

# CASE MANAGER'S CODING GUIDE FOR CARE COORDINATION SERVICES

Care coordination is a key part of the National Quality Strategy to improve the effectiveness, safety, and efficiency of the healthcare system.<sup>1</sup> To that end, the Centers for Medicare & Medicaid Services (CMS) supports both transitional care and complex care coordination with specific CPT® codes.<sup>2</sup>

## The Transitional Care Management (TCM) services codes

Healthcare professionals (HCPs) who provide moderate- or high-complexity medical decision-making to patients transitioning to the community from an inpatient setting can be reimbursed under **CPT codes 99495** and **99496**. An HCP who accepts care of the patient postdischarge without a gap and takes responsibility for care may use these codes for billing.<sup>3</sup>

### Who is eligible for TCM services?

Patients who require TCM services during their transition to the community setting and who have medical and/or psychosocial problems that require moderate- or high-complexity medical decision-making.

### What is the timeframe for providing services?

Starting on the date the patient is discharged from a hospital, services may be provided for up to 30 days.

### What services must be provided?

The following 3 components *must* be provided within the 30 days after discharge:

- An interactive contact by telephone, email, or face-to-face within 2 business days\*
- A face-to-face visit
- Certain non-face-to-face services

### Who can provide services?

Physicians and nonphysician practitioners (NPPs) including:

- Certified nurse-midwives
- Clinical nurse specialists
- Nurse practitioners
- Physician assistants
- Licensed clinical staff under the direction of a physician or NPP may provide some face-to-face services, including communication, education, assessment of treatment adherence, identification of community resources, and assisting in accessing needed care and services

\*Medicare requires that attempts to communicate continue after the first 2 attempts, until the patient and/or caregiver is reached directly.<sup>3</sup>

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### Which code should be used?

#### CPT code 99495

TCM services with *moderate* medical decision complexity. A face-to-face visit must take place *within 14 days of discharge*.

#### CPT code 99496

TCM services with *high* medical decision complexity. A face-to-face visit must take place *within 7 days of discharge*.

## What documentation is required?

- At a minimum, the following information must be documented in the medical record:
  - discharge date
  - date of interactive contact
  - date of face-to-face visit
  - complexity of medical decision-making

## Other information

- The face-to-face visit is part of the TCM service and is not billed separately
- Only 1 HCP may report TCM services
- Services may only be reported once per beneficiary during the 30-day period
- When you report CPT codes 99495 and 99496, you may not also report care plan oversight services (HCPCS codes G0181 and G0182) and End-Stage Renal Disease services (CPT codes 90951 to 90970)

## The Chronic Care Management (CCM) Services Codes<sup>2</sup>

### HCPs who treat patients with chronic conditions can be reimbursed for complex care coordination services

- Covered services include: developing and maintaining a comprehensive care plan, facilitating access to care and services, assessing and supporting patient compliance with treatment plan and medication adherence, patient/caregiver education, identifying resources, communicating with home health agencies, communicating aspects of care with patients and caregivers, and collecting health outcomes data and registry documentation. Regulatory requirements for billing CCM services are different from the rules for Evaluation and Management (E/M) and other services.

### CPT CODES<sup>2</sup>

**Code 99487** – Covers first hour of clinical staff time directed by a physician or other qualified HCP with no face-to-face time

**Code 99489** – Covers each additional 30 minutes of complex chronic care coordination

**Code 99490** – Covers at least 20 minutes of clinical staff time to support a beneficiary with  $\geq 2$  chronic conditions through non-face-to-face care management services

**Codes 99487 or 99489** – Can be reported only once per month by the physician or HCP for the first 31 to 75 minutes of service

The above codes overlap existing evaluation and management (E/M) CPT codes. When using the above codes, do not use the codes for care plan oversight services (CPT codes 99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), anticoagulant management (99358, 99364), medical team conferences (99366-99368), education and training (98960-98962, 99071, 99078), telephone services (98966-98968, 99441-99443), end-stage renal disease services (90951-90970), online medical evaluation services (98969, 99444), preparation of special reports (99080), analysis of data (99090, 99091), medication therapy management services (99605-99607), or transitional care management services (99495, 99496).<sup>2</sup>

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**References:** **1.** US Department of Health and Human Services. National Strategy for Quality Improvement in Health Care. 2015 Annual Report to Congress. <http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2015annrpt.pdf>. Accessed November 17, 2017. **2.** Pershing Yoakley & Associates (PYA). Coding and documentation of transitional and chronic care management services. <http://www.pyapc.com/coding-documentation-transitional-chronic-care-management-services/>. Accessed November 17, 2017. **3.** Centers for Medicare & Medicaid Services. Medicare Learning Network. Transitional care management services. <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf>. Accessed November 17, 2017.