## New! Care Management Services Policy

Our new care management services policy is effective January 1, 2022. The policy addresses our coverage of coordination of care including:

- Transitional care management
- Chronic care management
- Advanced care planning
- Care planning for cognitive impairment
- Integrated behavioral health

The full policy is attached. It can be found when you log in at **hap.org** and select *Benefit Admin Manual* under *More*.

# Care Management Services

## DESCRIPTION

**FUTURE EFFECTIVE - 01/01/2022**

As part of an overall population health management (PHM) program, Care Management (CM) services are management and support services generally provided by clinical staff, under the direction of a physician or other qualified health care professional or may be provided personally by a physician or other qualified health care professional to a Member residing at home basic care living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the Member or caregiver about the Member's clinical condition(s), care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living as part of an overall medical and comprehensive care management plan.

Integration of appropriate care management into the medical home is associated with reduced use of unnecessary medical resources, improved clinical outcomes, reduced hospital readmissions, and ER use.2 Specific Care Management service codes were created by the Center for Medicare & Medicaid Services (CMS) to incentivize better coordination of care, including transitional care management, chronic care management, advanced care planning, care planning for cognitive impairment, and integrated behavioral health complement the ongoing implementation of alternative payment models.

These activities are intended to better identify a Member's conditions, improve Member care outcomes, enhance Member experiences and reduce the need for low-value medical services by helping Members and caregivers more effectively manage health conditions. This policy addresses HAP's coverage of these services.

Please Note: *The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.*

## RELEVANT CODES

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| 90951-90970 | ESRD Management, with and without face-to-face visits, by age, per month |
| 98961 | Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients |
| 98962 | Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients |
| 98966 | Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion |
| 98967 | Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion |
| 98968 | Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion |
| 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, per 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, per calendar 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, per 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 |

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| | 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, per calendar month (List separately in addition to code for primary procedure) |
| 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) |
| 99439 | Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, 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 |
| 99446 - 99449 | Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional, VARIED TIMES |
| 99451 | Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time |
| 99452 | Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes |
| 99457 | Remote Physiologic Monitoring Treatment Management Services (RPM)<br>99457, CL1 ALL Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes |
| 99458 | Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure) |
| 99483 | Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver. |
| 99484 | Care management services for behavioral health conditions, 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: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team. |
| 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, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 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, comprehensive care plan established, implemented, revised, or monitored, 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, per calendar month (List separately in addition to code for primary procedure) |
| 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 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, per calendar month. |
| 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 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) |
| 99492 | Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and |

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| | provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies. |
| 99493 | Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment. |
| 99494 | Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure) |
| 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 |
| 99497 | Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate |
| 99498 | Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure) |
| G0181 | Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans |
| G0182 | Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more |
| G2064 | Comprehensive care management services for a single high risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development 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 |
| G2065 | Comprehensive care management for a single high risk disease services, e.g., principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development 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<br>CPT / HCPCS Coverage today Prolonged Office/Outpatient E/M Visit |
| G2212 | Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes) |
| G2214 | Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional |
| G9001 | Coordinated care fee, initial rate |
| G9002 | Coordinated care fee |
| G9007 | Coordinated care fee, scheduled team conference |
| G9008 | Coordinated care fee, physician coordinated care oversight services |
| S0257 | Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service) |

## COVERAGE CRITERIA

**Transitional Care Management (TCM)**: Services which healthcare personnel provide to Members following discharge from an inpatient hospital visit for a period of 29 days.

- Transitional Care Management (TCM) Services [99495, 99496] are used for a Member whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the

Member's community setting (home, domiciliary, rest home, or assisted living ). TCM commences upon the date of discharge and continues for the next 29 days.

