



Physician Services Version

KEY CONCEPTS OUTLINE

Module 7: Evaluation and Management Services

I. In General

A. CPT-Based Billing

1. Evaluation and management (E/M) services furnished to Medicare beneficiaries are usually (but not always) billed using the CPT E/M codes.
 - a. However, Medicare does not necessarily always follow the CPT E/M guidelines.
 - (i) **Caution** – individuals involved in billing for physician/practitioner services must be careful not to assume that a particular CPT E/M coding guideline applies to Medicare claims.

B. Evaluation and Management Level Selection

1. Effective January 1, 2023, CMS agreed to an alignment with the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel changes for E/M visits.
 - a. Exception: Prolonged service codes
 - b. The CY 2023 changes mirror changes that CMS adopted in CY 2021 for the office/outpatient E/M visit coding.
 - (i) The 2021 CMS adopted changes include:
 - (a) Deletion of CPT code 99201;
 - (b) Revisions to the E/M code descriptors;
 - (c) New time descriptors, where relevant; and

- (d) Revision of CPT E/M guidelines for levels of medical decision making.

2. Evaluation and Management Services

- a. Level selection is based on either medical decision-making or the total time of the visit.
- b. Office/Outpatient Visits
 - (i) Key components have been removed from the code descriptors.
 - (a) Times found in the code descriptors have been revised to a time-range rather than a typical time.
 - (1) Example:
 - a. CPT code 99213 has an associated time range of 20-29 minutes as opposed to the associated typical time in 2020 of 15 minutes.
- c. For additional E/M visits revised in CY 2023
 - (i) Key components have been removed from the code descriptors.
 - (1) Example:
 - a. For CY 2023, CPT code 99307 the code description states:
 - i. Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
 - b. Revised from the 2021 CPT code description that stated:
 - i. Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision

making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.

d. Hospital Inpatient and Observation Care Services

(i) For CY 2023, hospital inpatient and observation visits were merged into a single code set. <2023 AMA CPT Manual>

(a) CPT codes 99221-99233 are reported for inpatient or observation care services.

(1) CPT codes

(ii) Times associated with CPT codes 99221-99233 have been revised.

(1) For CY 2023 the code description for CPT 99221 is as follows:

a. CPT 99221 - **Initial hospital inpatient or observation care**, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low-level medical decision making. When using total time on the date of the encounter for code selection, **40 minutes must be met or exceeded.**

b. Compared to the CY 2022 code description for CPT 99221:

i. **Initial hospital care**, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. **Typically, 30**

minutes are spent at the bedside and on the patient's hospital floor or unit.

- e. Domiciliary, rest home, custodial care and home visits were also merged into a code set.
- f. Prolonged Evaluation and Management Services <See *Medicare Claims Processing Manual*, Chapter 12, §30.6.15.3>
 - (i) In CY 2023, The AMA finalized the newly created prolonged service CPT code for inpatient and observation evaluation and management services.
 - (a) CPT 99418 - Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)
 - (ii) Not in agreement with the AMA, CMS created alternate Medicare specific prolonged service codes based on service location.
 - (a) Prolonged Hospital Inpatient or Observation Services
 - (1) Reported with HCPCS G0316 - Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact.
 - a. HCPCS G0316 can be listed separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services
 - b. It should not be reported on the same date of service as other prolonged services for evaluation and management, specifically, CPT codes 99358, 99359, 99418, 99415, 99416).
 - c. G0316 should not be reported for any time unit less than 15 minutes.

(b) Prolonged Nursing Facility Services

- (1) Reported with HCPCS G0317, Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact
 - a. HCPCS G0317 can be listed separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services.
 - b. HCPCS G0317 should not be reported on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418.
 - c. G0317 should not be reported for any time unit less than 15 minutes.

(c) Prolonged Home or Residence Services

- (1) HCPCS G0318, Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact.
 - a. HCPCS G0318 can be listed separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services.
 - b. HCPCS G0318 cannot be reported on the same date of service as other prolonged services for evaluation and management, (CPT codes 99358, 99359, 99417).
 - c. Do not report G0318 for any time unit less than 15 minutes.

(d) Prolonged Office or Outpatient Visits

- (1) Effective January 1, 2021, CMS created a Medicare-specific code to be used as an alternative code to the CPT prolonged service codes 99358, 99359, and 99417. <MLN Matters MM12071>

(2) G2212 -Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact.

- a. HCPCS G2212 can be list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services
- b. HCPCS G2212 should not be reported on the same date of service as CPT codes 99354, 99355, 99358, 99359, 99415, 99416.
- c. Do not report G2212 for any time unit less than 15 minutes.

(e) Prolonged Cognitive Assessment Services

(1) Should be reported with HCPCS G2212. CMS guidance indicates that CPT codes are not to be reported for these services. <See *MLN Matters MM 12982*>

g. Visit Complexity Code – HCPCS G2211 <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.7(F)>

(i) Code Descriptor

(a) G2211 - Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.

(1) G2211 is an add-on code, which should be listed separately in addition to office/outpatient evaluation and management visit, for both new and established patients.

(2) The code should only be reported with CPT codes 99202 and 99215.

(3) Payment

- a. CMS will allow payment on the E/M visit complexity add-on code when:

- i. The base E/M code is reported on the same day by the same practitioner as an annual wellness visit, vaccine administration, or any Medicare Part B preventative service performed
- ii. CMS removed the previous prohibition of payment for G2211 on any claim with the -25 modifier

b. National Payment Rate for CY 2025 - \$15.53

C. Hospital inpatient/observation E/M add-on code for infectious diseases

1. HCPCS Code G0545

- a. Inpatient or observation care associated with a confirmed or suspected infectious disease by an infectious disease consultant, Including disease transmission risk assessment and mitigation, public health investigation, analysis, and testing, and complex antimicrobial therapy counseling and treatment
- b. Created to capture the intensity and complexity inherent to hospital inpatient or observation care associated with a confirmed or suspected infectious disease performed by a physician with specialized training in infectious diseases
- c. HCPCS G0545 is an add-on code and is reported separately in addition to hospital inpatient or observation evaluation and management visit, initial, same-day discharge, or subsequent
- d. National Payment Rate for CY 2025 - \$43.02

D. Post-Operative Follow-Up Visit

1. HCPCS Code G0559

- a. Post-operative follow-up visit complexity inherent to evaluation and management services addressing surgical procedure(s), provided by a physician or qualified health care professional who is not the practitioner who performed the procedure (or in the same group practice) and is of the same or of a different specialty than the practitioner who performed the procedure, within the 90-day global period of the procedure(s), once per 90-day global period, when there has not been a formal transfer of care and requires the following required elements, when possible and applicable: reading available surgical note to understand the relative success of the procedure, the anatomy that was affected, and potential

complications that could have arisen due to the unique circumstances of the patient's operation. research the procedure to determine expected post-operative course and potential complications (in the case of doing a post-op for a procedure outside the specialty). evaluate and physically examine the patient to determine whether the post-operative course is progressing appropriately. communicate with the practitioner who performed the procedure if any questions or concerns arise. (list separately in addition to office/outpatient evaluation and management visit, new or established

- b. Add-on Code created to capture post-operative care services
- c. Post-operative follow-up, visit complexity inherent to the evaluation and management services associated with surgical procedures **when provided by a different physician/practitioner than the performing surgeon**
- d. Coding and Billing Guidance
 - (i) Only to be billed with an E/M service for a new or established patient
 - (ii) During the 90-day global surgical package, G0559 should only be reported once
 - (iii) Cannot be billed by a physician/surgeon of the same group practice or the same specialty.

E. Concurrent Care

1. Definition

- a. Concurrent care is care furnished by multiple physicians in an "attending" (rather than a merely "consultative") role during the same period of time. < See *Medicare Benefit Policy Manual*, Chapter 15 § 30(D)>

2. Coverage Requirements < *Medicare Benefit Policy Manual*, Chapter 15 § 30(D)>

- a. The patient's condition must require the services of more than one physician in an "attending" role (e.g., the patient has more than one medical condition requiring diverse specialized care), and

- b. The individual services by each physician must be reasonable and necessary.

3. Same Specialty Limitation

CMS has indicated that, while Medicare could potentially cover concurrent care by multiple physicians in the same specialty or subspecialty, the need for concurrent care by physicians in the same specialty or subspecialty should be "infrequent." <Medicare Benefit Policy Manual, Chapter 15 § 30(D)>

II. Multiple E/M Encounters on the Same Day

A. The One Visit Per Day Rule

- 1. In general, a physician may not bill for more than one E/M visit on the same day. <Medicare Claims Processing Manual, Chapter 12 § 30.6.5>

- a. The Unrelated Visit Exception

- (i) Multiple visits involving the same patient are separately billable if the visits were for "unrelated problems" which could not be addressed during the same encounter. <Medicare Claims Processing Manual, Chapter 12 §§ 30.6.5, 30.6.7(B)>

- (a) Although not clear, it appears that CMS takes the position that it is not sufficient for the visits to be significant and separately identifiable, rather, the visits must be unrelated. <See Medicare Claims Processing Manual, Chapter 12 § 30.6.7(B)>

B. Physicians in the Same Group Practice

1. General Rule

- a. In general, physicians in the same group practice are treated as a single physician for E/M billing purposes. <See Medicare Claims Processing Manual, Chapter 12 § 30.6.5>
- (i) Presumably, this means that when two or more physicians in the same group practice see the same patient on the same day, only one E/M visit should be billed. <Medicare Claims Processing Manual, Chapter 12 § 30.6.5>
 - (a) The E/M level billed should reflect the combined services furnished during all visits on the same date. <Medicare Claims Processing Manual, Chapter 12 § 30.6.5>

2. Exceptions

a. The Different Specialty Exception

- (i) If two or more physicians from the same group practice see the same patient on the same day, each visit may be billed separately if the physicians are in different specialties. < *Medicare Claims Processing Manual*, Chapter 12 § 30.6.5>

- (a) Although not entirely clear, presumably, visits on the same day with physicians from the same group practice but in different specialties are separately billable even if the visits were for the same problem.

b. Unrelated Visits

- (i) As with a single physician, multiple visits involving the same patient are separately billable if the visits were for "unrelated problems." < *Medicare Claims Processing Manual*, Chapter 12 § 30.6.5>

