



PARAMOUNT

Care Management & Transitional Care Management Services

Policy Number: PG0161

Last Review: 09/22/2020

ADVANTAGE | ELITE | HMO
INDIVIDUAL MARKETPLACE |
PROMEDICA MEDICARE
PLAN | PPO

GUIDELINES

This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder contract. Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards. This guideline is solely for explaining correct procedure reporting and does not imply coverage and reimbursement.

SCOPE

Professional

Facility

DESCRIPTION

Care Management Services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, or may be provided personally by 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 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. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living.

Chronic Care Management (CCM) services, 99490 and 99491, are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CCM is care coordination services done outside of the regular office visit for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. These services are typically non-face-to-face and allow eligible practitioners to bill for at least 20 minutes or more of care coordination services per month. CCM services focus on characteristics of advanced primary care such as a continuous relationship with a designated member of the care team; patient support for chronic diseases to achieve health goals; 24/7 patient access to care and health information; receipt of preventive care; patient and caregiver engagement; and timely sharing and use of health information.

Complex Chronic Care Management (CCCM) services, 99487 and 99489, include criteria for chronic care management services as well as establishment or substantial revision of a comprehensive care plan; medical, functional, and/or psychosocial problems requiring medical decision making of moderate or high complexity; and clinical staff care management services for at least 60 minutes, under the direction of a physician or other qualified health care professional. Physicians or other qualified health care professionals may not report complex chronic care management services if the care plan is unchanged or requires minimal change (eg, only a medication is changed or an adjustment in a treatment modality is ordered). Patients who require complex chronic care management services have multiple illnesses, multiple medication use, inability to perform activities of daily living, require a caregiver, and/or repeat admissions or emergency department visits. CCCM patients have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Patients with complex diseases and morbidities qualifying for CCCM services demonstrate on or more of

the following, the need for the coordination of a number of specialties and services; the inability to perform activities of daily living and/or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver; psychiatric and other medical comorbidities (e.g. dementia and chronic obstructive pulmonary disease or substance abuse and diabetes) that complicate their care; and/or social support requirements or difficulty with access to care.

A physician or other qualified health care professional who reports codes 99487, 99489, 99490, may not report care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366, 99367, 99368), education and training (98960, 98961, 98962, 99071, 99078), telephone services (99366-98968, 99441-99443), on-line medical evaluation (98969, 99444), preparation of special reports (99080), analysis of data (99091), transitional care management services (99495, 99496), medication therapy management services (99605, 99606, 99607) and, if performed, these services may not be reported separately during the month for which 99487, 99489, 99490 are reported. Do not report 99487, 99489, 99490, and 99491 if reporting ESRD services (90951-90970) during the same month. If the care management services are performed within the postoperative period of a reported surgery, the same individual may not report 99487, 99489, 99490, and 99491.

CCM and CCCM differ in the amount of clinical staff service time provided; the involvement and work of the billing professional providers; and the extent of care planning performed. The estimated work time for CCC services is 60 minutes, while the work time for CCM services is 20 minutes.

Transitional Care Management (TCM) services, 99495 and 99496, 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). These services address any needed coordination of care performed by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support by providing first contact and continuous access.

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 and/or licensed clinical staff under his/her direction. These services address any needed coordination of care performed by multiple disciplines and community service agencies. The reporting individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs and activity of daily living support by providing first contact and continuous access.

A physician or other qualified health care professional who reports codes 99495, 99496, may not report care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366, 99367, 99368), education and training (98960, 98961, 98962, 99071, 99078), telephone services (99366-98968, 99441-99443), end stage renal disease services (90951-90970), on-line medical evaluation (98969, 99444), preparation of special reports (99080), analysis of data (99091), complex chronic care coordination services (99487-99489), medication therapy management services (99605, 99606, 99607), during the time period covered by the transitional care management services codes.

