Payment Policy | Transitional Care, Chronic Care and Complex Chronic Care Management

EFFECTIVE DATE: 05|01|2019
POLICY LAST UPDATED: 03|19|2019

OVERVIEW

This policy addresses payment guidelines for Transitional, Chronic Care and Complex Chronic Care Management codes.

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Not applicable

POLICY STATEMENT

BlueCHiP for Medicare

Transitional Care management services (TCM) are covered and separately reimbursed when the following payment guidelines are met.

- The 30-day TCM period begins on the date the member is discharged from of the following settings to home and continues for the next 29 days.
    - Inpatient Acute Care Hospital
    - Inpatient Psychiatric Hospital
    - Long Term Care Hospital
    - Skilled Nursing Facility
    - Inpatient Rehabilitation Facility
    - Hospital outpatient observation or partial hospitalization
    - Partial hospitalization at a Community Mental Health Center
- Only one health care professional may report TCM services.
- Report services once per member during the TCM period.
- You must furnish one face-to-face visit within certain timeframes as described by the CPT Code that is filed This face-to-face visit is part of the TCM service, and you should not report it separately
- The same health care professional may discharge the member 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 you report discharge day management services.
- Report reasonable and necessary evaluation and management (E/M) services (other than the required face-to-face visit) to manage the members clinical issues separately.
- You may not bill TCM services and services that are within a post-operative global period (TCM services cannot 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 you report CPT codes 99495 and 99496 for payment, you may not also report these codes during the TCM service period:
    - Care Plan Oversight Services
    - Home health or hospice supervision: HCPCS codes G0181 and G0182
    - End-Stage Renal Disease services: CPT codes 90951–90970

Chronic Care Management, and Complex Chronic Care Management services are covered and not separately reimbursed for all providers

Commercial Products
Transitional Care management, Chronic Care Management, and Complex Chronic Care Management services are covered and not separately reimbursed for all providers

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement, or Benefit Booklet for applicable office visit coverage.

CODING

BlueCHiP for Medicare
The following codes are covered and separately reimbursed:

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.

The following codes are covered but not separately reimbursed:

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.

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 care professional, per calendar month.

99489 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 care professional, per calendar month **;** 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)

Commercial Products
The following codes are covered but not separately reimbursed:

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

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RELATED POLICIES

None

PUBLISHED

Provider Update , May 2019
Provider Update, June 2017
Provider Update, June 2016
Provider Update, August 2015

REFERENCES

1. Department of Health and Human Services Centers for Medicare & Medicaid Services Transitional Care Management Services:https://**www.cms.gov**/Outreach-and-Education/**Medicare**-Learning...
2. Frequently Asked Questions about Billing the Medicare Physician Fee Schedule for Transitional Care Management Services https://**www.cms.gov**/**Medicare**/**Medicare**-Fee-for-Service-Payment/

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This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.