III. Evaluation and Management Services Furnished in Conjunction with an Injection

A. Significant, Separately Identifiable E/M Services are Separately Billable

- 1. If significant, separately identifiable E/M services are furnished on the same day as a drug administration service, both the drug administration service and the E/M service may be billed (with modifier -25 appended to the E/M code). < *Medicare Claims Processing Manual*, Chapter 12 § 30.6.7(D)>

a. Limitation

- (i) The E/M service may not be billed unless the service "meets a higher complexity level than CPT code 99211." < *Medicare Claims Processing Manual*, Chapter 12 § 30.6.7(D)>

IV. Inpatient Hospital Care

A. In General

1. "Per Day" Billing

- a. All inpatient or E/M encounters on the same day for the same patient must be billed using a single CPT code, regardless of whether or not the encounters were for related problems. < *Medicare Claims Processing Manual*, Chapter 12 § 30.6.9(B)>

- (i) The E/M level should be based on all services furnished on the same day. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9(B)>

2. Multiple Physicians

a. Covering Physicians

- (i) If two physicians both see the same patient on the same day and one physician is covering for the other physician, only the “primary physician” may bill for the inpatient E/M services furnished on that day. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9(C)>

b. Visits for Different Aspects of the Patient’s Care

- (i) If two physicians both furnish inpatient hospital E/M services on the same day, each physician may bill for his or services separately if:
 - (a) The physicians are in different specialties, and
 - (b) Each physician addresses a different diagnosis. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9(C)>

B. Initial Hospital Care or Observation Care Services

1. Principal Physician of Record

- a. Only one physician may be considered the principal physician of record, i.e., the admitting physician. The principal physician of record is the one who oversees the patient’s care from the other physicians/practitioners who may be providing specialty care. <Medicare Claims Processing Manual, Chapter 12 §30.6.9.1(G)>
- b. Reporting Initial Hospital or Observation Care Visits by the Principal Physician of Record
 - (i) The principal physician of record should report the AI modifier on the initial hospital care code to distinguish that s/he is the admitting physician. Reporting the AI modifier indicates Principal Physician of Record. <Medicare Claims Processing Manual, Chapter 12 §30.6.9.1(G)>

2. Initial Hospital Care Visits by Non-admitting Practitioners

- a. All non-admitting physicians and qualified non physician practitioners (where permitted) may report their initial evaluation of a hospital inpatient using the initial hospital or observation care codes (99221-99223) as long as the documentation demonstrates the work required by the code description is satisfied. Non-admitting practitioners should not report the AI modifier, because they are not considered the principal physician of record. <Medicare Claims Processing Manual, Chapter 12 §30.6.9.1(F) and (G)>

3. Hospital Admission from Another Site of Service

a. Services Furnished on the Day of Admission

- (i) All services furnished by the admitting physician on the date of an inpatient admission are considered to be part of the initial hospital care if the services are furnished "in conjunction with the inpatient admission." <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(A)>

- (a) This means that the admitting physician may not bill separately for any E/M services furnished in any other site of service (e.g., emergency department, physician office, or nursing facility) on the date of an inpatient admission in conjunction with the inpatient admission. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(A)>

- (1) The E/M level billed for the initial hospital care should be based solely on the E/M services furnished on the day of the admission and should not take into consideration E/M services furnished prior to the date of admission. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(F)>

- a. For example, if a physician took a comprehensive history in the office on one day and then admitted the patient to the hospital the next day, if the physician only performed a detailed history on the day of admission (because a comprehensive history had been performed the preceding day), the hospital admission would be billed as level one initial hospital care (CPT code 99221).

b. Services Furnished Prior to the Day of Admission

- (i) If a patient is seen in the office the day before an inpatient admission, the services furnished in the office are separately billable even if there

is less than 24 hours between the office visit and the inpatient admission. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(B)>

4. Multiple Physicians Participating in an Inpatient Admission

- a. Where two physicians participate in the same admission, both physicians may report the initial hospital or observation care codes. Only the “admitting physician” may report the AI modifier to distinguish that s/he is the principal physician of record. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(G)>
- (i) **Caution** – presumably, the other physician may not bill separately if he or she is in the same group practice and specialty as the admitting physician. <Medicare Claims Processing Manual, Chapter 12 § 30.6.5>

5. Admission and Discharge on the Same Day

- a. Where a Medicare patient is admitted to inpatient care and discharged on the same date, the following guidelines apply:
 - (i) Contractors pay only the initial hospital care code if the length of stay is less than 8 hours. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1 (C)>
 - (ii) If the length of stay is at least 8 hours but less than 24 hours, then the practitioner may report CPT codes 99234-99236 (Observation or Inpatient Care Services Including Admission and Discharge Services). <Medicare Claims Processing Manual, Chapter 12 § 30.6.8. (C)>

C. Hospital Discharge Services

1. Hospital Visits on the Date of Hospital Discharge

- a. When subsequent hospital care (i.e., an inpatient hospital visit) is furnished by the discharging physician on the day of discharge prior to the time of discharge, only the hospital discharge services should be billed – the subsequent hospital care is not separately billable. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.2(C)>

2. Nursing Facility Admission on the Date of Hospital Discharge

- a. If the patient is discharged from the hospital and admitted to a nursing facility on the same date by the same physician, both the hospital

discharge and the nursing facility admission are billable. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.2(D)>

V. Observation Services

A. Initial Observation Care Services

1. Billing Limitations Applicable to Initial Observation Care

- a. A physician may not bill for initial observation care unless the physician both:
 - (i) Ordered observation services for the patient; and
 - (ii) Was responsible for the patient during the observation stay.
<Medicare Claims Processing Manual, Chapter 12 § 30.6.8(A)>
- b. Any other physician who furnishes E/M services to a patient while the patient is in observation must bill for his or her services using a new or established outpatient visit code as appropriate. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(A)>
- c. The physician billing for initial observation care (i.e., the physician who “placed” the patient in observation) may not bill for any other E/M services furnished on the same date observation care was initiated.
<Medicare Claims Processing Manual, Chapter 12 § 30.6.8(A)>

2. Documentation Issues

- a. Documentation Requirements
 - (i) A physician may not bill for observation unless the medical record contains the following documentation:
 - (a) Dated and timed physician’s orders regarding the care the patient is to receive while in observation;
 - (b) Nursing notes;
 - (c) Progress notes prepared by the physician while the patient was in observation; and
 - (d) The length of time the patient was in observation. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(A) and (C)>

b. Limitations on the Use of Emergency Department and Clinic Documentation

- (i) Observation services must be separately documented (as described above). Documentation prepared as a result of an emergency department or clinic encounter is not sufficient to support billing for initial observation care. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(A)>

B. Patients Discharged from Observation on the Same Date as the Initial Observation

1. Where a Medicare observation patient is placed in observation and discharged on the same date, the following guidelines apply:
 - a. Contractors are instructed to pay only the initial observation if the length of stay is less than 8 hours. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8 (B)>
 - b. If the length of stay is at least 8 hours but less than 24 hours, then the practitioner may report CPT codes 99234-99236 (Observation or Inpatient Care Services Including Admission and Discharge Services). <Medicare Claims Processing Manual, Chapter 12 § 30.6.8 (B)>
2. When a patient is discharged from observation on a different date from the initial observation date, the physician providing the observation discharge services should bill separately for the observation discharge services (CPT codes 99238 and 99239). <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(B)>

C. Subsequent Observation Care

1. Payment for subsequent observation care services is limited to the treating physician. Other practitioners seeing the patient in observation should use the appropriate outpatient visit code. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(B)>

D. Patient Admitted as an Inpatient from Observation

1. Inpatient Admission on the Same Date as the Placement in Observation
 - a. If the same physician who admitted a patient to observation, later on the same date admits the patient as an inpatient, the physician may not bill for either the initial observation or the observation discharge services.

Rather, only the inpatient admission (i.e., the “initial hospital care”) is billable. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(D)>

2. Inpatient Admission on a Different Date

- a. If a physician admits an observation patient as an inpatient on a date other than the date of the initial observation, the physician may separately bill for observation services furnished on dates prior to the date of the inpatient admission. However, the physician may not separately bill for observation-related services (including the observation discharge services) furnished on the date of the inpatient admission. <Medicare Claims Processing Manual, Chapter 12 § 30.6.8(D)>

VI. Emergency Department Visits

A. Site of Service Limitation

1. Emergency department services (CPT codes 99281 - 99285) should only be billed if the patient was actually seen in a hospital emergency department. It would not be appropriate to bill for emergency department services furnished in any other site of service. <Medicare Claims Processing Manual, Chapter 12 § 30.6.11(B)>
 - a. The term “emergency department” is defined as “an organized hospital-based facility for the provision of unscheduled or episodic services to patients who present for immediate medical attention.” <Medicare Claims Processing Manual, Chapter 12 § 30.6.11(B)>
 - (i) It is not clear whether CMS follows the CPT rule that a facility must be open 24 hours a day to be considered an emergency department.

B. Non-Emergency Services Furnished in the Emergency Department

1. CMS takes the position that where a physician provides non-emergency services in an emergency department, the services may generally still be billed as emergency department services. <Medicare Claims Processing Manual, Chapter 12 § 30.6.11(C)>

C. Billing of Emergency Department Services by Non-Emergency Department Physicians

1. General Rule

- a. In general, any physician furnishing services in an emergency department may bill his or her services as emergency department services. *<Medicare Claims Processing Manual, Chapter 12 § 30.6.11(A), 30.6.11(C)>*
 - (i) Exception – where a physician asks a patient to meet the physician in the emergency department as an alternative to the physician's office and the patient is not registered as a patient in the emergency department, the physician should bill for his or her services as an outpatient visit rather than an emergency department service. *<See Medicare Claims Processing Manual, Chapter 12 § 30.6.11(C)>*

2. Emergency Department Services Provided by the Patient's Personal Physician at the Request of an Emergency Department Physician

- a. Where a patient is advised to go to the emergency department by a non-emergency department physician and the emergency department physician subsequently requests that the non-emergency department physician come to the hospital to evaluate the patient and advise the emergency department physician whether the patient should be admitted, the non-emergency department physician should bill as follows.
 - (i) If the non-emergency department physician admits the patient as an inpatient, the physician should bill for the appropriate level of initial hospital care. *<See Medicare Claims Processing Manual, Chapter 12 § 30.6.11(E)>*
 - (ii) If the patient is not admitted as an inpatient, both the emergency department physician and the non-emergency department physician should bill for the appropriate level of emergency department services. *<See Medicare Claims Processing Manual, Chapter 12 § 30.6.11(E)>*
 - (iii) If the non-emergency department physician advises the emergency department physician by phone and does not physically see the patient, the physician may not bill for his or her participation in the patient's care. *<See Medicare Claims Processing Manual, Chapter 12 § 30.6.11(E)>*

