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.

DESCRIPTION
Chronic care management (CCM) services include management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional (QHP), 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. The physician or other QHP provides or oversees the management and/or coordination of service, as needed, for all medical conditions, psychological needs, and activities of daily living.

The physician or QHP must document and share with the patient and/or caregiver a plan of care that addresses the physical, mental, cognitive, social, functional and environmental assessment. The electronic care plan must be comprehensive in nature and address all health problems of the patient. All care team members furnishing services must have access to the electronic care plan at all times. The care plan would typically include, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions
- Medication Management
- Community/social services ordered
- Direction and coordination with agencies and specialists unconnected to the practice
- Identification of the individual responsible for each intervention
- Requirements for periodic review
- Revision of the care plan when applicable

The face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals and agencies; and revising, documenting and implementing a care plan or teaching self-management is used in determining the care management clinical staff time for the month. Only the time of the clinical staff of the reporting professional is counted; and when two or more clinical staff members are meeting about the patient only the time of one clinical staff member may be counted.

POLICY

<table>
<thead>
<tr>
<th>HMO, PPO, Individual Marketplace, &amp; Elite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complex chronic care management services (99487, 99489) do not require prior authorization.</td>
</tr>
<tr>
<td>Chronic care management services (99490) do not require prior authorization.</td>
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<tr>
<td>Code G0506 does not require prior authorization.</td>
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<tr>
<th>Advantage</th>
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<tr>
<td>Complex chronic care management services (99487, 99489) are considered incidental and not eligible for separate reimbursement.</td>
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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 (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).

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

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.

**HMO, PPO, Individual Marketplace, Elite**

Practitioners who furnish a CCM initiating visit and personally perform extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code may also bill HCPCS code G0506 (Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services [billed separately from monthly care management services] [Add-on code, list separately in addition to primary service]). G0506 is reportable once per CCM billing practitioner, in conjunction with CCM initiation.

**Advantage**

Code G0506 is non-covered.

**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**

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>99487</td>
<td>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.)</td>
</tr>
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<td>99489</td>
<td>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)</td>
</tr>
<tr>
<td>99490</td>
<td>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.)</td>
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**HCPCS CODE**

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<td>G0506</td>
<td>Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)</td>
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**REVISION HISTORY EXPLANATION**

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.

REFERENCES/RESOURCES
Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
Ohio Department of Medicaid http://jfs.ohio.gov/
American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
Industry Standard Review
Hayes, Inc.