic condition lasting at least three (3) months, which is the focus of the care plan
- The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization
- The condition requires development or revision of disease-specific care plan
- The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

CCM and Comprehensive Care Management Documentation Requirements:

- The eligible practitioner can only bill **one CCM code per month per qualifying patient**.
- The initiation of CCM services **must occur during a face-to-face visit** with the billing practitioner.
- Obtaining **advance consent from the patient is required**. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:
    1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
    2. As the central coordinator of the patient's care plan the billing CCM codes is intended for PCP use. However, other specialties may bill CCM codes if they are the *primary* coordinator of the patient's continuing care (e.g. Oncology) Only a **single practitioner can furnish and be paid for CCM services once per calendar month per patient**.
    3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.
- **Documentation of a Comprehensive Care Plan is required**. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
    1. Problem List
    2. Expected outcomes and prognosis
    3. Measurable treatment goals

4. Symptom management
5. Planned interventions and identification of the individuals responsible for each intervention.
6. Medication Management
7. Community and Social services ordered
8. A description of how services and specialists outside of the practice will be directed/coordinated.
9. Schedule for periodic review and when required, revision of the care plan.

- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.
- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month. For complex CCM (CPT 99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

Total Time (in minutes)	Code(s) to bill	Quantity
1-30	Cannot be billed	N/A
31-75	99487	1
76-105	99487 + 99489	1 1
106-135	99487 + 99489	1 2
136-195	99487 + 99489	1 3
196-225	99487 + 99489	1 4

MEDICARE ADVANTAGE REIMBURSEMENT GUIDELINES:

The Plan follows published CMS guidelines for Care Coordination services. See the reference section below for sources. This is representative of some guidelines and not an all-inclusive list.

REFERENCES:

- Chronic Care Management Services; Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- Delaware PCP and Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743

- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs

- Summary of CCM Service Requirements, Advisory https://www.advisory.com/-/media/Advisory-com/Research/PPR/Resources/2017/Summary-of-CCM-Service-Requirements.pdf

- Cognitive Assessment and Care Planning Services https://www.alz.org/careplanning/downloads/cms-consensus.pdf

- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section. *Current Procedure Terminology Manual* (CPT®) is copyright American Medical Association. All rights Reserved. The AMA assumes no liability for the data contained in this policy.

- AAP News and Journals Gateway https://www.aappublications.org/news/2017/11/02/Coding110217

- Care Coordination Services and Payment for Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs); Centers for Medicare & Medicaid Services, MM10175. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10175.pdf

- Advanced Care Planning; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

- Transitional Care Management Services; Centers for Medicare & Medicaid Services, MLN Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

POLICY UPDATE HISTORY INFORMATION:

01 / 2019	Implementation
05 / 2019	Clarified that TCM services during global period cannot be billed by the same practitioner
01 / 2020	Added codes G2058, G2064, G2065

Highmark Reimbursement Policy Bulletin

HIGHMARK.

CLICK HERE FOR HISTORY VERSION

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	May 20, 2019	**Revised Date:**	May 1, 2019
Date Reviewed:	May 2019		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE** ☒
Applicable Medicare Advantage Market	**PA**	☐	**WV**	☐	
Applicable Claim Type	**UB**	☐	**1500**	☒	

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy's direction and regional applicability. This policy supersedes and replaces any prior Plan guidance, including bulletins, in direct conflict with the guidance provided in this Reimbursement Policy.

REIMBURSEMENT GUIDELINES:

Transitional Care Management (TCM) Services: 99495, 99496

Codes 99495 and 99496 are used to report transitional care management services (TCM). These services are for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional (QHP) and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan in West Virginia, Pennsylvania and Delaware.

Definitions

Transitional Care Management: Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of 29 days.

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional may include:

1. communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. communication with agencies and other community services utilized by the patient;
3. patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. assessment and support for treatment regimen adherence and medication management;
5. identification of available community and health resources;
6. facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

1. obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);
2. reviewing need for or follow-up on pending diagnostic tests and treatments;
3. interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
4. education of patient, family, guardian, and/or caregiver;
5. establishment or reestablishment of referrals and arranging for needed community resources;
6. assistance in scheduling any required follow-up with community providers and services.

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services, such as, Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners, or Physician Assistants.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit

may not take place on the same day in which the discharge day management services are reported.

- You may not bill TCM services that are within a post-operative global period (TCM services will not be paid if any of the 30 day TCM period falls within a global period for a procedure code billed by the same practitioner).
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).
- The place of service should correspond to the place of service of the required face-to-face visit.
- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.
- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM DOCUMENTATION REQUIREMENTS:

The following information must be documented, at a minimum, in the patient's medical record:

- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision making actions and the level of complexity (moderate or high).

Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure 99497).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan in West Virginia, Pennsylvania and Delaware.

Definitions

Advance Care Planning: A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion
- Patient/surrogate/family "given opportunity to decline"
- Details of discussion (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of Advanced Care Planning (ACP) services, the patient must provide consent and consent must be documented in the medical record.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.
- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- Reimbursement for 99497 and 99498 are limited to the following specialties: PCP or internal Medicine (NP's and PA's)
- 99498 must be reported in conjunction with 99497

Chronic Care Management (CCM) services: 99487, 99489, 99490, and 99491

These codes and services are separately reimbursed in adherence to Delaware PCP and Chronic Care Mandate Senate Bill # 227.

Chronic care management services (CCM) are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services many include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

***Note:** Coverage for CCM in Delaware is subject to the specific terms of the member's benefit plan. For West Virginia and Pennsylvania members, please reference Reimbursement Policy RP-041 Services Not Separately Reimbursed.

Definitions

Chronic care management: Services in the Chronic Care Management Services program, as administered by the Centers for Medicare and Medicaid Services, and includes Current Procedural Terminology ("CPT") codes 99487, 99489, 99490, and 99491.

Primary care: Health care provided by a physician or an individual license under *Title 24 to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes family practice, pediatrics, internal medicine, and geriatrics.

***Note** – Title 24 licensed providers include physician assistants and advanced practice registered nurses.

Care Management activities performed by clinical staff includes the following:

1. communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. communication with home health agencies and other community services utilized by the patient;
3. collection of health outcomes data and registry documentation;
4. patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
5. assessment and support for treatment regimen adherence and medication management;
6. identification of available community and health resources;
7. facilitating access to care and services needed by the patient and/or family;
8. ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service;
9. development, communication, and maintenance of a comprehensive care plan;
10. creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
11. A copy of the plan of care must be given to the patient and/or caregiver

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 a comprehensive care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes in duration, in a calendar month, are *not* reported separately.

99490: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99491: Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, 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

CCM Documentation Requirements:

- The practitioner can only bill one CCM code per month per qualifying patient.
- The initiation of CCM services must occur during a face-to-face visit with the billing practitioner.
- Obtaining advance consent from the patient is required. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:

1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
2. Only a single practitioner can furnish and be paid for CCM services in a calendar month.
3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.

- Documentation of a Comprehensive Care Plan is required. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
  1. Problem List
  2. Expected outcomes and prognosis
  3. Measurable treatment goals
  4. Symptom management
  5. Planned interventions and identification of the individuals responsible for each intervention.
  6. Medication Management
  7. Community and Social services ordered
  8. A description of how services and specialists outside of the practice will be directed/coordinated.
  9. Schedule for periodic review and when required, revision of the care plan.
- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.
- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month. For complex CCM (CPT 99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

Total Time (in minutes)	Code(s) to bill	Quantity
1-30	Cannot be billed	N/A
31-75	99487	1
76-105	99487 + 99489	1 1
106-135	99487 + 99489	1 2
136-195	99487 + 99489	1 3
196-225	99487 + 99489	1 4

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy: RP-041 Services Not Separately Reimbursed

REFERENCES:

- Chronic Care Management Services- Department of Health and Human Services Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- Delaware PCP and Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743

- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs

- Summary of CCM Service Requirements, Advisory https://www.advisory.com/-/media/Advisory-com/Research/PPR/Resources/2017/Summary-of-CCM-Service-Requirements.pdf

- Cognitive Assessment and Care Planning Services https://www.alz.org/careplanning/downloads/cms-consensus.pdf

- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section. *Current Procedure Terminology Manual* (CPT®) is copyright American Medical Association. All rights Reserved. The AMA assumes no liability for the data contained in this policy.

POLICY UPDATE HISTORY INFORMATION:

01 / 2019	Implementation
05 / 2019	Clarified that TCM services during global period cannot be billed by the same practitioner

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-043		
Subject:	Care Management		
Effective Date:	January 1, 2019	**End Date:**	
Issue Date:	November 30, 2018	**Revised Date:**	
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☐	**WV** ☐		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy's direction and regional applicability.

REIMBURSEMENT GUIDELINES:

Transitional Care Management (TCM) Services: 99495, 99496

Codes 99495 and 99496 are used to report transitional care management services (TCM). These services are for a new or established patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days.

TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional (QHP) and/or licensed clinical staff under his/her direction. The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.

Note: Coverage for TCM services is subject to the specific terms of the member's benefit plan in West Virginia, Pennsylvania and Delaware.