VII. Consultations

A. Not Recognized by Medicare

1. Effective January 1, 2010, consultation codes are no longer recognized by Medicare Part B. Physicians and other practitioners may code e/m visits that represent where the visit occurred, and the complexity of the visit performed. <Medicare Claims Processing Manual, Chapter 12 § 30.6.9.1(F)>

B. Coordinating Benefits When the Primary Payer Still Recognizes Consultation Codes

1. When the primary payer still recognizes consultation codes, practitioners have two options for reporting the services to Medicare for secondary payment consideration. Practitioners billing for these services may either:
 - a. Bill the primary payer an-e/m code (other than a consult) that is appropriate for the service, and then report the amount actually paid by the primary payer along with the same e/m code to Medicare for determination of whether payment is due; or
 - b. Bill the primary payer using a consultation code that is appropriate for the service and then report the amount actually paid by the primary payer, along with a non-consult e/m code that is appropriate for the service to Medicare for a determination of whether payment is due. <MLN Matters SE 1010>

VIII. Split (or Shared) Visits

A. Definition

1. CMS defines a split (or shared) visit as an E/M visit in the facility setting that is performed in part by both a physician and an NPP who are in the same group, in accordance with applicable laws and regulations. <86 Fed Reg 65151>
2. Services Are furnished in a facility setting by a physician and an NPP in the same group, where the facility setting is defined as an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under § 410.26(b)(1).

B. New or Established Patients

1. CMS indicated in the 2022 MPFS final rule the split (or shared) visits can be provided to both new and established patients

- C. Split (or shared) visits may be provided and billed for critical care services and certain nursing facility visits.
- D. Billing for split (or shared) services < *Medicare Claims Processing Manual*, Chapter 12, §30.6.18>
 - 1. The practitioner (either the physician or non-physician practitioner) who provides the substantive portion of the split (or shared) visit bills for the visit.
 - a. The substantive portion may be determined based on either:
 - (i) More than half of the total practitioner time; or
 - (ii) the medical decision making.
 - 2. Split (or shared) visits are reported with the appropriate evaluation and management code and the split-shared modifier.
 - a. FS - Split (or shared) evaluation and management visit

IX. Critical Care Services

A. Definition of Critical Care Services

- 1. For Medicare purposes, services should be considered “critical care” only if, in addition to meeting the CPT definition of critical care, they meet both of the following sets of criterion.
 - a. Clinical Condition Criterion
 - (i) There is a high probability of sudden, clinically significant, or life-threatening deterioration in the patient's condition which requires the highest level of physician preparedness to intervene urgently. <See *Medicare Claims Processing Manual*, Chapter 23 § 20.7.6.3.2(C)>
 - b. Treatment Criterion
 - (i) There are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician and withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant, or life-threatening deterioration in the patient's condition. < See *Medicare Claims Processing Manual*, Chapter 23 § 20.7.6.3.2(C)>

B. Site of Service Issues

1. Critical care services may be furnished in any site of service so long as the services furnished qualify as critical care. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12(A)>

C. Counting Critical Care Time

1. The only time that may be counted for purposes of billing for critical care services is time spent by the physician working exclusively on the critical care patient's case at the patient's bedside or elsewhere in the unit or on the same floor. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12.2>
 - a. The critical care time and the services rendered must be documented in order to bill for critical care services.
2. Concurrent Critical Care Services
 - a. Critical care services performed by physicians of different specialties may be reported for the same patient on the same day. <86 Fed Reg 65157>
 - b. Beginning CY 2022, critical care services may be furnished as a split shared visit.
 - c. Bundled services as listed in the AMA CPT manual are not separately payable

D. Coding Critical Care Services

1. Critical care services are reported with CPT codes 99291 and 99292.
 - a. CPT 99291 - Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.
 - b. CPT 99292 - Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service).
 - (i) Caution: CMS clarified 104 minutes of critical care must be provided to report CPT 99292x1 and 99292x2 <85 FR 65160>

E. Critical Care Services Furnished Concurrently by Practitioners in the Same Group and of the Same Specialty <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12.4>

1. When a practitioner furnishes the initial critical care in its entirety, the practitioner reports CPT code 99291.

- a. Any additional practitioners providing critical care concurrently to the same patient on the same date will report CPT code 99292.
- 2. When a practitioner begins furnishing critical care; but, does not meet the required time to report CPT code 99291, another practitioner of the same specialty and group can continue to deliver critical care and the time of the of the practitioners can be aggregated to meet the time requirement to bill CPT code 99291.
 - a. Time spent furnishing critical care past the requirements for CPT code 99291 can only be reported by a practitioner (same specialty/group) when an additional 30 minutes of critical care is provided on the same date.

F. Critical Care and Other E/M Services Provided on the Same Day

- 1. Practitioners may bill E/M services provided on the same day as critical care services when the documentation supports the medical necessity <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12.6>
 - a. The practitioner must document the following:
 - (a) The E/M visit was provided prior to the critical care service at a time when the patient did not require critical care,
 - (b) The visit was medically necessary, and
 - (c) The services are separate and distinct,
 - (1) No duplicative elements from the critical care service provided later in the day. <86 Fed Reg 65161>
 - (ii) Reporting/Coding
 - (a) Practitioners must report modifier -25 on the claim for the initial E/M service when reporting these critical care services.
- 2. Critical Care Services Furnished During the Global Surgical Period
 - a. Pre-operative and Post-operative Critical care are included in the surgical package of many procedures with a 10 or 90 day global period; however, critical care unrelated to a procedure with a global surgical period may be separately reported and reimbursed when the following requirements are met:

- (i) The service must meet the definition of critical care and require the full attention of the physician or the qualified healthcare professional;
- (ii) The critical care provided is above and beyond the procedure performed; and
- b. Unrelated to the specific anatomic injury or the general surgical procedure performed. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12.7>

G. Critical Care Documentation Requirements

1. Each practitioner must document the total critical care time they provided.
2. Documentation should indicate that the services furnished to the patient, including any concurrent care, were medically reasonable and necessary.
3. The role of each practitioner provided concurrent care should be clearly identified in the medical record.
4. If critical care is provided as a split (or shared) service, the documentation must indicate the following:
 - a. Critical care services were provided by both practitioner and the care they each provided;
 - b. The record must be signed and dated by the billing provider; and
 - c. Total time of each practitioner must be documented. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.12.8>

X. Nursing Facility Visits

A. Federally Required Monitoring Visits

1. Medicare covers physician services necessary to satisfy federal requirements for the monitoring of nursing facility residents. However, Medicare policy does not cover additional E/M visits furnished solely to meet state law requirements for a facility admission or other additional visits "to satisfy facility or other administrative purposes," unless there was a medical reason

for the visit. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(B)>

a. Frequency limits on “monitoring” visits

- (i) Although not clear, CMS appears to take the position that nursing facility monitoring visits may not be billed more frequently than once every 30 days for the first 90 days after admission and every 60 days thereafter. <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(B)>
- (a) However, these limits do not prohibit physicians from billing for more frequent visits if the visits are otherwise medically necessary (i.e., the visits are for some medical reason other than routine monitoring). <See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(B)>

B. Nursing Facility Visits by Non-Physician Practitioners

1. Federally Required Monitoring Visits

a. Skilled Nursing Facility (SNF) Residents

- (i) The “initial visit” for a SNF resident must be furnished by a physician. <Medicare Claims Processing Manual, Chapter 12 § 30.6.13(A)>
- (ii) Initial visits performed by the admitting physician should be identified with the AI modifier. Other physicians evaluating the patient for specialty care should report the Initial Nursing Facility Care Codes without the AI modifier. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(C)>
- (a) Visits after the “initial visit” may be performed by a non-physician practitioner so long as the non-physician practitioner is permitted to furnish the service under applicable state law and the other Medicare requirements applicable to non-physician practitioners are met. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(C)>
- (1) Medically necessary e/m visits provided by NPPs in the SNF may be considered for reimbursement under the subsequent nursing facility care codes (99307-99310) even if the visits are provided prior to the physician’s initial visit. < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(C)>

b. Nursing Facility (NF) Visits

- (i) The initial visit by a non-physician practitioner is covered so long as the non-physician practitioner is not an employee of the nursing facility, the non-physician practitioner is permitted to furnish the service under applicable state law and the other Medicare requirements applicable to non-physician practitioners are met. <See *Medicare Claims Processing Manual*, Chapter 12 §§ 30.6.13(A), 30.6.13(C)>
- (ii) Other visits by a non-physician practitioner are covered so long as the non-physician is permitted to furnish the service under applicable state law and the other Medicare requirements applicable to non-physician practitioners are met. < See *Medicare Claims Processing Manual*, Chapter 12 §§ 30.6.13(A), 30.6.13(C)>

C. Place of Service Code Issues

- 1. The following place of service codes should be used to bill for E/M services furnished to SNF/NF residents: < See *Medicare Claims Processing Manual*, Chapter 12 § 30.6.13(A)>
 - a. SNF Residents in a Covered Part A Stay
 - (i) POS 31 - SNF
 - b. Other SNF Residents
 - (i) POS 32 - NF
 - c. NF Residents
 - (i) POS 32 – NF

XI. Care Plan Oversight Services

A. Scope of Services

- 1. Care plan oversight is the physician supervision of a patient under the care of a home health agency or hospice that requires complex and multidisciplinary care modalities involving:
 - a. Regular physician development and/or revision of care plans,

- b. Review of subsequent reports of patient status,
- c. Review of laboratory results and other studies,
- d. Communication with other healthcare professionals not in the same practice,
- e. Integration of new information into the care plan, and
- f. Adjustments to therapy. <See *Medicare Benefit Policy Manual*, Chapter 15 § 30 (G)>

B. Coverage Limitations

- 1. Care plan oversight services are subject to numerous limitations on coverage as set forth in the Medicare Benefit Policy Manual, Chapter 15 § 30(G).

