ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

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# Care Coordination Procedure Codes and Descriptions

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| **G9004** | **Comprehensive Care Management** | Comprehensive Care Management consists of the following activities:<br>• Complete a comprehensive health assessment/reassessment inclusive of medical/behavioral/rehabilitative and long term care and social service needs.<br>• Complete/revise an individualized patient-centered plan of care with the member to identify member's needs/goals and include family members and other social supports as appropriate.<br>• Consult with multidisciplinary team on client care plan/needs/goals.<br>• Consult with primary care physician and/or any specialists involved in the treatment plan.<br>• Conduct client outreach and engagement activities to assess on-going emerging needs and to promote continuity of care and improve health outcomes.<br>• Prepare client crisis intervention plan. |
| **G9005** | **Care Coordination and Health Promotion** | Care Coordination and Health Promotion consists of the following activities:<br>• Coordinate with service providers and health plans as appropriate to secure necessary care, share crisis intervention (provider) and emergency info.<br>• Link/refer client to needed services to support care services to support care plan/treatment goals, including medical/behavioral health care; patient education and self- help/recovery and self-management.<br>• Conduct case reviews with interdisciplinary team to monitor/evaluate client status/service needs.<br>• Advocate for services and assist with scheduling of needed services.<br>• Coordinate with treating clinicians to assure that services are provided and to assure changes in treatment or medical conditions are addressed.<br>• Monitor/support/accompany the client to scheduled medical appointments.<br>• Crisis intervention, revise care plan/goals required. |
| **G9007** | **Transitional Care** | Transitional Care consists of the following activities:<br>• Follow up with hospitals/ER upon notification of a client's admission and/or discharge to/from an ER, hospital/residential/rehabilitative setting.<br>• Facilitate discharge planning from an ER, hospital/residential/rehabilitative setting to a safe transition/discharge where care needs are in place.<br>• Notify/consult with treating clinicians, schedule follow up appointments and assist with medication reconciliation.<br>• Link client with community supports to assure that needed services are provided.<br>• Follow up post discharge with client/family to assist client care plan needs/goals. |

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| **G9010** | **Patient and Family Support** | Patient and Family Support consists of the following activities:<br>• Develop/review/revise the individual's plan of care with the client/family to ensure that the plan reflects individual's preferences, education and support for self- management.<br>• Consult with client/family/caretaker on advanced directives and educate on client rights and health care issues, as needed.<br>• Meet with client and family, inviting any other providers to facilitate needed interpretation services.<br>• Refer client/family to peer supports, support groups, social services, entitlement programs as needed.<br>• Collaborate/coordinate with community based providers to support effective utilization of services based on client/family need. |
| **G9011** | **Referral to Social Services** | Referral to Social Services consists of the following activities<br>• Identify resources and link client with community supports as needed.<br>• Collaborate/coordinate with community base providers to support utilization of services based on client/family need. |

**Modifier U6 – Face-to-face visit. Modifier U6 must accompany any care coordination procedure code that is billed during the face-to-face visit. Telehealth services provided in accordance with 89 Illinois Administrative Code Section 140.403 may qualify as a face-to-face visit.**