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 may 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.

   o The patient must be provided a copy of the Comprehensive Care Plan.
   o The incremental and total time spent each month providing CCM services must be documented in the medical record.
   o 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).

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RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy: RP-041 Services Not Separately Reimbursed

REFERENCES:


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


POLICY UPDATE HISTORY INFORMATION:

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<tr>
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<th>Update Description</th>
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<tr>
<td>01 / 2019</td>
<td>Implementation</td>
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<tr>
<td>05 / 2019</td>
<td>Clarified that TCM services during global period cannot be billed by the same practitioner</td>
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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).

<table>
<thead>
<tr>
<th>Total Time (in minutes)</th>
<th>Code(s) to bill</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-30</td>
<td>Cannot be billed</td>
<td>N/A</td>
</tr>
<tr>
<td>31-75</td>
<td>99487</td>
<td>1</td>
</tr>
<tr>
<td>76-105</td>
<td>99487 + 99489</td>
<td>1</td>
</tr>
<tr>
<td>106-135</td>
<td>99487 + 99489</td>
<td>2</td>
</tr>
<tr>
<td>136-195</td>
<td>99487 + 99489</td>
<td>3</td>
</tr>
<tr>
<td>196-225</td>
<td>99487 + 99489</td>
<td>4</td>
</tr>
</tbody>
</table>

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy: RP-041 Services Not Separately Reimbursed
REFERENCES:


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