C. Documentation Requirements

- 1. A physician who furnishes care plan oversight services must document:
 - a. The date the services were furnished,
 - b. The length of time spent furnishing the services, and
 - c. The nature of the services furnished. <See *Medicare Benefits Policy*, Chapter 15 § 30(G)>

D. Coding and Billing Requirements

- 1. Coding Issues
 - a. The CPT codes for care plan oversight services are not billable to Medicare. Care plan oversight services furnished for Medicare beneficiaries must be billed using one of the following HCPCS codes: <See *Medicare Claims Processing Manual*, Chapter 12 § 100.1.4>
 - (i) G0179 – Physician recertification services for Medicare covered services of a home health agency.
 - (ii) G0180 – Physician certification services for Medicare covered services of a home health agency.
 - (iii) G0181 – Physician supervision of a patient receiving Medicare covered home health services provided by a home health agency, 30 minutes or more.

(a) Carriers will allow non-physician practitioners to report G0181 for home health care plan oversight even though they are not allowed to certify a patient for home health or sign the plan of care. < See *Medicare Claims Processing Manual*, Chapter 12 § 180.1(B)>

(iv)G0182 – Physician supervision of a patient receiving services under a Medicare approved hospice, 30 minutes or more.

(a) Carriers will allow non-physician practitioners to report G0182, along with modifier GV for hospice care plan oversight services. < See *Medicare Claims Processing Manual*, Chapter 12 § 180.1(B)>>

2. General Billing Requirements

- a. Care plan oversight services must be billed on a separate claim (i.e., no other services may be billed on the same claim as the care plan oversight services). <Medicare Claims Processing Manual, Chapter 12 § 180.1(A)>
- b. Care plan oversight services must be billed after the end of the month in which the services were furnished. <Medicare Claims Processing Manual, Chapter 12 § 180.1(A)>
- c. Only one unit of care plan oversight services is billable per month. <Medicare Claims Processing Manual, Chapter 12 § 180.1(A)>
- d. Claims submitted for care plan oversight services must include the Medicare provider number of the home health agency or hospice that provided Medicare covered services to the beneficiary during the time the care plan oversight services were furnished. <Medicare Claims Processing Manual, Chapter 12 § 180.1(C)>
 - (i) **Alert:** This requirement was rescinded due to the lack of data field for this information on the HIPAA Standard ASC X12N 837. It is waived temporarily while a new version of the electronic standard format is being developed. <Medicare Claims Processing Manual, Chapter 12 § 180.1 (C)>
- e. An E/M service must have been furnished to the beneficiary within six months immediately preceding the first CPO service. <Medicare Benefit Policy Manual, Chapter 15 § 30.G.6>

3. Additional Billing Requirements Applicable to Care Plan Oversight Services Furnished in Connection with Certification of a Home Health Plan of Care

- a. A physician may not bill for care plan oversight services furnished in connection with home health certification (G0180) or recertification (G0179) unless the same physician signed the home health or hospice plan of care. <Medicare Benefit Policy Manual, Chapter 15 § 30.G>
- b. Care plan oversight services furnished in connection with home health certification (G0180) may only be billed if the patient has not received Medicare-covered home health services during the preceding 60-day period. <Medicare Claims Processing Manual, Chapter 12 § 180.1(B)>
- c. Care plan oversight services furnished in connection with home health recertification (G0179) may only be billed when the patient has received home health services for at least 60 days or one certification period. <Medicare Claims Processing Manual, Chapter 12 § 180.1(B)>
 - (i) In general, G0179 may be billed only once every 60 days. <Medicare Claims Processing Manual, Chapter 12 § 180.1(B)>
 - (a) Exception – G0179 may be billed more than once every 60 days if, prior to expiration of an existing recertification period, the patient began a new episode of care that required a new plan of care. <Medicare Claims Processing Manual, Chapter 12 § 180.1(B)>

XII. Care Management Services

- A. Care and support services provided by clinical staff under the direction of a physician or NPP to a patient residing at home, domiciliary, rest home or assisted living facility.
 - 1. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. See the CPT Manual for the complete list of care management activities.
 - a. If the physician or other qualified health care professional (e.g., nurse practitioner or physician assistant) supplies the time, that time may also count toward the 20 minutes.
 - 2. Patients must have two or more chronic continuous or episodic health conditions that place the patient at significant risk and are expected to last at least 12 months or until death.
 - 3. Services may be reported on a monthly basis by a single physician/NPP.

4. Reporting is dependent on whether the care management service is provided by clinical staff versus the physician or qualified health care professional. Time may or may not be face-to-face with the patient.
 - a. Clinical staff time on the same day of an e/m is not counted toward the care management service.
5. Billing practices must provide 24/7 access to physicians, NPPs, or clinical staff to address urgent needs, provide continuity of care, and utilize an electronic health record system so that providers have timely access to clinical information. See the CPT Manual for the complete list of practice requirements.
6. Care management services may not be reported by the surgeon when performed during the post-op period.
7. Many services are included in care management and are therefore not separately reported such as care plan oversight services (99339, 99340, 99374-99380), medical team conferences (99366, 99367, 99368), transitional care management services (99495, 99496), etc. See the CPT Manual for the complete list.
8. CPT categorizes care management services as either Chronic Care Management or Complex Chronic Care Management.

B. Chronic Care Management Services

1. Non-complex Chronic Care Management (CPT 99490, 99491, and 99439)
 - a. CPT Code 99491 - CCM services provided personally by a physician or other qualified health care professional for at least 30 minutes.
 - b. CPT code 99490 - non-complex CCM is a 20-minute timed service provided by clinical staff to coordinate care across providers and support patient accountability.
 - c. At least 20 minutes of clinical staff time must be spent in care management activities for the month.
 - d. Medicare recognizes this service. Reimbursement is similar to an established patient level 2 office visit.
 - e. Can be performed under general supervision <CMS Chronic Care Management Fact Sheet, May 2015>

- f. Practitioner must inform eligible patients of the availability of and obtain consent for the CCM service before furnishing or billing the service. In some instances, there are certified electronic health record implications for this consent. Verify if you must meet these requirements before billing <CMS Chronic Care Management Fact Sheet, May 2015>
 - g. CPT code 99439 - each additional 20 minutes of clinical staff time spent providing non-complex CCM directed by a physician or other qualified health care professional. Add-on code to be reported in conjunction with CPT code 99490.
 - (i) Add-on code to be reported in conjunction with CPT code 99480.
 - h. More information available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>
- C. Complex Chronic Care Management Services (99487-99489)
1. Complex chronic care management service (99847), must meet the following required elements:
 - a. Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
 - b. Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
 - c. Establishment or substantial revision of a comprehensive care plan with moderate or high complexity medical decision making
 - d. 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
 - e. CPT 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)
 2. Complex Chronic Care Management should not be reported when the care plan is unchanged or requires only minimal change (e.g., medication is changed or an adjustment in a treatment modality is ordered).

D. Principal Care Management (PCM) Services (G2064-G2065)

1. Beginning January 1, 2020, Medicare created PCM codes for comprehensive care management for a single high-risk disease.
 - a. Appropriate when the beneficiary only has a single high-risk disease or when the beneficiary has multiple chronic conditions, but the practitioner is providing comprehensive care for a single condition.
 - b. Management of a single condition may be more common with specialists.
 - c. The distinguishing feature in the codes is dependent on who is doing the comprehensive care management:
 - (i) G2064 Comprehensive care management services for a single high-risk disease at least 30 minutes of **physician or other qualified health care professional** time per calendar month
 - (j) G2065 Comprehensive care management services for a single high-risk disease at least 30 minutes of **clinical staff** time per calendar month...
 - a. Both codes require 30 minutes of time during the calendar month.
 - b. CMS intends to monitor these new codes for the unintended consequence of fragmented care or inappropriate care that overlaps into duplicative services.

E. Advanced Primary Care Management (APCM)

1. New bundle of services reflective of advanced primary care delivery model
2. Incorporate elements of:
 - a. Principle care management, transitional care, chronic care management, communication technology-based services
3. Practitioner is:
 - a. Focal point of ongoing healthcare services
 - b. Responsible for all primary care services

4. Services are:
 - a. Designated care management under 42 *CFR* §410.26(b)(5)
 - b. Provided by clinical auxiliary staff under general supervision
 - c. Directed by physician/qualified health professional responsible for all primary care
5. Reported with the following HCPCS Codes:
 - a. G0556 -reported for one chronic condition expected to last at least 12 months or until patient expires,, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month...
 - b. G0557 - for a patient with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month...
 - c. G0558 - for a patient that is a qualified Medicare beneficiary with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,....

F. Chronic Pain Management

1. For CY 2023 CMS finalized two HCPCS codes for chronic pain management services performed by physicians or other qualified healthcare professionals. <MLN Matters MM12982>
 - a. HCPCS G3002 - Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy,

complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month.

(i) To report G3002, 30 minutes must be met or exceeded.

b. HCPCS G3003 - Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for G3002).

(i) To report HCPCS G3003, 15 minutes must be met or exceeded.

G. Transitional Care Management (TCM) Services (99495-99496)

1. Used for new or established patients whose medical problems require moderate or high complexity medical decision during transition from an inpatient hospital setting (includes acute care, rehab, long-term acute care hospital), partial hospital, observation status or SNF/NF to a community setting (home, domiciliary, rest home or assisted living).
2. TCM starts on the date of discharge and continues for the next 29 days.
3. An interactive contact with the patient or caregiver, as appropriate, must occur within two business days of discharge.
 - a. Contact may be face-to-face, telephonic, or by electronic means.
4. TCM entails one face-to-face visit in combination with non-face-to-face services. Medication reconciliation and management must occur no later than the date of the face-to-face visit.
 - a. Face-to-Face Visit Rules
 - (i) The first face-to-face visit is included in the TCM. Other e/m services provided subsequently may be separately reported.
 - (ii) The visit must occur within 14 days of discharge if the medical decision making is of moderate complexity. Use code 99495.
 - (iii) The visit must occur within 7 days of discharge if the medical decision making is of high complexity. Use code 99496.