Definitions

Transitional Care Management: Services which healthcare personnel provide to patients following discharge from an inpatient hospital visit for a period of 29 days.

99495: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 14 calendar days of discharge, with moderate medical decision complexity

99496: Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Face-to-face visit, within 7 calendar days of discharge, with high medical decision complexity

Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional may include:

1. communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
2. communication with agencies and other community services utilized by the patient;
3. patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
4. assessment and support for treatment regimen adherence and medication management;
5. identification of available community and health resources;
6. facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care provider may include:

1. obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);
2. reviewing need for or follow-up on pending diagnostic tests and treatments;
3. interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
4. education of patient, family, guardian, and/or caregiver;
5. establishment or reestablishment of referrals and arranging for needed community resources;
6. assistance in scheduling any required follow-up with community providers and services.

TCM Additional Billing Information and Guidelines:

- Physicians (any specialty) and non-physician practitioners may bill TCM services, such as, Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners, or Physician Assistants.
- CNMs, CNSs, NPs, and PAs may furnish non-face-to-face TCM services under supervision of a Physician or non-physician practitioner.
- Only one health care professional may report TCM services.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. However, the required face-to-face visit may not take place on the same day in which the discharge day management services are reported.
- TCM services should not be reported within a post-operative global period.
- When reporting TCM services, the health care professional may not also report care plan oversight services, home health or hospice supervision (HCPCS G0181, G0182), end-stage renal disease services (CPT codes 90951-90970), chronic care management services (chronic care

management and transitional care management periods cannot overlap), prolonged evaluation and management services without direct patient contact (CPT codes 99358, 99359) or other services excluded by CPT reporting rules).

- The place of service should correspond to the place of service of the required face-to-face visit.
- At a minimum, the date the beneficiary was discharged, the date in which the health care professional made an interactive contact with the member and/or caregiver, the date in which the face-to-face visit was furnished, and the complexity of medical decision making (moderate or high) should be documented in the member's record.
- The date of service should be reported as the date of the required face-to-face visit and need not hold the claim until the end of the service period.
- Medical decision making is defined by the E/M Services Guidelines. The medical decision making over the service period reported is used to define the medical decision making of TCM.

TCM DOCUMENTATION REQUIREMENTS:

The following information must be documented, at a minimum, in the patient's medical record:

- Date the patient was discharged.
- Date of the interactive contact with the patient and/or caregiver.
- Date of the face-to-face visit, and
- Details of the medical decision making actions and the level of complexity (moderate or high).

Advance Care Planning (ACP) Services: 99497, 99498

Codes 99497 and 99498 are used to report the face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a patient pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Medical Orders for Life-Sustaining Treatment (MOLST).

When using codes 99497 and 99498, no active management of the problem(s) is undertaken during the time period reported.

99497: Advance care planning (ACP) including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional that includes the following elements:

- First 30 minutes, face-to-face with the patient, family member(s), and/or surrogate

99498: Each additional 30 minutes (List separately in addition to code for primary procedure 99497).

Note: Coverage for ACP services is subject to the specific terms of the member's benefit plan in West Virginia, Pennsylvania and Delaware.

Definitions

Advance Care Planning: A process to help patients with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

ACP Documentation Requirements:

The following information must be documented, at a minimum, in the patient's medical record:

- Total time in minutes spent on discussion
- Patient/surrogate/family "given opportunity to decline"
- Details of discussion (e.g. Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up)
- Before the delivery of Advanced Care Planning (ACP) services, the patient must provide consent and consent must be documented in the medical record.

ACP Additional Billing Information and Guidelines:

- Code 99497 and 99498 are NOT separately reimbursed when performed on the same day as a Medicare Annual Well visit (G0438 or G0439) or Preventive Medicine visit (99381-99397).
- Code 99497 and 99498 are separately reimbursed when filed as the only service rendered on that date or when filed with 99211-99215.
- Do not report 99497 and 99498 on the same date of service as 99291, 99292, 99468, 99469, 99471, 99472, 99475, 99476, 99477, 99478, 99479, 99480 or 99483.
- Reimbursement for 99497 and 99498 will be limited to once per calendar year
- Reimbursement for 99497 and 99498 are limited to the following specialties: PCP or internal Medicine (NP's and PA's)
- 99498 must be reported in conjunction with 99497

Chronic Care Management (CCM) services: 99487, 99489, 99490, and 99491

These codes and services are separately reimbursed in adherence to Delaware PCP and Chronic Care Mandate Senate Bill # 227.

Chronic care management services (CCM) are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services many include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis.

Care management for chronic conditions includes systematic assessment of the patient's medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of patient self-management of medications.

