

Clinician-Directed Care Coordination Services to Change for the CSHCN Services Program

Effective for dates of service on or after January 1, 2009, benefits for clinician-directed care coordination services will change for the Children with Special Health Care Needs (CSHCN) Services Program.

Clinician-directed care coordination services are a benefit only when provided through a primary care clinician, specialist, or subspecialist who attests that he or she is providing the medical home for the client.

The medical home is a partnership between the client, the client's family, and the primary care clinician. In providing a medical home for the client, the primary care clinician directs care coordination with the client and the client's family.

When requesting authorization for non-face-to-face clinician-directed care coordination, providers must use the revised [CSHCN Services Program Authorization Request for Non-Face-to-Face Clinician-Directed Care Coordination Services](#) form.

Specialist or Subspecialist Telephone Consultations

Telephone consultations (procedure code 3-99499 with modifier U9) are initiated when the specialist or subspecialist receives a telephone call from the clinician providing the medical home. During the telephone call, the specialist or subspecialist assesses and manages the client's condition by providing advice or a referral to a more appropriate provider. Telephone consultations are limited to two every six months by the same provider.

Telephone consultations may be reimbursed to physicians in the office (place of service [POS] 1), home (POS 2), inpatient (POS 3), outpatient (POS 5), and other (POS 9) settings and must be billed with modifier U9 or the claim will be denied.

Telephone consultations are payable to a specialist or subspecialist when the clinician providing the medical home contacts the specialist or subspecialist for advice or a referral and the consultation is at least 15 minutes in duration.

The clinician providing the medical home must maintain the following documentation in the client's medical record:

- Start and stop times showing that the consultation was at least 15 minutes long
- The reason for the call
- The specialist's or subspecialist's medical opinion
- The recommended treatment and/or laboratory services
- The name of the specialist or subspecialist

The specialist or subspecialist must maintain documentation of the telephone consultation using the [Specialist/Subspecialist Telephone Consultation Form for Non-Face-to-Face Clinician Directed Care Coordination Services](#) or similar clinical record documentation. These records are subject to retrospective review. The supporting documentation must include, but is not limited to, the following:

- The client's name, date of birth, and CSHCN Services Program identification number
- Start and stop times indicating the consultation lasted at least 15 minutes

- The reason for the call
- The specialist's or subspecialist's medical opinion
- The recommended treatment and/or laboratory services
- The name and phone number of the clinician providing the medical home
- Provider information for the specialist or subspecialist and the clinician providing the medical home

Care Plan Oversight

Care plan oversight (procedure codes 1-99339, 1-99340, 1-99374, 1-99375, 1-99377, and 1-99378) requires authorization and is limited to a maximum of one service per month. Authorizations are approved for a six-month period.

Medical Team

Medical team conferences (procedure code 1-99367) are limited to one service per six months by any provider.

Prolonged Services

Prolonged services (procedure code 1-99358 and 1-99359) are limited to one service per lifetime by the same provider. Additional prolonged non-face-to-face services may be authorized if the provider submits supporting documentation for authorization.

Procedure code 1-99358 must be used to report the first hour of prolonged services and must be billed with the appropriate physician evaluation and management (E/M) procedure code listed in the table below. Prolonged services of less than 30 minutes are considered part of the physician's E/M service being provided.

Procedure Codes				
1-99201	1-99202	1-99203	1-99204	1-99205
1-99211	1-99212	1-99213	1-99214	1-99215
1-99221	1-99222	1-99223	1-99231	1-99232
1-99233	3-99241	3-99242	3-99243	3-99244
3-99245	3-99251	3-99252	3-99253	3-99254
3-99255	1-99304	1-99305	1-99306	1-99307
1-99308	1-99309	1-99310	1-99318	1-99324
1-99325	1-99326	1-99327	1-99328	1-99334
1-99335	1-99336	1-99337	1-99341	1-99342
1-99343	1-99344	1-99345	1-99347	1-99348
1-99349	1-99350			

Procedure code 1-99359 is used to report an additional 15 to 30 minutes of prolonged non-face-to-face services beyond the first hour. Prolonged services of less than 15 minutes beyond the first hour are considered part of the first hour.