State of New Mexico
Medical Assistance Program Manual

Supplement

HUMAN SERVICES DEPARTMENT

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TO: Physicians, Certified Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives, Physician Assistants, Psychiatrists, Certified Nurse Specialists (Psychiatric Certification)

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THROUGH: Kari Armijo, Deputy Director, Medical Assistance Division KLA

SUBJECT: Chronic Care Management Services and Transitional Care Management Services

Chronic Care Management (CCM) and Transitional Care Management (TCM) are critical components of primary care that contribute to better health and care for individuals. Chronic care management and transitional care management services for patients with multiple chronic conditions are covered by New Mexico Medicaid retroactive to July 1, 2019.

Physicians (MD and DO), Psychiatrists, Certified Nurse Midwives, Clinical Nurse Specialists (Medical and Psychiatric), Nurse Practitioners, and Physician Assistants may bill for CCM and TCM services as primary care physicians. In certain circumstances, specialty practitioners may also provide and bill for these services. Services that are not provided directly by the billing practitioner must be provided by clinical staff under the direction and supervision of the billing practitioner on an "incident to" basis (as an integral part of services provided by the billing practitioner), subject to applicable State law, licensure, and scope of practice. The billing practitioner must order services, maintain contact with auxiliary personnel and retain professional responsibility for all services. The clinical staff are either employees of or working under contract for the billing practitioner to whom Medicaid directly pays for CCM and TCM services. Time spent directly by the billing practitioner or clinical staff counts toward the threshold clinical staff time required to be spent during a given month in order to bill for these services. Non-clinical staff time cannot be counted toward the threshold.

Chronic Care Management (CCM)

Patients with multiple (two or more) chronic conditions expected to last at least twelve (12) months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline are eligible for CCM services. The billing practitioner must obtain patient consent before furnishing or billing CCM. Consent may be verbal or written but must be

documented in the medical record informing them about the availability of CCM services, explaining that only one practitioner can furnish and be paid for CCM services during a calendar month, and notifying them of the right to stop CCM services at any time (effective at the end of the calendar month). Informed patient consent need only be obtained once prior to furnishing CCM, or if the patient chooses to change the practitioner who will furnish and bill CCM.

Chronic care management services include structured recording of patient health information, maintaining a comprehensive electronic care plan, managing transitions of care and other care management services, and coordinating and sharing patient health information timely within and outside of the practice. Characteristics of this advanced primary care include continuous relationship with a designated member of the care team; patient support for chronic diseases to achieve health goals; 24/7 patient access to care and health information; receipt of preventive care; patient and caregiver engagement; and timely sharing and use of health information.

Important components include:

- Systematic assessment of the patient'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;
- Oversight of patient self-management of medications;
- Coordinating care with home and community based clinical service providers;
- Managing transitions between and among health care providers and settings, including referrals to other clinicians, and follow-up after an emergency department visit or facility discharge; and
- Timely creation and exchange/transmission of continuity of care document(s) with other practitioners and providers.

Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial Fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious diseases such as HIV/AIDS

Only one practitioner may be paid for CCM services during a given calendar month. This practitioner must report either complex or non-complex CCM for a given patient for the month (not both). The following codes must be used to bill for CCM:

Non-Complex CCM

99490 – Chronic care management services, to include at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following requirements:

- 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, and monitored.

G0506 – Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring CCM services (reportable once per CCM billing practitioner, in conjunction with 99490, with CCM initiation), with the following requirements:

- Face-to-face visit with the billing practitioner for new patients or patients not seen within one year prior to the commencement of CCM;
- Practitioner personally performs extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code.

Complex CCM services

99487 – CCM services, requiring moderate or high complexity of medical decision-making, with at least 60 minutes of clinical staff time, 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;
- At least 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

99489, use with 99487 only – 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)

G0506 – Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring CCM services (reportable once per CCM billing practitioner, in conjunction with 99487, with CCM initiation) with the following requirements:

- Face-to-face visit with the billing practitioners for new patients or patients not seen within one year prior to the commencement of CCM;
- Practitioner personally performs extensive assessment and CCM care planning outside of the usual effort described by the initiating visit code.

Billing Practitioner Concurrent Billing Limitations

CCM cannot be billed during the same service period as HCPCS codes G0181/G0182 (home health care supervision/hospice care supervision), or CPT codes 90951-90970 (certain End-Stage Renal Disease services). CCM should not be reported for services furnished during the 30-day transitional care management services period (CPT 99495, 99496). Complex CCM and prolonged Evaluation and Management (E/M) services (99354 – 99357, 99358 – 99359, 99415 – 99416, 99360) cannot be reported the same calendar month. CCM and TCM service periods cannot overlap.