- (a) If the medical decision making is of high complexity, but the visit does not occur until day 8 post-discharge, use code 99495.
- 5. Only one individual may report TCM services and only once per patient within 30 days of discharge.
- 6. The same provider may report hospital or observation discharge services (99238-99239, or 99217) and TCM.
- 7. TCM services provided in the postoperative period by the surgeon are considered bundled and not separately reported.
- 8. Documentation Requirements for TCM
 - a. Documentation in the medical record must at a minimum indicate:
 - (i) Date the beneficiary was discharged;
 - (ii) Date the interactive contact with the beneficiary and/or caregiver was made;
 - (iii) Date that the face-to-face visit occurred; and
 - (iv) The complexity of medical decision making (moderate or high).
- 9. For additional details on Medicare requirements for TCM, see the TCM fact sheet: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf>

XIII. Mental Health

- A. Psychiatric Collaborative Care and Behavioral Integration Services (99492, 99493, 99494)
 - 1. Billed by treating physician/Primary Care Provider (PCP)
 - 2. The consulting psychiatrist and the care manager are then paid by the PCP through a contract, employment, or other arrangement.
 - 3. All bulleted items must be performed to report the service
 - a. Example 99492
 - (i) Tracking patient follow-up and progress using the registry, with appropriate documentation;

- (ii) Participation in weekly caseload consultation with the psychiatric consultant;
- (iii) Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
- (iv) Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- (v) Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- (vi) Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment. <CMS FAQs Behavioral Integration Services>

B. General Behavioral Health Integration Services Provided by Clinical Psychologists (CP) or Clinical Social Workers (CSW)

1. CMS created and finalized a new HCPCS code for CY 2023 to account for the monthly care integration for mental health services provided by a CP or a CSW when serving as a focal point of care integration <MLN Matters MM12982>
2. HCPCS Code G0323 - Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. (these services include the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team).

C. Safety Planning Interventions and Crisis Care Updates

1. G0560 – Safety planning interventions for patients with suicidal ideation or overdose risk
 - a. Billed in 20-minute increments when the billing practitioner performs the service
 - b. Applies in various settings to ensure accessible crisis care
2. G0544 – Post-crisis follow-up care
 - a. Requires specific protocols for telephonic follow-up after emergency department discharge
 - b. Covers up to 4 follow-up calls per month as part of bundled crisis care services < *MLN Booklet*, MLN909432 April 2025 >
3. Safety Plan
 - a. *Recognize warning signs*
 - b. *Employ internal coping strategies*
 - c. *Utilizing social contacts and social settings: distraction from suicidal thoughts*
 - d. *Utilize family members, significant others, caregivers, and friends to help solve the crisis*
 - e. *Contact mental health professionals, crisis services, or agencies*
 - f. *Making the environment safe (including restricting access to lethal means)*< *MLN Booklet*, MLN909432 April 2025 >

D. Advance Care Planning (99497-99498)

1. Advance care planning is making decisions about the care patients would want to receive in the event they become unable to speak for themselves.
2. These are time-based codes which may or may not involve completing relevant legal forms.
3. Other e/m services may be reported with advance care planning when performed at the same time.
 - (i) Exception: Advance care planning cannot be reported with critical care or intensive care services.

4. When advance care planning services are provided during the Annual Wellness Visit (AWV -- G0438 or G0439), the deductible and co-pay will be waived. <MLN Matters Article MM9271>

- i. It is necessary to report modifier 33 (preventive service) on the advance care planning code(s). <MLN Matters Article MM9271>

XIV. Dental and Oral Health Issues

- A. In the 2023 Medicare Physician Fee Schedule Final Rule, CMS clarified its interpretation of the current statute regarding dental services.

1. Under current law, Medicare is prohibited from making payments for "...services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth." <Social Security Act §1862(a)(12)>

- a. Exceptions to the prohibition:

- (i) Can apply "in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services."

- B. CMS clarified Medicare's current policy which indicates, medically necessary dental services under both Parts A and B if they are "incident to and as an integral part" a covered procedure.

- C. The clarification of the statute, the 2023 Medicare Physician Fee Schedule Final Rule, codifies the following:

1. Dental services can continue to be made based on the interpretation that these services "are inextricably linked to, and substantially related and integral to the clinical success of, an otherwise covered medical service," including:

- a. Dental or oral examination as part of a comprehensive workup prior to a renal organ transplant surgery;

- b. Reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor;

- c. Wiring or immobilization of teeth in connection with the reduction of a jaw fracture;
 - d. Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and
 - e. dental splints only when used in conjunction with medically necessary treatment of a medical condition.
2. The Final Rule also finalizes a policy that Medicare can pay for ancillary services that contribute to the success of dental services (e.g., X-rays, anesthesia administration, and operating room use).
3. Payment can now be made for dental services under Medicare Parts A and B for:
- a. CY 2023 - dental or oral examinations, including necessary treatment, performed as part of a comprehensive workup prior to any organ transplant surgery or prior to cardiac valve replacement or valvuloplasty procedures.
 - b. CY 2024 - dental or oral examination performed as part of a comprehensive workup in either the inpatient or outpatient setting prior to or at the same time as Medicare-covered treatments for head and neck cancer.

Version 08/01/2025
Check for Updates



Transitional Care Management Services



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What's Changed?

- No substantive content updates.

In this booklet, **you** refers to physicians or health care professionals providing TCM services.

Medicare may cover transitional care services during the **30-day period** that begins when a physician discharges a Medicare patient from an inpatient stay and continues for the next 29 days. These services help eligible patients transition back to a community setting after a stay at certain facility types.

Transitional Care Management Services Requirements

Required patient transitional care management (TCM) services include:

- Supporting a patient's transition to a community setting
- Health care professionals accepting patients at the time of post-facility discharge **without a service gap**
- Health care professionals taking responsibility for a patient's care
- Moderate or high complexity medical decision making for patients with medical or psychosocial problems

The 30-day TCM period begins the day the patient is discharged from 1 of these inpatient or partial hospitalization settings and continues for the next 29 days:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Inpatient rehabilitation facility
- Long-term care hospital
- Skilled nursing facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

After an inpatient discharge, the patient must return to their community setting. These could include a:

- Home
- Domiciliary (like a group home or boarding house)
- Nursing facility
- Assisted living facility

Who Can Provide TCM Services?

TCM services include both face-to-face visits and non-face-to-face services. These health care practitioners can provide services associated with face-to-face TCM services and can supervise auxiliary personnel (including clinical staff):

- Physicians (any specialty)
- Non-physician practitioners (NPPs) legally authorized and qualified to provide the services in the state where they practice:
 - Certified nurse-midwives (CNMs)
 - Clinical nurse specialists (CNSs)
 - Nurse practitioners (NPs)
 - Physician assistants (PAs)

CNMs, CNSs, NPs, and PAs may provide non-face-to-face TCM services “incident to” services of a physician and other CNMs, CNSs, NPs, and PAs.

Supervision

TCM codes are care management codes. Auxiliary personnel may assign them for TCM non-face-to-face services under the general supervision of the physician or NPP subject to applicable state law, scope of practice, and the Medicare Physician Fee Schedule incident to rules and regulations.

CNMs, CNSs, NPs, and PAs may also provide the non-face-to-face TCM services incident to the physician’s services.

TCM Components

When a patient discharges from an approved inpatient setting, provide at least these TCM components during the 30-day service period:

Interactive Contact

- You (or clinical staff under your direction) must contact the patient or their caregiver by phone, by email, or face-to-face within 2 business days after the patient’s discharge from the inpatient or partial hospitalization setting
 - “Clinical staff” means someone who’s supervised by a physician or other qualified health care professional and is allowed by law, regulation, and facility policy to perform or assist in a specialized professional service but doesn’t individually report that professional service
- The interactive contact must be performed by clinical staff who can address patient status and needs beyond scheduling follow-up care
- You may report the service if you make 2 or more unsuccessful separate contact attempts in a timely manner (and if you meet the other service requirements, including a timely face-to-face visit)
- Document your attempts in the patient’s medical record
- Continue trying to contact the patient until you’re successful
- If the face-to-face visit isn’t within the required timeframe, you can’t bill TCM services (see the [face-to-face](#) section)



Non-Face-to-Face Services

- You and your clinical staff (as appropriate) must provide patients with medically reasonable and necessary non-face-to-face services within the 30-day TCM service period
- Clinical staff under your direction may provide certain non-face-to-face services

Physician or NPP Non-Face-to-Face Services

Physicians or NPPs may provide these non-face-to-face services:

- Review discharge information (for example, discharge summary or continuity-of-care documents)
- Review the patient's need for, or follow up on, diagnostic tests and treatments
- Interact with other health care professionals who may assume or reassume care of the patient's system-specific problems
- Educate the patient, family, guardian, or caregiver
- Establish or reestablish referrals and arrange needed community resources
- Help schedule required community providers and services follow-up

Auxiliary Personnel Under Physician or NPP General Supervision Non-Face-to-Face Services

Auxiliary personnel may provide these non-face-to-face TCM services under general supervision:

- Communicate with the patient
- Communicate with agencies and community service providers the patient uses
- Educate the patient, family, guardian, or caregiver to support self-management, independent living, and activities of daily living
- Assess and support treatment adherence, including medication management
- Identify available community and health resources
- Help the patient and family access needed care and services

Face-to-Face Visit

You must provide 1 face-to-face visit within the timeframes described by these 2 CPT codes:

- **99495** — Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge At least moderate level of medical decision making during the service period Face-to-face visit, within 14 calendar days of discharge
- **99496** — Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge High level of medical decision making during the service period Face-to-face visit, within 7 calendar days of discharge

Don't report the TCM face-to-face visit separately.

Telehealth Services

You can provide CPT codes 99495 and 99496 through [telehealth](#). We pay for a limited number of Part B services that you provide to an eligible patient using a telecommunications system.

Medication Reconciliation & Management

You must provide medication reconciliation and management on or before the face-to-face visit date.

TCM Concurrent Billing

You can bill certain other care management services concurrently with TCM services when medically reasonable and necessary and if time and effort aren't counted more than once. See the following table for commonly used codes.