- TCM is comprised of one face-to-face visit within the specified time frames, in combination with non-face-to- face services The health care professional accepts care of the member post-discharge from the facility setting without a gap. The health care professional takes responsibility for the member's care.
    1. Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional may include:
        a. Communication (with Member, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
        b. Communication with agencies and other community services utilized by the Member;
        c. Member and/or family/caretaker education to support self-management, independent living, and activities of daily living;
        d. Assessment and support for treatment regimen adherence and medication management;
        e. Identification of available community and health resources;
        f. Facilitating access to care and services needed by the Member and/or family.
    2. Non-face-to-face services provided by the physician or other qualified health care provider may include:
        a. Obtaining and reviewing the discharge information (e.g., discharge summary or continuity of care documents);
        b. Reviewing need for or follow-up on pending diagnostic tests and treatments;
        c. Interaction with other qualified health care professionals who will assume or reassume care of the Member s system-specific problems;
        d. Education of Member, family, guardian, and/or caregiver;
        e. Establishment or reestablishment of referrals and arranging for needed community resources;
        f. Assistance in scheduling any required follow-up with community providers and services.

**Advance Care Planning (ACP)**: A process to help Members with decision-making capacity guide future health care decisions in the event that they become unable to participate directly in their care.

- Codes 99497 and 99498 are used to report the face-to-face service between a PCP physician or other qualified health care professional and a Member, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. An advance directive is a document appointing an agent and/or recording the wishes of a Member pertaining to his/her medical treatment at a future time should he/she lack decisional capacity at that time. Examples of written advance directives include, but are not limited to, Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, and Physician Orders for Scope of Treatment (MI-POST).

**General Behavioral Health Integration Care Management (BHI)**: The care a Member experiences as a result of a team of primary care and behavioral health clinicians, working together with Members and families, using a systematic and cost-effective approach to provide Member-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

- BHI services [99494] are intended to be billed by the Member s PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.
- Member has ONE of the following:
    1. Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the Member and which place the Member at significant risk of death, acute exacerbation/decompensation, or functional decline. The service elements must meet ALL of the following requirements:
        a. Structured recording of Member health information using Certified EHR Technology and includes demographics, problems, medications, and medication allergies that inform the care plan, care coordination, and ongoing clinical care.
        b. 24/7 access to physicians or other qualified health care professionals or clinical staff including providing Member /caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week, and continuity of care with a designated member of the care team with whom the Member is able to schedule successive routine appointments.
        c. Comprehensive care management including systematic assessment of the Member's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of Member self-management of medications.
        d. Comprehensive care plan including the creation, revision, and/or monitoring of an electronic care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed.
        e. Care plan information made available electronically (including fax) in a timely manner as appropriate and a copy of the plan of care given to the Member and/or caregiver.
        f. Management of care includes the management of transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities; timely creation and exchange/transmit continuity of care document(s) with other practitioners and providers.
        g. Coordination with home- and community-based clinical service providers, and documentation of communication to and from home- and community-based providers regarding the Member's psychosocial needs and functional deficits in the Member 's medical record.
        h. Enhanced opportunities for the Member and any caregiver to communicate with the practitioner regarding the Member's care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.
    2. A behavioral health or psychiatric condition currently treated by the practitioner, including substance use disorders, that, in the clinical judgment of the practitioner, warrants BHI services. The service elements must meet all of the following requirements:
        a. Initial assessment or follow-up monitoring, including the use of applicable validated rating scales.
        b. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for Members who are not progressing or whose status changes. Facilitating and coordinating treatment (such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation).
        c. Continuity of care with a designated member of the care team.

**Psychiatric Collaborative Care Management (PCCM)** [99492, 99493, 99494, G2214]: Behavioral health services delivered via a specific evidence-based model. Care is managed by a behavioral health care manager (BHCM), under direction of a treating physician or qualified health care professional (QHP) in consultation with a medical professional trained in psychiatry or behavioral health and qualified to prescribe the full range of medications.