POLICY

HMO, PPO, Elite/ProMedica Medicare Plan, Individual Marketplace

Chronic care management services (99490 and 99491) do not require prior authorization.

Complex chronic care management services (99487, 99489) do not require prior authorization.

Code G0506 does not require prior authorization.

Code G2058 does not require prior authorization

Transitional Care Management services (99495 and 99496) do not require prior authorization.

Advantage

Complex chronic care management services (99487, 99489) are considered incidental and not eligible for separate reimbursement.

Chronic care management services (99490 and 99491) and Transitional Care Management services (99495 and 99496) are non-covered.

Code G0506 and G2058 are non-covered.

COVERAGE CRITERIA

HMO, PPO, Individual Marketplace, Elite/ProMedica Medicare Plan

CARE MANAGEMENT:

Care Management activities performed by clinical staff includes the following:

- communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- collection of health outcomes data and registry documentation;
- patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family;
- management of care transitions not reported as part for transitional care management (99495, 99496);
- ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service;
- A copy of the plan of care must be given to the patient and/or caregiver

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

- Provide 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 or week;
- Provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- Provide timely access and management for follow-up after an emergency department visit or facility discharge;
- Utilize an electronic health record system so that care providers have timely access to clinical information'
- Use a standardized methodology to identify patients whom require care management services;
- Have an internal care management process/function whereby a patient identifies as meeting the requirements for these services starts receiving them in a timely manner;
- Use a form and format in the medical record that is standardized within the practice;
- Be able to engage and educate patients and caregivers as well as coordinate care among all serve professionals, as appropriate for each patient.

A Comprehensive Care Plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals

- Symptom management
- Planned interventions and identification of the individuals responsible for each intervention
- Medication management
- Community/social services ordered
- A description of how services of agencies and specialists outside the practice will be directed/coordinated
- Schedule for periodic review and, when applicable, revision of the care plan

Chronic care management services (99490) are covered when at least 20 minutes of clinical staff time directed by a physician or QHP, per calendar month is completed 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

Do not report 99490 in the same calendar month as 99487, 99489, and 99491.

Members must be informed that their personal health information will be shared.

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 be treated or managed in accordance with the CPT level of care.

Chronic care management services (99491) are covered when 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.

Do not report 99491 in the same calendar month as 99487, 99489, and 99490.

Do not report 99491 in conjunction with 99339, 99340.

Complex chronic care management services (99487)

Complex chronic care management (99487) requires the following 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 of 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 QHP, per calendar month

Complex chronic care management services of less than 60 minutes of duration in a calendar month are not reported separately.

Complex chronic care management services (99489)

Complex chronic care management (99489) is required for 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 the 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 chronic care management services during a calendar month.

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:
 - 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).
 - Only a single practitioner can furnish and be paid for CCM services in a calendar month.
 - 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.
- 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.

TRANSITIONAL CARE MANAGEMENT:

Transitional Care Management activities performed by clinical staff includes the following:

- communication and engagement with patient, family members, guardian or caretaker, surrogate Decision makers, and/or other professionals regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- collection of health outcomes data and registry documentation;
- patient and/or family/caregiver education to support self-management, independent living, and Activities of daily living;
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- 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 be include:

- obtaining and reviewing the discharge information (e.g., discharge summary, as available, or continuity of care documents(s));
- reviewing need for or follow-up on pending diagnostic tests and treatments'
- interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
- education of patient, family, guardian, and/or caregiver;
- establishment or reestablishment of referrals and arranging for needed community resources;
- Assistance in scheduling any required follow-up with community providers and services.

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.

Transitional care management services (99495)

Services, which healthcare personnel provide to patients with medical and/or psychosocial problems that require moderate or high complexity medical decision making following discharge from an inpatient hospital, visit for a period of 29 days.