Table: HCPCS Codes You Can Bill Concurrently

HCPCS Code	Descriptor
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month

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HCP Code	Descriptor
90953	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90956	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month

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HCPCS Code	Descriptor
90959	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age

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HCPCS Code	Descriptor
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
93792	Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment
98976	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
98978	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days

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HCPCS Code	Descriptor
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure)
99091	Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

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HCPCS Code	Descriptor
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)
99487	Complex chronic care management services 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
99489	Complex chronic care management services 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; 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)
99490	Chronic care management services 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

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HCPSC Code	Descriptor
99491	Chronic care management services 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month
99439	Chronic care management services 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 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)
G0181	Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans
G0182	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

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Medical Decision Making

Patients who get TCM must need moderate medical decision making (if you're billing CPT code 99495) or high-level medical decision making (if you're billing CPT code 99496). The levels of medical decision making are defined in the [2023 CPT E/M Guidelines](#). Medical decision making, which refers to establishing diagnoses, assessing the status of a condition, and selecting a management option, is defined by 3 elements:

- **Problems:** The number and complexity of problems addressed during the encounter
- **Data:** The amount and complexity of data to be reviewed and analyzed, like medical records, diagnostic tests, and other information
- **Risk:** The risk of complications and morbidity or mortality of patient management

Billing TCM Services

TCM services billing tips:

- Only 1 physician or NPP may report TCM services.
- Report services once per patient during the TCM period.
- The same health care professional may discharge the patient from the hospital, report hospital or observation discharge services, and bill TCM services. The required face-to-face visit **can't** take place on the same day you report discharge day management services.
- Report reasonable and necessary E/M services (except the required face-to-face visit) to manage the patient's clinical issues separately.
- You **can't** bill TCM services within a post-operative global surgery period (we don't pay for TCM services if any of the 30-day TCM period falls within a global surgery period for a procedure code billed by the same practitioner).
- At a minimum, document this information in the patient's medical record:
 - Patient discharge date
 - Patient or caregiver first interactive contact date
 - Face-to-face visit date
 - Medical decision making (moderate or high)

Advance Health Equity

Resources are available to help you understand and identify disparities that may affect TCM:

- [Building an Organizational Response to Health Disparities](#) — Resources and concepts for improving equity and responding to disparities. Topics include data collection, data analysis, culture of equity, quality improvement, and interventions.
- [Guide for Reducing Disparities in Readmissions](#) — Overview and case studies of key care coordination and readmission issues and strategies for racially and ethnically diverse Medicare patients.

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Resources

- [2013 Medicare Physician Fee Schedule Final Rule](#)
- [Care Management](#)
- [Evaluation & Management Visits](#)
- [Federally Qualified Health Center](#)
- [Information for Rural Health Clinics](#)
- [Rural Health Information Hub: Transitional Care Management](#)

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Check for Updates



Chronic Care Management Services



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What's Changed?

We added information about advanced primary care management (APCM) (page 11).

Substantive content changes are in dark red.

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Chronic care management (CCM) is managing a patient's multiple (2 or more) chronic conditions expected to last at least 12 months, or until their death. Chronic conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline. CCM is a critical primary care service that contributes to better patient health and care.

We pay for CCM services provided to patients with multiple chronic conditions under the Physician Fee Schedule (PFS).

Note: In this booklet, “you” refers to practitioners. “We” refers to CMS.

As the billing practitioner, you don't need to offer face-to-face CCM services to Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) patients because CCM describes non-face-to-face services.

Note: We require an [initiating visit](#) before you start CCM services.

CCM Service Elements: Highlights

CCM services are extensive, including:

- Structured recording of patient health information
- Maintaining comprehensive electronic care plans
- Managing care transitions and other care management services
- Coordinating and sharing patient health information promptly within and outside the practice

CCM service elements apply to both non-complex CCM (at least 30 minutes per month) and complex CCM (at least 60 minutes per month) unless otherwise specified.

You'll typically provide CCM services outside of face-to-face patient visits and focus on advanced primary care characteristics like:

- A continuous patient relationship with a chosen care team member
- Support for the patient to achieve health goals
- 24/7 patient access to care and health information
- Preventive care for the patient
- Patient and caregiver engagement
- Sharing patient health information promptly



CCM Service Practitioners

These practitioners may bill CCM services:

- [Physicians](#) (medical doctors (MDs) and doctors of osteopathy (DOs))
- [Certified nurse-midwives](#) (CNMs)
- [Clinical nurse specialists](#) (CNSs)
- [Nurse practitioners](#) (NPs)
- [Physician assistants](#) (PAs)

Note: Primary care practitioners most often bill CCM services, but some specialty practitioners may also provide and bill them. CCM services aren't within the scope of practice of limited-license physicians and practitioners like clinical psychologists, podiatrists, or dentists, but CCM practitioners may consult these practitioners, or refer patients to them, to coordinate and manage care.

For CCM services you don't personally provide, clinical staff can provide them under your direction on an "incident to" basis (as an integral part of services provided by the billing practitioner). This is subject to applicable state law, licensure, and scope of practice.

Clinical staff are employees or people working under contract with the billing practitioner, and we directly pay those practitioners for CCM services.

Supervision

We assign CCM codes describing clinical staff activities (CPT 99487, 99489, 99490, and 99439) as "general supervision" under the PFS. General supervision means the billing practitioner doesn't personally provide the service but it's done under their overall direction and control. We don't require you to be physically present during the service.



Patient Eligibility

Eligible CCM patients have multiple (2 or more) chronic conditions expected to last at least 12 months or until the patient's death or that place them at significant risk of death, acute exacerbation or decompensation, or functional decline. These services aren't typically face-to-face and allow eligible practitioners to bill at least 20 minutes or more of care coordination services per month. Check [Medicare eligibility](#).

Billing practitioners may consider identifying patients who require CCM services using criteria suggested in CPT guidance (such as number of illnesses, number of medications, or repeat admissions or emergency department visits) or the profile of typical patients in the CPT language.

Examples of [chronic conditions](#) include but aren't limited to:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid arthritis)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular disease
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Diabetes
- Glaucoma
- HIV and AIDS
- Hypertension (high blood pressure)
- Substance use disorders

Although patient cost sharing applies to the CCM service, some patients have [supplemental insurance \(Medigap\)](#) to help cover CCM cost sharing. Also, CCM may help avoid the need for more costly services in the future by proactively managing a patient's health, rather than only treating severe or acute disease and illness.

Initiating Visit

Before CCM services can start, we require an initiating visit for new patients or patients who you haven't seen within the previous 1 year. Conduct the initiating visit during a comprehensive face-to-face [evaluation and management](#) (E/M) visit, [annual wellness visit](#) (AWV), or [initial preventive physical exam](#) (IPPE).

If you don't discuss CCM during an E/M visit, AWV, or IPPE, it can't count as the initiating visit. A face-to-face initiating visit isn't part of CCM and can be separately billed.

If you personally provide extensive assessment and care planning outside the usual effort described by the initiating visit and CCM codes, you may also bill HCPCS code G0506 once, as part of an initiating visit.

Patient Consent

Get the patient's written or verbal consent for CCM services before you bill for them. This helps make sure patients are engaged and aware of their cost-sharing responsibilities and helps prevent duplicate practitioner billing. Inform the patient of these items and document in their medical record:

- The availability of CCM services
- Their possible cost-sharing responsibilities
- That only 1 practitioner can provide and bill CCM services during a calendar month
- Their right to stop CCM services at any time (effective at the end of the calendar month)
- That you explained the required information and whether the patient accepted or declined services

Patients must provide informed consent only once unless they switch to a different CCM practitioner.

Electronic Recording of Patient Health Information

Record the patient's demographics, problems, medications, and medication allergies using a version of [certified electronic health record](#) (EHR) that's acceptable under the EHR Incentive Programs as of December 31 of the CY before each PFS payment year. [Promoting Interoperability Programs](#) has more EHR technology information.

Comprehensive Care Plan

Create, revise, and monitor (per code descriptors) a patient-centered, electronic comprehensive care plan based on a physical, mental, cognitive, psychosocial, functional, and environmental assessment and an inventory of resources and supports.

A comprehensive care plan focusing on managing chronic conditions may include:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Revision and monitoring (per code descriptors), when necessary
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners
- Periodic review

Note: Make the [plan](#) available promptly both within and outside the billing practice, and when necessary, give patients and caregivers a copy of the care plan.

We have several [care planning tools](#) and [resources](#).

Medical Decision-Making

Complex CCM services require and include moderate- to high-complexity medical decision-making by the physician or other billing practitioner.

24/7 Access to Care & Care Continuity

Access to care and care continuity should include:

- Providing 24-hour-a-day, 7-day-a-week (24/7) access to physicians or other qualified practitioners or clinical staff so patients can discuss urgent needs no matter the day or time
- Choosing a care team member with whom the patient can schedule routine appointments and who's regularly in touch with the patient to help them manage their chronic conditions
- Giving patients and caregivers a way to communicate with their practitioners about their care by phone and through secure messaging, secure web, or other asynchronous non-face-to-face consultation methods (like email or a secure electronic patient portal)

Comprehensive Care Management

Comprehensive care management should:

- Assess the patient's medical, functional, and psychosocial needs
- Make sure the patient gets timely recommended preventive services
- Review medications and any potential interactions
- Oversee the patient's medication self-management
- Coordinate care with home- and community-based clinical service providers
- Communicate with home- and community-based providers about the patient's psychosocial needs and functional decline, and document it in the patient's medical record



Manage Care Transitions

You can manage care transitions among health care providers and settings by:

- Including referrals to other clinicians, or following up after an ED visit or after discharges from hospitals, skilled nursing facilities, or other health care facilities
- Creating continuity-of-care documents and promptly exchanging or sharing them with other practitioners

Concurrent Billing

Consider these guidelines when billing for concurrent services:

- You can't report non-complex CCM and complex CCM for the same patient in a calendar month (don't report 99491 and 99437 in the same calendar month as 99487, 99489, 99490, or 99439).
- You can't bill CCM during the same service period as HCPCS code G0181 (home health care supervision), HCPCS code G0182 (hospice care supervision), or CPT codes 90951–90970 (certain ESRD services).
- You can report CCM codes 99487, 99489, 99490, and 99491 for services provided during the 30-day transitional care management (TCM) service period (CPT codes 99495 and 99496).
- You can't report complex CCM and prolonged E/M services in the same calendar month.
- You can't count time toward the CCM service code for any other billed code.
- RHCs and FQHCs can bill CCM and TCM services for the same patient during the same period.
- You can bill either remote physiologic monitoring (RPM) or remote therapeutic monitoring (RTM), but not both, concurrently with any CCM or TCM service.
- Consult CPT instructions for other codes you can't bill concurrently with CCM. Other provider billing restrictions may apply if you're taking part in a CMS-sponsored model or demonstration program.

CCM service codes include care coordination and care management payment for a patient with multiple chronic conditions within Original Medicare. We won't duplicate payments for the same or similar services for patients with chronic conditions already paid for under the various demonstration initiatives. Get more information on potentially duplicated billing by consulting the CMS staff responsible for [demonstration initiatives](#).