- PCCM services are intended to be billed by the Member's PCP and not by the other providers consulting as part of the care team

**Chronic Care Management (CCM)**: Services encompassing the oversight and education activities by health care professionals to help Members with chronic diseases and health conditions, such as but not limited to, fibromyalgia, diabetes, sleep apnea, multiple sclerosis, lupus, and high blood pressure, to better understand their condition and successful management of it.

- Chronic Care Management (CCM) services [99487, 99489, 99490, 99491, 99437, 99439] are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional to a Member residing at home or in a domiciliary, rest home, or assisted living facility . Services many include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the Member or caregiver about the Member's condition, care plan, and prognosis.
- Care management for chronic conditions includes systematic assessment of the Member‘s medical, functional, and psychosocial needs; assessment and activation of system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions, and oversight of the Member's self-management of medications.
    1. CCM activities performed by clinical staff includes the following activities (list may not be all-inclusive):
        a. Communication and engagement with Member, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care,
        b. Communication with home health agencies and other community services utilized by the Member,
        c. Collection of health outcomes data and registry documentation,
        d. Member and/or family/caregiver education to support self-management, independent living, and activities of daily living,
        e. Assessment and support for treatment regimen adherence and medication management;
        f. Identification of available community and health resources,
        g. Facilitating access to care and services needed by the Member and/or family,
        h. Ongoing review of Member status, including review of laboratory and other studies not reported as part of an E/M service,
        i. Development, communication, and maintenance of a comprehensive care plan,
        j. Creation, revision, and/or monitoring (as per code descriptors) of an electronic person-centered care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues with particular focus on the chronic conditions being managed,
        k. A copy of the plan of care must be given to the Member and/or caregiver.

**Principle Care Management (PCM)**: Services supporting one serious chronic condition by a specialist or primary care physician for one complex chronic condition lasting at least three months, which is the focus of the care plan; the condition is of sufficient severity to place the Member at risk of hospitalization or to have been the cause of a recent hospitalization.

- Comprehensive care management services for a single high risk disease [99424, 99425, 99426, 99427], (such as: principal care management) for at least 30 minutes time per calendar month. Member must have at least one complex chronic condition lasting at least 3 months, which is the focus of the care plan, meeting ANY of the following:
    a. The condition is of sufficient severity to place the Member at risk of hospitalization or have been the cause of a recent hospitalization,
    b. The condition requires development or revision of disease specific care plan,
    c. The condition requires frequent adjustments in the medication regimen,
    d. The management of the condition is unusually complex due to comorbidities

**Care Coordination**: The deliberate organization of Member care activities between two or more participants (including the Member) involved in a Member's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required Member care activities and is often managed by the exchange of information among participants responsible for different aspects of care. Care coordination codes are legacy care management codes within Michigan and are appropriate for licensed staff engaging in care management. Many of these codes are MDHHS State-preferred codes, meaning that they are tracked by MDHHS for the Medicaid program.

- Care coordination codes [G9001, G9002, G9007, G9008, S0257, 98961, 98962, 98966, 98967, 98968] are classified as legacy care management codes within Michigan. Many of these codes are MDHHS State-preferred codes, meaning that they are tracked by MDHHS for the Medicaid program. Some of these codes overlap with newer Care coordination codes, please refer to the Provider Billing Manual to determine which codes may be billed concurrently.

**Primary Care/Medical Home:** Health care provided by a physician or an individual licensed to provide health care, with whom the Member has initial contact and by whom the Member may be referred to a specialist and includes internal medicine, family practice, general practice, pediatrics, CRNP PCP, geriatric medicine, multi-specialty (where the performing provider specialty is internal medicine, family practice, general practice, CRNP PCP, PA PCP, pediatrics, or geriatric medicine), and physician subspecialists responsible for caring for Members with chronic conditions.

**Comprehensive Care**: The practice of continuing comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a Member over a period of time in relationship to family, life events and environment.

**Care Plan Oversight (CPO)**: Physician supervision of any Member's under home health or hospice is called Care Plan Oversight [G0181, G0182].

