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Internal Medicine Coding Alert

CPT® 2013: Learn To Use New Care Coordination Codes

Your chance to report services across multiple specialties for a single patient.

CPT® 2013 introduces three new E/M codes that may help internists and other qualified health care professionals get paid for long-term patient care coordination. Read on for all you need to know about reporting care for patients with ongoing chronic conditions, straight from experts at the American Medical Association's CPT® and RBRVS 2013 Annual Symposium in Chicago.

Analyze the Codes Themselves

The AMA approved two base codes and one add-on for the new group:

99487 -- Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

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 -- ... 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).

"The key here is to remember you only report 99487 or 99488 once per calendar month," say experts. "And pay attention to the fact that one base code includes a face-to-face visit and the other doesn't. You also need at least all 60 minutes of 99487 or 99488 before you consider reporting the add-on code."

Verify Appropriate Situations for Reporting

CPT® coding guidelines state that codes 99487-99489 are "patient-centered management and support services" that "typically involve clinical staff implementing a care plan directed by the physician or other qualified health care professional."

The codes (dubbed the CCCC codes or the 4C codes for "complex chronic care coordination") represent the work of the physician and his or her clinical staff in coordinating a patient's care across multiple disciplines.

"The patient typically has one or more chronic conditions," Ellington explains. "The physician or other qualified health care professional oversees the coordination and management of the services needed for all of the patient's medical conditions. Parts of the plan can range from medication oversight to psychosocial needs to activities of daily living."

"Some patients may have weaknesses in their social support, which increases their health risk and the need for coordination," Ellington adds. "The more co-morbidities a patient has, the more it complicates his care. The work associated with these codes helps cover those gaps."

Get Answers to Top Questions

Ellington touched on several issues during his presentation that will help physicians and coders know what to expect from the CCCC codes. Highlights included:

How do these codes work with services provided by other clinical staff? As stated in the descriptors, you report codes 99487-99489 based on the time spent by clinical staff under the direction of the physician or other qualified health

care professional who oversaw the coordination of the patient's care during that calendar month. Services provided by clinical staff drive the times associated with the codes.

What happens if the patient is admitted to a hospital and our physician sees her there? If a face-to-face visit is provided during the month by the physician or other qualified health care professional, regardless of site of service, then you will report 99488, assuming all other conditions for reporting the code are met.

How do we handle CCCC with other office visits during the month? If the patient comes to your office for E/M services beyond the first visit included in 99488, you may report those encounters separately as appropriate (such as 99213, Office or other outpatient visit for the evaluation and management of an established patient ...). The time spent during that visit does not affect the total time for CCCC that month.

What will we be paid? "CMS considers these codes as bundled services and incident to the care being provided," Ellington says. "Report them, but they're not separately payable." Other insurers might recognize and pay for the codes, so discuss this during contract negotiations.

Will criteria be developed to designate moderate and high complexity for these cases? If not, what should providers use? "For now, it's the same as with E/M visits, but expanding through 30 days," Ellington says. "The patient may not need high complexity care during the first visit, but might over time. We didn't want to tie the hands of physicians with specific levels of care."

Can we report these codes with any other services? Although the CCCC codes can work in conjunction with some other services (such as an office visit), CPT® guidelines note several services you can't report with 99487-99499. For example, you shouldn't report CCCC during the same calendar month as 90951-90970 for end stage renal disease or care plan oversight services, 99374-99378. Check CPT® for the complete list of services that are not separately reportable when reporting 99487-99489.

Bottom line: "Follow the thread of the patient's care over 30 days," Ellington advises. "You may have a patient visit, you may not. But be sure you have documentation of everything your practice does, so you can report the care at the end of the month."