***Note:** Coverage for CCM in Delaware is subject to the specific terms of the member's benefit plan. For West Virginia and Pennsylvania members, please reference Reimbursement Policy RP-041 Services Not Separately Reimbursed.

Definitions

Chronic care management: Services in the Chronic Care Management Services program, as administered by the Centers for Medicare and Medicaid Services, and includes Current Procedural Terminology ("CPT") codes 99487, 99489, 99490, and 99491.

Primary care: Health care provided by a physician or an individual license under *Title 24 to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes family practice, pediatrics, internal medicine, and geriatrics.

***Note** – Title 24 licensed providers include physician assistants and advanced practice registered nurses.

Care Management activities performed by clinical staff includes the following:

1. communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
2. communication with home health agencies and other community services utilized by the patient;
3. collection of health outcomes data and registry documentation;
4. patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
5. assessment and support for treatment regimen adherence and medication management;
6. identification of available community and health resources;
7. facilitating access to care and services needed by the patient and/or family;
8. ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service;
9. development, communication, and maintenance of a comprehensive care plan;
10. creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed;
11. A copy of the plan of care must be given to the patient and/or caregiver

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 a comprehensive care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month

99489: Each additional 30 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):

- Elements for 99487 apply
- Report code 99489 in conjunction with 99487
- Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month

Note: Complex CCM services of less than 60 minutes in duration, in a calendar month, are *not* reported separately.

99490: Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, 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

Note: Services of less than 20 minutes duration, in a calendar month, are *not* reported separately. The physician or QHP may still report evaluation and management services for specific problems treated or managed in accordance with the CPT level of care.

99491: Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, 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

CCM Documentation Requirements:

- The practitioner can only bill one CCM code per month per qualifying patient.
- The initiation of CCM services must occur during a face-to-face visit with the billing practitioner.
- Obtaining advance consent from the patient is required. This consent MUST be documented in the patient's medical record prior to the delivery of CCM services. The practitioner must inform the patient of the following:
    1. The availability of CCM services, what is included in the CCM service, and any applicable cost sharing requirements (DE members do not have associated cost share for CCM services).
    2. Only a single practitioner can furnish and be paid for CCM services in a calendar month.
    3. The patient has the right to stop CCM services at any time and would become effective at the end of the calendar month after the time of the patient's request to discontinue services.

- Documentation of a Comprehensive Care Plan is required. This document must be separate from all other visit documentation and be available to the Health Plan for auditing as required. The practitioner should document a comprehensive care plan in the medical record after initiation of CCM services. The Comprehensive Care Plan should include (at a minimum) the following:
    1. Problem List
    2. Expected outcomes and prognosis
    3. Measurable treatment goals
    4. Symptom management
    5. Planned interventions and identification of the individuals responsible for each intervention.
    6. Medication Management
    7. Community and Social services ordered
    8. A description of how services and specialists outside of the practice will be directed/coordinated.
    9. Schedule for periodic review and when required, revision of the care plan.
- The patient must be provided a copy of the Comprehensive Care Plan.
- The incremental and total time spent each month providing CCM services must be documented in the medical record.
- Practitioners may report CPT 99490 or 99491 at the conclusion of the service period, or after completion of the minimum clinical staff service time. When the time threshold to bill is met, the practitioner may choose that date as the date of service, and need not hold the claim until the end of the month. For complex CCM (CPT 99487, 99489), practitioners should report the service code(s) at the conclusion of the service period because in addition to specified clinical staff service time, the code(s) include moderate or high complexity medical decision-making (determined by the problems addressed by the reporting practitioner during the month).

Total Time (in minutes)	Code(s) to bill	Quantity
1-30	Cannot be billed	N/A
31-75	99487	1
76-105	99487 + 99489	1 1
106-135	99487 + 99489	1 2
136-195	99487 + 99489	1 3
196-225	99487 + 99489	1 4

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy: RP-041 Services Not Separately Reimbursed

REFERENCES:

- Chronic Care Management Services- Department of Health and Human Services Centers for Medicare & Medicaid Services https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

- Delaware PCP and Chronic Care Mandate Senate Bill # 227 https://legis.delaware.gov/BillDetail/26743

- AIMS Center Advancing Integrated Mental Health Solutions http://aims.uw.edu/resource-library/cms-behavioral-health-integration-payment-cheat-sheet-fqhcs-and-rhcs

- Summary of CCM Service Requirements, Advisory https://www.advisory.com/-/media/Advisory-com/Research/PPR/Resources/2017/Summary-of-CCM-Service-Requirements.pdf

- Cognitive Assessment and Care Planning Services https://www.alz.org/careplanning/downloads/cms-consensus.pdf

- Current version of AMA CPT Manual, Evaluation and Management (E/M) Service Code Section.