- These Member's receive complex healthcare that requires a physician to be involved on an ongoing basis. CPO is only covered for Members who are in a hospice or home care setting.
- CPO is only covered for HAP/AHL Members who are receiving hospice or Home health care services.

**SDoH Z-CODES:**
Social determinants of health (SDoH) are conditions and influences in the environments where people are born, grow, live, work and age. These social factors can impose significant barriers to a Member's health and wellness and ultimately influence their health outcomes. SDoH may affect a Member's ability to adhere to a recommended clinical treatment plan. Understanding these influences allows for a more holistic review a Member's health. Z codes

represent reasons for encounters and identify non-medical factors that may influence a Member's health outcomes.

**For ALL services**:

1. Conditions that may warrant care management include, but are not limited to the following:
    a. Alzheimer's or related dementia
    b. Asthma/COPD/Chronic Respiratory Conditions
    c. Cancer
    d. Chronic Kidney Disease
    e. Depression/Anxiety
    f. Diabetes
    g. Heart Failure/Ischemic Heart Disease
    h. Hypertension
    i. Osteoarthritis/Inflammatory Arthritis
    j. Osteoporosis
2. Documentation must be available in the Member's medical record and include the minimum information:
    a. Member must provide consent for the services and that consent must be documented in the medical record in addition to an acknowledgement that services may be subject to additional cost share responsibilities.
    b. Transitional Care Management (TCM) services:
        i. Date the Member was discharged.
        ii. Date of the interactive contact with the Member and/or caregiver.
        iii. Date of the face-to-face visit, and
        iv. Details of the medical decision-making actions and the level of complexity (moderate or high).
    c. Advance Care Planning (ACP) services:
        i. Total time in minutes spent on discussion along with beginning and ending times.
        ii. Member /surrogate/family "given opportunity to decline;"
        iii. Details of discussion (such as: Who was involved? What was discussed? Understanding of illness, spiritual factors. Why are they making the decisions they are making? Was any advance directive offered/filled out? Follow-up).
    d. General BHI Care Management services:
        i. Member has been seen in the past year by a HAP contracted or Affilited provider.
        ii. Discussion that the Member has the right to stop care coordination services at any time (effective at the end of the calendar month).
        iii. Permission to consult with relevant specialist.
        iv. NOTE: BHI services are intended to be billed by the Member's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.
    e. Psychiatric Collaborative Care Management (PCCM) services:
        i. NOTE: PCCM services are intended to be billed by the Member's PCP and not by other providers consulting as part of the care team. All applicable practice expenses associated with the delivery of services are considered part of the single reimbursement to the PCP.

3. Coverage of services is based on the Member's subscriber documents. Please refer to those resources for information regarding eligibility for coverage, network or provider requirements. If the Member has coverage for the services discussed in this policy, then the medical criteria applies.
    a. Care Management Services are covered for the following HAP/AHL Members:
        i. Large group, Small group (QHP) and Individual (QHP) HAP HMO, POS, AHL EPO.EPA and PPO Members.
        ii. Medicare Advantage Plan Members
        iii. HAP Empowered Medicaid products
        iv. HAP Empowered MI Health Link (MMP)
4. Authorizations for Care Management Services are not needed. CM services may be subject to Medical Director review.
5. Medicaid Providers should refer to:
    a. The Michigan Medicaid Provider Manual for coverage criteria, located at: **http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf**
    b. The Michigan Medicaid Fee Schedule located at: **http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html**

## EXCLUSIONS

1. Care Plan Oversight (CPO) is not covered for Members who are in a skilled nursing facility (SNF) or other nursing facilities. NOTE: A basic-care facility where a Member receives custodial care is considered the Member's home.