Transitional care management (99495) requires the following elements

- Communication (direct contact, telephone, electronic) with the patient and/or caregivers within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

Transitional care management services (99496)

Services, which healthcare personnel provide to patients with medical and/or psychosocial problems that require moderate or high complexity medical decision making following discharge from an inpatient hospital, visit for a period of 29 days.

Transitional care management (99496) requires the following elements

- Communication (direct contact, telephone, electronic) with the patient and/or caregivers within 2 business days of discharge
- Medical decision making of at least high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

Do not report 99495, 99496 in conjunction with 93792, 93793.

Do not report 90951-90970, 98960-98962, 98966-98969, 99071, 99078, 99080, 99091, 99339, 99340, 99358, 99359, 99366-99368, 99374-99380, 99441-99444, 99487-99489, 99605-99607, when performed during the service time of codes 99495 or 99496.

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 within 30 days of discharge from an inpatient hospital, outpatient hospital, or skilled nursing facility stay.
- TCM should only be reported once during the TCM period.
- The same health care professional may discharge the beneficiary from the hospital, report hospital Alternatively, 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.
- Do not report TCM services when the professional provider reports a procedure with an assigned global period (eg, 10 days, 90 days); in this instance, TCM services are included in the post-operative payment for the procedure.
- Do not report TCM services when the patient is discharged from the hospital to a skilled nursing facility.
- Evaluation & Management (E&M) services performed on the day of discharge, as part of the discharge management services cannot be considered the TCM face-to-face visit.

CODING/BILLING INFORMATION

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
99487	Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately.)
99489	Complex chronic care coordination services; 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)
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. (Complex chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately.)
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.
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; medical decision-making of at least moderate complexity during the service period; face-to-face visit, within 14 calendar days of discharge.
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; medical decision making of high complexity during the service period; face-to-face visit, within 7 calendar days of discharge.
HCPCS CODE	
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
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). (Do not report G2058 for care management services of less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month.) (Use G2058 in conjunction with 99490.) (Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491.)

REVISION HISTORY EXPLANATION

ORIGINAL EFFECTIVE DATE: 01/01/2013

02/10/15: Policy title changed from Complex Care Coordination Services to Care Management Services. Removed deleted CPT code 99488 and added new CPT code 99490. Determined chronic care management services (99490) are covered and considered eligible for separate reimbursement for MedSelect and Medigap only. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.

03/08/16: Chronic care management services (99490) are now covered without prior authorization for Advantage. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.

03/14/17: Title changed from Care Management Services to Chronic Care Management (CCM) Services. Codes 99487 & 99489 are now eligible for separate reimbursement for HMO, PPO, Individual Marketplace, & Elite per CMS guidelines. Code 99490 is now covered for HMO, PPO, Individual Marketplace, & Elite per CMS guidelines. Added code G0506 as covered for HMO, PPO, Individual Marketplace, & Elite per CMS guidelines, & non-covered for Advantage. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.

11/13/18: Code 99490 is now non-covered for Advantage per ODM guidelines. Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee.

11/14/19: Title changed from Chronic Care Management (CCM) Services to Care Management & Transitional Care Management Services. Adding Transitional Care Management Services. Updating and revised documentation to reflect the 2019 criteria and guidelines. Policy reviewed and updated to reflect the current clinical evidence per the Medical Policy Steering Clinical Work Group, 111419.

09/22/20: Procedure G2058 is a new procedure code as of 1/1/2020, added to the medical policy. Procedure G2058 is listed as NC on the ODM fee schedule. Procedures 99487, 99489, 99490, 99491, 99495, 99496, G0506 remain NC or Bundled on the ODM fee schedule.

12/15/2020: Medical policy placed on the new Paramount Medical Policy Format

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
 American Medical Association, *Current Procedural Terminology (CPT®)* is copyright American Medical Association. All rights reserved. Professional ISBN:978-62202-752-12019 AMA CPT Professional, Evaluation and Management (E/M) Services Guidelines, pages 49-55.

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

Industry Standard Review

Hayes, Inc.