Transitional Care Management

TCM services are furnished to patients who have medical and/or psychosocial problems that require moderate or high complexity medical decision-making following the patient's discharge from an inpatient acute care hospital, inpatient psychiatric hospital, long-term care hospital, skilled nursing facility, inpatient

rehabilitation facility, hospital outpatient observation, partial hospitalization, or partial hospitalization at a community mental health center. Following discharges from one of these settings, the patient must be returned to his or her community setting, such as home, domiciliary, a rest home, or assisted living. The billing practitioner takes responsibility for the patient's care and accepts care of the patient post-discharge from the facility setting without a gap.

The thirty (30) day TCM period begins on the date the beneficiary is discharged from the inpatient setting and continues for the next 29 days. During the thirty (30) days, the following components must be furnished in order to bill for TCM:

1. Within two (2) business days following the patient's discharge to the community setting, an interactive contact must be made with the patient and/or caregiver, as appropriate. The contact may be via telephone, e-mail or face-to-face by the billing practitioner or clinical staff, addressing patient status and needs beyond scheduling follow-up care.
2. The following non-face-to-face services must be furnished to the patient unless it is determined that they are not medically indicated or needed. Clinical staff under the billing practitioner may provide certain non-face-to-face services.
    - Physicians, Nurse Practitioners and Nurse Specialists must:
        - Obtain and review discharge information (for example, discharge summary or continuity of care documents);
        - Review the need for or follow-up on pending diagnostic tests and treatments;
        - Interact with other health care professionals who will assume or reassume care of the patient's system-specific problems;
        - Provide education to the patient, family, guardian, and/or caregiver;
        - Establish or re-establish referrals and arrange for needed community resources;
        - Assist in scheduling required follow-up with community providers and services.
    - Clinical staff, under the direction and supervision of the billing Physician, Nurse Practitioners and Nurse Specialists, must:
        - Communicate with agencies and community services the patient uses;
        - Provide education to the patient, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living;
        - Assess and support treatment regimen adherence and medication management (medication reconciliation and management must be furnished no later than the date the primary practitioner furnished the face-to-face visit);
        - Identify available community and health resources;
        - Assist the patient and/or family in accessing needed care and services.
3. Face-to-face visits with high medical decision complexity must be performed within seven (7) days of discharge; face-to-face visits with moderate medical decision complexity must be performed within fourteen (14) days of discharge.

Only one practitioner may report TCM services once per patient during the TCM period. The billing practitioner may discharge the patient from the inpatient setting, 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 the discharge day management services are reported.

The following codes must be used for Transitional Care Management:

99495 – TCM services with the patient or caregiver within two business of discharge, when such communication involves medical decision making of at least moderate complexity and a face-to-face visit within 14 days of discharge;

99496 – TCM services with the patient or caregiver within two business day of discharge, when such communication involves medical decision making of high complexity and a face-to-face visit within seven days of discharge.

Determining the complexity of medical decision making is determined by considering these factors:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed;
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedures(s), and/or the possible management options.

Type of Decision Making	# of Possible Diagnoses &/or Management Options	Amount &/or Complexity of Data to be Reviewed	Risk of Significant Complications, Morbidity &/or Mortality
Straight forward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Note: *To qualify for a given type of medical decision making, two of the three elements must either be met or exceeded.*

Attempts to communicate with the patient or caregiver should continue after the first two attempts in the required two business days until they are successful. If two or more separate attempts are made in a timely manner and documented in the medical record but are unsuccessful, and if all other TCM criteria are met, the service may be billed; **however**, attempts to communicate must continue until successful. TCM cannot be billed if the face-to-face visit is not furnished within the required timeframe as defined in the CPT codes above.

Billing Practitioner Concurrent Billing Limitations

Report reasonable and necessary evaluation and management (E/M) services (other than the required face-to-face visit) to manage the patient's clinical issues separately. TCM services cannot be paid if any of the 30-day TCM period falls within a global post-op period for a procedure code billing by the same billing practitioner. TCM cannot be billed during the same service period as HCPCS codes G0181/G0182 (home health care supervision/hospice care supervision), or CPT codes 90951-90970 (certain End-Stage Renal Disease services), care plan oversight services, prolonged E/M services without direct patient contact (CPT codes 99358, 99359), other services excluded by CPT reporting rules. CCM and TCM service periods cannot overlap.

Questions regarding this Supplement should be directed to 505-827-6252.