**REFERENCES:**


1. Medicare Learning Network. Chronic Care Management Services. Center for Medicare & Medicaid Services. ICN MLN909188 July 2019. **https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/chroniccaremanagement.pdf**
2. JAMA Intern Med. 2018;178(9):1165-1171.
3. 2021 ICD-10-CM, Centers for Medicare Medicaid Service (CMS) **https://www.cms.gov/medicare/icd-10/2021-icd-10-cm**
4. ICD-10 Coding, Social Determinants of Health, American Hospital Association. **https://www.aha.org/system/files/2018-04/value-initiative-icd-10-code-social-determinants-of-health.pdf**
5. Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2017, CMS Office of Minority Health, January 2020. **https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf**


**RESOURCES:**

1. CMS Care Management: **https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management**
2. American College of Physicians Chronic Care Management Toolkit: **https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf**

3. American Academy of Family Practice – Key Functions of Medical Home – Care Management: **https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/medical-home/care-management.html**
4. American Academy of Pediatrics – Practice Management – Coding Fact sheets: **https://www.aap.org/en/practice-management/practice-financing/coding-and-valuation/coding-fact-sheets/**

MEDICAID REFERENCE:

Michigan Medicaid Provider Manual. **http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf**

1. BENEFICIARY ELIGIBILITY
    a. 2.1 BENEFIT PLANS
        i. Health Home - MI Care Team, Managed Care Organization
        Behavioral Health and Intellectual and Developmental Disability Supports and Services
    b. SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM
        i. 4.3 ESSENTIAL ELEMENTS - Team-Based Service Delivery
    c. SECTION 19 – OPIOID HEALTH HOME
        i. 19.1 GENERAL INFORMATION
        ii. 19.4 COVERED SERVICES
        iii. 19.6 PROVIDER ENROLLMENT AND OHH DESIGNATION
    d. SECTION 20 – BEHAVIORAL HEALTH HOME
        i. 20.1 GENERAL INFORMATION
        ii. 20.4. COVERED SERVICES
        iii. 20.6 PROVIDER ENROLLMENT AND BHH DESIGNATION
2. Federally Qualified Health Centers and Tribal Health Centers
    a. SECTION 7 – MI CARE TEAM (PRIMARY CARE HEALTH HOME BENEFIT)
        i. 7.1 GENERAL INFORMATION
        ii. 7.4 COVERED SERVICES
3. MI Health Link
    a. 5.4 HOSPICE
4. Pharmacy
    a. SECTION 21 - MEDICATION THERAPY MANAGEMENT
        i. 21.2 COVERED SERVICES
5. Practitioner
    a. 14.3.D. COLLABORATIVE CARE TEAM CRITERIA
    b. 14.3.H. REIMBURSEMENT

This Benefit policy discusses the medical criteria for covered services. Coverage of services for Members is based on the Member's subscriber documents and are subject to all terms and conditions including specific exclusions and limitations. This type of document includes the following: Subscriber contract and associated riders; Member Benefit Guide; or an Evidence of Coverage document (for Medicare Advantage Members).
**HAP HMO/POS and AHL EPO/PPO Members**:
If there is a discrepancy between this policy and coverage described in the subscriber documents, the Member's subscriber documents will apply.
**ASO Members**:
Coverage as discussed in this policy may not apply to employer groups that are self-funded (referred to as an ASO group [Administrative Services Only]). Each ASO group determines the coverage available to their members which is found in the ASO Benefit Guide and associated riders. If a member has coverage for the type of service covered by this policy, then the medical criteria as discussed in this policy applies to those services.
**Medicare Advantage Plan Members:**
Coverage is based on Medicare (CMS) regulations and guidelines which include the NCDs (National Coverage Decision) and LCDs (Local Coverage Decision) for our area. When no coverage determination has been made by CMS, then this policy will apply.
**Medicaid Plan Members:**
For Medicaid/Healthy Michigan Plan members coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: **http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html**. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: **http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html**, the Michigan Medicaid Provider Manual will apply.

## EFFECTIVE DATE

01/01/2022

## REVISED DATE

12/17/2021

## REVIEWED DATE

12/01/2021