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CCM Codes

Chronic care management codes are based on time per calendar month and if you’re personally doing the services or your clinical staff does them under your supervision.

Table 1 shows the differences between chronic care management and complex chronic care management as defined by CPT.

Table 1. CCM Required Elements

Required Elements	Chronic Care Management	Complex Chronic Care Management
Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient	✓	✓
Chronic conditions that place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline	✓	✓
Comprehensive care plan established, implemented, revised, or monitored	✓	✓
Moderate or high complexity medical decision making	N/A	✓

We also pay for **chronic pain management and treatment** as a monthly bundle that includes:

- Diagnosis
- Assessment and monitoring
- Administration of a validated pain rating scale or tool
- Development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and wanted outcomes
- Overall treatment management
- Facilitation and coordination of any necessary behavioral health treatment
- Medication management
- Pain and health literacy counseling
- Any necessary chronic pain-related crisis care
- Ongoing communication and care coordination between relevant practitioners providing care; for example, physical therapy and occupational therapy, complementary and integrative approaches, and community-based care

You need to provide the initial chronic pain management visit face-to-face with the patient for at least 30 minutes.

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Table 2 tells you which code to use for each service based on who's doing the service and how long they're doing it each month. We show add-on codes with the + symbol in front of the code.

Table 2. Applicable CCM Codes

Code	Care Type	Staff Type	Time
99490	Chronic care management	Clinical staff	First 20 minutes
+99439	Chronic care management	Clinical staff	Each additional 20 minutes
99491	Chronic care management	Physician or other qualified health care professional	First 30 minutes
+99437	Chronic care management	Physician or other qualified health care professional	Each additional 30 minutes
99487	Complex chronic care management	Clinical staff	First 60 minutes
+99489	Complex chronic care management	Clinical staff	Each additional 30 minutes
G3002	Chronic pain management and treatment	Physician or other qualified health care professional	First 30 minutes (Must meet or exceed 30 minutes)
+G3003	Chronic pain management	Physician or other qualified health care professional	Each additional 15 minutes (Must meet or exceed 15 minutes)

Clinical Staff & Practitioner Time Requirements

CPT codes 99487, 99489, 99490, and 99439 include time spent directly by the billing practitioners or clinical staff. Time spent by the billing practitioner may also count toward the time threshold if not used to report 99491.

CPT codes 99491 and 99437 include only time that's spent personally by the billing practitioner. Clinical staff time doesn't count toward the required reporting time threshold code.



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Other Care Management Services

Advanced Primary Care Management

Advanced Primary Care Management (APCM) services combine elements of several existing care management and communication technology-based services you may have already been billing for your patients. They're billed once per calendar month. The benefit of these bundled services is that they don't require you to count minutes per month to bill. They were designed to reflect the reality that patient needs often change from month to month. This payment bundle includes the essential elements of advanced primary care, including:

- Principal care management (PCM)
- TCM
- CCM
- Interprofessional consultations
- Online digital E/M (e-visits)

APCM Codes

- G0556: Level 1, for people with 0 or 1 chronic condition
- G0557: Level 2, for people with 2 or more chronic conditions
- G0558: Level 3, for people with 2 or more chronic conditions and Qualified Medicare Beneficiary status

PCM

PCM services focus on a single, high-risk chronic condition expected to last at least 3 months that places the patient at significant risk of hospitalization, acute exacerbation or decompensation, functional decline, or death.

You can provide PCM services monthly if the patient needs them. After 1 year, we require another initial visit to continue the services. You can't bill for PCM services of less than 30 minutes per calendar month.

PCM Codes: 99424, 99425, 99426, 99427

Principal Illness Navigation

You can provide principal illness navigation (PIN) services following an initiating [E/M](#) visit that addresses 1 serious, high-risk condition, illness, or disease with these characteristics:

- This condition is expected to last at least 3 months and places the patient at significant risk of hospitalization, nursing home placement, acute exacerbation or decompensation, functional decline, or death
- The condition requires developing, monitoring, or revising a disease-specific care plan and may also need to change medications or treatments regularly or get significant help from a caregiver

Auxiliary personnel who meet [specific requirements](#) perform PIN services. G0140 and G0146 are designed specifically for auxiliary personnel like peer support specialists to provide navigation for behavioral health conditions.

PIN Codes: G0023, G0024, G0140, and G0146

Community Health Integration

Community health integration (CHI) services help patients who have unmet social needs that affect the diagnosis and treatment of their medical problems find and connect with clinical and social support resources.

You may provide CHI services monthly, as medically necessary, following an initiating E/M visit (CHI initiating visit) where you find social determinants of health needs that significantly limit your ability to diagnose or treat the patient problems addressed in the visit.

Community-based organizations may employ community health workers, care navigators, peer support specialists, and other auxiliary personnel if you provide the required supervision for these services, like other care management services.

CHI Codes: G0019 and G0022

TCM

[TCM](#) is a comprehensive set of services designed to make sure patients get coordinated and continuous care as they transition from an inpatient health care setting (like a hospital, skilled nursing facility, or rehabilitation facility) back to their community (which could be their home, an assisted living facility, or another outpatient environment).

We may cover transitional care services during the 30-day period that starts when a physician discharges a Medicare patient from an inpatient stay and continues for the next 29 days.

TCM Codes: 99495 and 99496

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Resources

- [CCM Materials for FQHCs](#)
- [CCM Materials for RHCs](#)
- [CCM Materials for Hospital Outpatient Departments](#)
- [CCM Materials for Physicians](#)
- [FAQs for CCM Billing](#)

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Behavioral Health Integration Services



What's Changed?

We made significant updates to explain recent policy changes.

- Added new HCPCS codes for safety planning and crisis care (page 3)
- Clarified new HCPCS codes and billing requirements for digital mental health treatment (page 11)
- Expanded consultation services for mental health providers (pages 12-13)

Substantive content changes are in dark red.

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The medical community now widely considers integrating behavioral health care with primary care, known as behavioral health integration or BHI, an effective strategy for improving outcomes for millions of Americans with mental or behavioral health conditions.

Tip: We make separate payment to physicians and non-physician practitioners for BHI services they supply over a calendar month service period.

What is BHI?

BHI is a type of care management service. In recent years, we expanded care management codes to describe services that involve:

- Direct patient contact, in-person or face-to-face services, or services without direct patient contact
- A single encounter, a monthly service, or both
- Timed services
- Specific conditions
- The work of the billing practitioner, auxiliary personnel, specifically clinical staff, or both

New for CY 2025

To make behavioral health care more accessible, we added new codes in the CY 2025 Medicare Physician Fee Schedule (MPFS) Final Rule. These updates focus on helping patients at risk of suicide and improving follow-up care after a crisis.

Safety Planning & Crisis Care Updates

We encourage providers to use safety planning for patients at risk of suicide. To support this effort, we introduced new billing codes:

- G0560 – Safety planning interventions for patients with suicidal ideation or overdose risk
 - Billed in 20-minute increments when the billing practitioner performs the service
 - Applies in various settings to ensure accessible crisis care
- G0544 – Post-crisis follow-up care
 - Requires specific protocols for telephonic follow-up after emergency department discharge
 - Covers up to 4 follow-up calls per month as part of bundled crisis care services

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BHI Services Using the Psychiatric Collaborative Care Model

Since 2017, we've made separate payments to physicians and non-physician practitioners supplying BHI services using the Psychiatric Collaborative Care Model (CoCM) approach to patients during a calendar month. In 2018, we established payment for general BHI services using models other than CoCM and began making payment for these services using CPT codes:

- 99492
- 99493
- 99494

Tip: CPT time rules apply to general BHI and CoCM services. See the [BHI Coding Summary Table](#) for more information.

HCPSC Code G2214: Refining Coding for CoCM Services

We added the BHI service in the [CY 2021 MPFS Final Rule \(CMS-1734-F\)](#) and began payment on January 1, 2021, for:

- Initial or subsequent psychiatric collaborative care management
- First 30 minutes of behavioral health care manager activities in a month
- Services in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional

An example of when to use this code is when you see a patient for services, then hospitalize them or refer them for specialized care, and you don't meet the number of minutes needed to bill using the current coding.

HCPSC Code G0323: Care Management Services for Behavioral Health Conditions

- Introduced in CY 2023 to describe general BHI that a clinical psychologist (CP) or clinical social worker (CSW) performs
- Accounts for monthly care integration, with the CP or CSW serving as the focal point for mental health services
- Requires at least 20 minutes of CP or CSW time per calendar month

Tip: Psychiatric diagnostic evaluation, CPT code 90791, serves as the initiating visit for G0323.

Psychiatric CoCM

Use CPT codes 99492, 99493, and 99494, and HCPCS code G2214 to bill for monthly CoCM services. Studies show this BHI approach improves outcomes.

What is CoCM?

This figure is a model of behavioral health integration that enhances usual primary care by adding 2 key services to the primary care team, particularly for patients whose conditions aren't improving:

- Care management support for patients receiving behavioral health treatment
- Regular psychiatric inter-specialty consultation
- A team of 3 delivers CoCM:
 - Behavioral Health Care Manager
 - Psychiatric Consultant
 - Treating (Billing) Practitioner

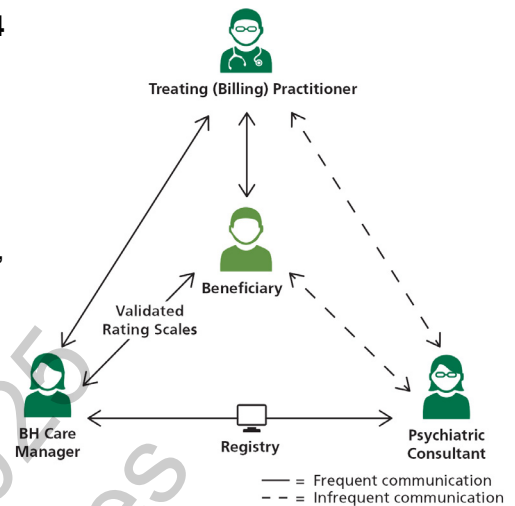


Figure 1: Illustration of a CoCM model

CoCM Care Team Members



- **Behavioral Health Care Manager** – A designated provider with formal education or specialized training in behavioral health, including social work, nursing, or psychology, working under the oversight and direction of the billing practitioner
- **Patient** – An active member of the care team
- **Psychiatric Consultant** – A medical provider trained in psychiatry and qualified to prescribe the full range of medications
- **Treating (Billing) Practitioner** – A physician or non-physician practitioner (physician assistant or nurse practitioner) who typically works in primary care but may specialize in other fields such as cardiology or oncology

