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

EFFECTIVE DATE: 01|01|2025
POLICY LAST REVIEWED: 10|2|2024

OVERVIEW

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

MEDICAL CRITERIA

Not applicable

PRIOR AUTHORIZATION

Not applicable

POLICY STATEMENT

Commercial Products and Medicare Advantage Plans

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

COVERAGE

Transitional Care Management, Chronic Care Management, Complex Chronic Care Management and Principal Care Management services are covered under the office visit category when provided by network providers. These services are not covered if provided by non-network providers.

For Commercial and Medicare Advantage plans, except health savings account (HSA) -qualified high deductible health plans (HDHPs), member cost share will not apply to these services. However, for members in HSA-qualified HDHPs, the deductible must first be met; once the deductible is met, coverage without cost share will apply to these services.

Transitional, Chronic Care, Complex Care and Principal Care Management services (as outlined in this Policy) are limited to the following provider types:

Primary Care Physician (PCP)
Nurse Practitioner Primary Care (NP-PCP)
Physician Assistant Primary Care (PA-PCP)

Transitional, Chronic Care, Complex Care and Principal Care Management services (as outlined in this Policy) are limited to the following Place of Service (POS):

11 - Office

50 - FQHC

2 - Telehealth Other than Patient's Home

10 - Telehealth Patients Home

12 - Home

As care management functions are delegated, it is the expectation that care management be conducted directly by the physicians and clinical staff within the practice. Subcontracting or outsourcing of care management functions by a practice to an independent entity is subject to the review and approval of BCBSRI. The subcontractor's program must meet the requirements and standards for care management outlined within the Advanced Primary Care Policy and the applicable guidelines for care management billing. The practice shall be solely responsible for the oversight of the subcontracted entity.

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

Commercial Products and Medicare Advantage Plans

The following code(s) are covered and separately reimbursed:

Transitional Care Management (TCM)

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.

Principal Care Management (PCM)

99424 Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; *first* 30 minutes provided *personally* by a physician or other qualified health care professional time in care-management activities during a calendar month**.

+99425 Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; *each additional* 30 minutes provided *personally* by a physician or other qualified health care professional time for at least another 30 minutes spent on care management during the month** (list separately in addition to code for primary procedure)

99426 Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; *first* 30 minutes of *clinical staff* time directed* by physician or other qualified health care professional time in care-management activities during a calendar month**

+99427 Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; *each additional* 30 minutes of *clinical staff* time directed* by a physician or other qualified health care professional**l(list separately in addition to code for primary procedure)

***For Principal Care Management services, a maximum allowance for CPT Codes 99424 and 99425 cannot exceed combined total of 60 minutes per month. CPT Codes 99426 and 99427 cannot exceed a combined total of 60 minutes per month.*

***** *A **clinical staff member** is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Clinical staff are employees (leased or contracted) who do not individually report their service. Clinical staff includes medical assistants, licensed practical nurses, registered nurses, and others.*

Chronic Care Management (CCM)

99490 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; *first* 20 minutes of *clinical staff* time directed by a physician or other qualified health care professional, once per calendar month.**

+99439 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, comprehensive care plan established, implemented, revised, or monitored; 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)

***For Chronic Care Management services, a maximum allowance for CPT Codes 99490 and 99439 cannot exceed combined total of 60 minutes per month.*

+G0506 Comprehensive assessment of and care planning by the physician or other qualified health practitioner for patients requiring Chronic Care Management (CCM) services, per calendar year, per practitioner**;** *personally* performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

Commercial Products and Medicare Advantage Plans

The following code(s) are covered but ***not separately reimbursed***:

+99437 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)

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; each *additional* 30 minutes of *clinical staff* time directed by a physician or other qualified health care professional, once per calendar month (List separately in addition to code for primary procedure)

99491 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; *first* 30 minutes provided *personally* by a physician or other qualified health care professional, once per calendar month

RELATED POLICIES

Non-Reimbursable Health Service Codes Policy

PUBLISHED

Provider Update, December 2024
Provider Update, December 2023
Provider Update, January 2020
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-Servicment/
3. MLN909188 – Chronic Care Management Services (cms.gov)
4. Chronic Care Management Frequently Asked Questions (cms.gov)

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