Complex Care Coordination Services

Code	Description
99487	Complex chronic care coordination services; first hour of clinic staff time directed **by a physician or other qualified health care professional** with no face-to-face visit, per calendar year
99488	First hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month
99489	+99489 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 the code for primary procedure.)

Complex chronic care coordination services are management and support services that are provided by physicians, other qualified health care professionals, and clinical staff to individuals who reside at home or in a domiciliary, rest home, or assisted living facility. These services typically require coordination of care by multiple disciplines and community service agencies.

- One or more chronic continuous or episodic health conditions expected to last at least 12 months, or until the death of the patient
- Conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Problems that require medical decision-making of moderate or high complexity and require extensive clinical staff support.

  The reporting physician or other qualified health care professional must
  - Develop and/or update the plan of care
  - Document the plan of care and share it with the patient and/or caregiver
  - Manage and/or coordinate the services required for the patient's medical conditions, psychosocial needs, and activities of daily living
  - Direct the care plan as provided by clinical staff

  Reportable clinical staff time includes:
  - Face-to-face and non-face-to-face time spent communicating with the patient and/or family, caregivers, other professionals, and agencies
  - Revising, documenting, and implementing the care plan
  - Collecting health outcomes data and registry documentation

- Teaching patient and/or family/caregiver patient self-management
- Facilitating access to care and other services needed by the patient and/or family
- Assessment and support for adherence to the care plan

Complex Care Coordination

- 99487 – 2.41 / $82.03*
- 99488 – 5.40 / $183.82*
- 99489 – 1.21 / $42.00*

* 2012 Medicare Conversion Factor of 34.034 is used – actual payment may vary for 2013 and/or by payer fee schedule

Transitional Care Management Services

Code	Description
99495	• Transitional Care Management Services with the required elements: 1. Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge 2. Medical decision making of at least moderate complexity during the service period 3. Face-to-face visit, within 14 calendar days of discharge
99496	• Transitional Care Management Services with the following required elements: 1. Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge 2. Medical decision making of high complexity during the service period 3. Face-to-face visit, within 7 calendar days of discharge

Transitional care management includes services provided to an established patient whose medical and/or psychosocial problems require moderate- or high-complexity medical decision-making during the transition from an inpatient hospital setting, observation care setting, or skilled nursing facility/nursing facility to the patient's home, domiciliary, rest home, or assisted living facility.

- The **reporting physician or other qualified health care professional** oversees the management and/or coordination of services.
- Only one physician or other qualified health care professional may report these services and only once per patient with 30 days of discharge.
- The TCM services begin on the date of discharge and continue for the next 29 days.
- Includes one face-to-face visit in addition to non-face-to-face services performed by the physician or other qualified health care professional and/or licensed clinical staff under the direction of the physician or other qualified health care professional.
- Non-face-to-face services provided by the physician or other qualified health care provider may include obtaining and reviewing the discharge information; reviewing, ordering, or following up on pending diagnostic tests and treatment; communication/interaction with other qualified health care professionals, family, or caregiver education; and arranging referrals and community resources as necessary.
- Clinical staff time (under the direction of the physician or other qualified health care professional) may include:
    - Face-to-face and non-face-to –face time spent communicating with the patient and/or family, caregivers, other professional, and agencies
    - Revising, documenting, and implementing the care plan
    - Collecting health outcomes data and registry documentation
    - Teaching patient and/or family/caregiver patient self –management
    - Facilitating access to care and other services needed by the patient and/or family

Transitional Care

- 99495 – 4.82 / $164.07*
- 99496 – 6.79 / $231.13*

* 2012 Medicare Conversion Factor of 34.034 is used – actual payment may vary for 2013 and/or by payer fee schedule

Care Plan Oversight Services

Code	**Description**
Not under home health supervision	
99339	**Individual physician supervision** of a patient (patient not present) in home, domiciliary, or rest home requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication for purposes of assessment or care decisions with healthcare professional(s), family member(s), surrogate decision maker(s), and/ or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99340	**≥30 minutes**
Under home health supervision	
99374	**Physician supervision** of a patient under care of home health agency(patient not present) in home, domiciliary, or rest home requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication for purposes of assessment or care decisions with healthcare professional(s), family member(s), surrogate decision maker(s), and/ or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99375	**≥30 minutes**

These codes may be billed only once per month and are not cumulative. For example, a 99340 should not be billed in the same month as a 99339, and a 99375 should not be billed in the same month as a 99374. Do not report 99339, 99340 or 99374, 99375 during the same month with 99487-99489. Do not report 99339, 99340 or 99374, 99375 when performed during the service time of codes 99495 or 99496.

Care plan oversight reimbursement:

Code	RVU	Reimbursement*
99339	2.07	70.45
99349	2.91	99.03
99374	1.87	63.64
99375	2.92	99.38

* 2012 Medicare Conversion Factor of 34.034 is used – actual payment may vary for 2013 and/or by payer fee schedule

Careplan oversight in nursing facility or hospice

Code	Description
99377	**Physician supervision** of a hospice patient (patient not present) requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication for purposes of assessment or care decisions with healthcare professional(s), family member(s), surrogate decision maker(s), and/ or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99378	≥30 minutes
99379	**Physician supervision** of a nursing facility patient (patient not present) patient requiring complex and multi-disciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication for purposes of assessment or care decisions with healthcare professional(s), family member(s), surrogate decision maker(s), and/ or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99380	≥30 minutes

These codes may be billed only once per month and are not cumulative. For example, a 99377 should not be billed in the same month as a 99378, and a 99379 should not be billed in the same month as a 99380. Do not report 99377-99380 during the same month with 99487-99489. Do not report 99377-99380 when performed during the service time of codes 99495 or 99496.

Code	RVU	Reimbursement*
99377	2.03	69.08
99378	3.04	103.46
99379	2.03	69.08
99380	3.04	103.46

* 2012 Medicare Conversion Factor of 34.034 is used – actual payment may vary for 2013 and/or by payer fee schedule