Payment Policy

Chronic Care Management for Non-Face to Face Care Coordination

Purpose

The purpose of this payment policy is to define how Health New England (HNE) reimburses Chronic Care Management codes for Non-Face to Face Care (e.g. medication reconciliation, coordination among providers, arrangements for social services, remote patient monitoring) Coordination.

Applicable Plans

- ☐ Commercial Self Funded
- ☐ Commercial Fully Funded
- ☒ Medicare Advantage
- ☐ Be Healthy

NOTE: This payment policy applies to HNE's Medicare Advantage Line of Business Only

Definitions

For purposes of this policy, Chronic Care Management (CCM) refers to services provided to HNE Members diagnosed with 2+ chronic conditions expected to persist at least 12 months (or until death) that place individuals at significant risk of death, acute exacerbation/decompensation or functional decline.

Requirements

Before furnishing any CCM services, the provider must obtain the member's written consent and retain that document in the member's medical record. The member must acknowledge that the provider has explained:
(a) the nature of CCM,
(b) how the service is accessed,
(c) that the member's health information will be shared among providers electronically for purposes of care coordination, and
(d) that the member will be responsible for any copayment or deductible.

A comprehensive care plan is required and needs to be maintained and shared with the patient and the provider must manage care transitions.
CMS recommends the provider furnish an annual wellness visit (HCPCS G0438, G0439) or an initial preventative physical exam (G0402) to the member; there is no prerequisite service to bill for CCM.

HNE has adopted CMS guidelines for the scope of services required to bill for Chronic Care management Non-Face to Face services.

Billing/Reimbursement

Providers should bill with CPT code 99490 and must meet all of the requirements for this code as outlined in the Current Procedural Terminology (CPT®[1]), guidelines and consistent with CMS guidelines.

Both a PCP and a Specialist can NOT bill for this code on the same member.

Providers practicing within the scope of their license who may bill this code include: Physicians (regardless of specialty), advanced practice registered nurses, physician assistants, clinical nurse specialists, and certified nurse midwives (or the provider to which such individual has reassigned his/her billing rights). Other non-physician practitioners and limited-license practitioners are not eligible.

CMM services may be billed once every 30 days, provided that at least 20 minutes of non-face-to-face care management services are furnished during that time period. Only one provider can bill CCM services for a specific member. Time spent by Provider office staff that are not clinical cannot count their time towards the 20 minute requirement. This code should not be billed during the same calendar month as transitional care management.

If a face-to-face visit is provided during the 30-day period by the practitioner who is furnishing CCS services, the practitioner should report the appropriate E/M code in addition to the CCM codes(s). This rule also applies to the annual wellness visit.

Services are subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible), as applicable.

PCPs being reimbursed for HNE's Medicare Advantage lines of business, under primary care capitation or a care management capitation payment will not be separately reimbursed for this CCM service.

HNE reserves the right to audit claims billed for this service.

Medicare Advantage
HNE will follow Medicare reimbursement guidelines.

Commercial
HNE will not reimburse for CCM services.

Be Healthy
HNE will not reimburse for CCM services.

Authorization Requirements

None

[1] CPT® is a registered trademark of the American Medical Association.

Attachments

None

Important Note About This Reimbursement Policy

Providers are responsible for submission of accurate claims. All EDI claims must be submitted in accordance with HIPAA 5010 Standards and Paper claims must be submitted on either CMS1500 or CMS1450 (UB04) claim forms. HNE's reimbursement policy includes the use of Current Procedural Terminology (CPT®[2]), guidelines from the Centers for Medicare and Medicaid Services (CMS), and other coding guidelines. Providers will be reimbursed based on the codes(s) that correctly describe the health care services provided.

HNE may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to HNE enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, the type of provider agreement and the terms of that agreement, the HNE Provider Manual, and/or the enrollee's benefit coverage documents.

HNE reserves the right to audit any provider and/or facility to ensure compliance with the guidelines stated in this payment policy in accordance with our provider review policy.

Resources

American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

HNE Provider Manual

History

[2] CPT® is a registered trademark of the American Medical Association.