CoCM Service Components

- **Initial assessment:** The primary care team assesses patients and administers validated rating scales.
- **Joint care planning:** The primary care team works with the patient to revise the care plan if the condition isn't improving adequately. Treatment may include pharmacotherapy, psychotherapy, or other recommended treatments.
- **Ongoing follow-up:** The behavioral health care manager follows up proactively and systematically using validated rating scales and a registry.
 - Assesses treatment adherence, tolerability, and clinical response using validated rating scales

- Delivers brief, evidence-based psychosocial interventions such as behavioral activation or motivational interviewing
- Provides 70 minutes of behavioral health care manager time in the first month, 60 minutes in following months, and an add-on code adds 30 more minutes in any month
- **Systematic case review:** The behavioral health care manager and psychiatric consultant conduct regular caseload reviews:
 - The behavioral health care manager and psychiatric consultant review the patient's treatment plan and status weekly, and if the patient isn't improving, discuss potential revisions
 - The primary care team continues or adjusts treatment, including referral to behavioral health specialty care, as needed

General BHI

Practitioners use **CPT code 99484** to bill for monthly services using BHI care models other than CoCM that:

- Systematically assess and monitor patients
- Adjust care plans for patients not improving adequately
- Provide a continuous relationship with an appointed care team member

You may also use **CPT code 99484** to report models of care that don't involve a psychiatric consultant, or behavioral health care manager, although these personnel may deliver General BHI services. We expect to refine this code over time, as more information becomes available about other BHI care models in use.

General BHI Service Parts

- Initial assessment, including administering applicable validated clinical rating scales
- Systematic assessment and monitoring, using applicable validated clinical rating scales
- The primary care team's joint care planning with the patient, with care plan revision for patients whose condition isn't improving
- Facilitation and coordination of behavioral health treatment
- Continuous relationship with an appointed care team member

General BHI Care Team Members



- **Treating (Billing) Practitioner** – A physician or non-physician practitioner, such as a PA, NP, CNS, or CNM, typically in primary care but may be in another specialty, like cardiology, oncology, or psychiatry.
- **Patient** – A member of the care team.
- **Potential Clinical Staff** – The billing practitioner delivers the service in full or uses qualified clinical staff to deliver services using a team-based approach. Clinical staff includes contractors who meet the qualifications for the CoCM behavioral health care manager or psychiatric consultant.

Tip: We allow psychiatric consultants and other care team members to offer certain services remotely under BHI codes.

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Eligible Conditions

We classify eligible conditions as any mental, behavioral health, or psychiatric condition, including substance use disorders, that the billing practitioner treats and determines require BHI services. These conditions may be pre-existing or the billing practitioner may diagnose and refine them over time.

Tip: Patients may, but don't need to have, comorbid, chronic, or other medical conditions that the billing practitioner manages.

Relationships & Roles of Care Team Members

Practitioners use BHI codes to bill and get paid for services using models of care with well-defined roles and relationships among care team members. The following roles and relationships describe all BHI services unless noted:

Incident To

We consider BHI services delivered by other members of the care team, under the direction of the billing practitioner, incident to the billing practitioner's services. These services are subject to the state law, licensure, and scope of practice that applies to their practice specialty. The billing practitioner either employs or contracts with the other care team members. Medicare pays the billing practitioner directly.

Initiating Visit

We require an initiating visit for new patients or patients not seen within 1 year before the start of BHI services. This visit establishes the patient's relationship with the billing practitioner and makes sure the billing practitioner assesses the patient before starting BHI services.

Treating (Billing) Practitioner



- Directs the behavioral health care manager or clinical staff
- Oversees the patient's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed
- Stays involved through ongoing oversight, management, collaboration, and reassessment
- May deliver the General BHI service in its entirety

Behavioral Health Care Manager (Needed for CoCM; Optional for General BHI)



- Gives assessment and care management services, including:
 - Administering validated rating scales
 - Developing and updating behavioral health care plans for behavioral or psychiatric health problems
 - Revising care plans for patients not progressing or whose status changes
 - Delivering brief psychosocial interventions

- Collaborating continuously with the billing practitioner
- Maintaining the patient registry
- Consulting with the psychiatric consultant
- Has a continuous relationship with the patient and:
 - Is available to deliver services face-to-face with the patient
 - Has collaborative, integrated relationship with the rest of the care team
- Can work with the patient outside of regular clinic hours as necessary to perform the behavioral health care manager's duties
- May or may not be a practitioner who meets all the requirements to independently deliver and report services to Medicare
- Doesn't include administrative or clerical staff; you don't count time spent solely on administrative or clerical duties toward the time threshold to bill the BHI codes

Psychiatric Consultant (Needed for CoCM; Optional for General BHI)



- Takes part in regular review of clinical status of patients getting BHI services
- Tells the billing practitioner and behavioral health care manager about diagnosis
- Recommends ways for resolving issues with patient adherence and tolerance of behavioral health treatment
- Adjusts behavioral health treatment for patients who aren't progressing
- Manages any negative interactions between patients' behavioral health and medical treatments
- Can (and typically will) be remotely located
- Is generally not expected to have direct patient contact, prescribe medications or deliver other treatment directly to the patient
- Can and should offer a referral for direct provision of psychiatric care when clinically indicated

Clinical Staff (May Provide General BHI)



- Maintains continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team
- May or may not be a provider who meets all the requirements to independently deliver and report services to Medicare
- Doesn't include administrative or clerical staff time
- May (but isn't required to) include a behavioral health care manager or psychiatric consultant

Supervision

We assign BHI services that the billing practitioner doesn't personally perform as general supervision under the Medicare Physician Fee Schedule (MPFS). General supervision alone doesn't create a qualifying relationship between the billing practitioner and other care team members. We define general supervision as the service delivered under the overall direction and control of the billing practitioner, and that doesn't require their physical presence during provision of services.

Advance Consent

Before starting BHI services, the patient must give the billing practitioner permission to consult with relevant specialists, which includes talking with a psychiatric consultant. The billing practitioner must inform the patient that cost sharing applies for both face-to-face and non-face-to-face services even if supplemental insurers cover cost sharing.

We don't require written consent.

- You may get verbal consent from the patient
- You must document it in the medical record

Tip: MPFS payment is available whether the patient spends part or all of the month in a facility stay or institutional setting. Report the place of service (POS) where the billing practitioner would normally deliver face-to-face care to the patient. Medicare can make separate Part B payment to hospitals, including critical access hospitals, when the billing practitioner reports a hospital outpatient POS.

Table 1: BHI Coding Summary

BHI Codes	Behavioral Health Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M) †	N/A	Usual work for the visit code
Care management services for behavioral health conditions (HCPCS code G0323)	At least 20 minutes of clinical psychologist or clinical social worker time per calendar month	15 minutes
CoCM First Month (CPT code 99492)	70 minutes per calendar month	30 minutes
CoCM Subsequent Months** (CPT code 99493)	60 minutes per calendar month	26 minutes
Add-On CoCM (Any month) (CPT code 99494)	Each additional 30 minutes per calendar month	13 minutes
General BHI (CPT code 99484)	At least 20 minutes per calendar month	15 minutes
Initial or subsequent psychiatric collaborative care management (HCPCS code G2214)	30 minutes of behavioral health care manager time per calendar month	Usual work for the visit code

**CoCM is delivered monthly for an episode of care. The episode ends when the patient meets targeted treatment goals, doesn't meet them and is referred for direct psychiatric care, or has a break in care with no CoCM for 6 consecutive months.

†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services (TCM).

Full Code Descriptors

CPT Code 99484: Care Management Services for Behavioral Health Conditions

Care management services for behavioral health conditions involve at least 20 minutes of clinical staff time per calendar month under a physician or other qualified health care professional's direction. The services must include:

- Initial assessment or follow-up monitoring, including using applicable validated rating scales
- Behavioral health care planning about behavioral or psychiatric health problems, including revision for patients not progressing or whose status changes
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, or psychiatric consultation
- Continuity of care with an appointed care team member

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New Digital Mental Health Treatment Codes

Along with traditional care, digital mental health treatments are now being used to help manage behavioral health conditions. Starting January 1, 2025, we established 3 new HCPCS codes for Digital Mental Health Treatment (DMHT):

- G0552 – Supply of a DMHT device, initial education, and onboarding per treatment course that supports a behavioral therapy plan
- G0553 – First 20 minutes per month of treatment management, including:
 - Physician or qualified professional review of patient data from the device
 - Patient or caregiver communication at least once per month
- G0554 – Each additional 20 minutes per month of DMHT device-related management, billed separately from G0553

Key Reporting Requirements

- The DMHT device must be FDA-approved to bill G0552
- The billing practitioner must cover the cost of getting and supplying the device
- Supplying the device must be part of the billing practitioner's services under an ongoing treatment plan
- We allow G0553 and G0554 to be billed only if the patient is actively using the DMHT device
- We'll monitor the use of digital mental health treatment devices to assess their impact on behavioral health care

CPT Code 99492: Initial Psychiatric CoCM

Initial psychiatric collaborative care management includes the first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and that the treating physician or other qualified health care professional directs. Required elements include:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional
- Initial patient assessment, including administering validated rating scales, with the development of an individualized treatment plan
- Review by the psychiatric consultant with modifications of the plan, if recommended
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with proper documentation, and participation in weekly caseload consultation with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques like behavioral activation, motivational interviewing, and other focused treatment strategies

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CPT Code 99493: Follow Up Psychiatric CoCM

Follow up psychiatric collaborative care management includes the first 60 minutes in a following month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional. Required elements include:

- Tracking patient follow-up and progress using the registry, with proper documentation
- Participating in weekly caseload consultation with the psychiatric consultant
- Coordinating mental health care with the treating physician or other qualified health care professional and any other treating mental health providers
- Reviewing progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations supplied by the psychiatric consultant
- Provision of brief interventions using evidence-based techniques like behavioral activation, motivational interviewing, and other focused treatment strategies
- Monitoring patient outcomes using validated rating scales and planning for relapse prevention as patients achieve remission of symptoms, reach other treatment goals, and prepare for discharge from active treatment

CPT Code 99494: Add-On for Initial & Subsequent Psychiatric CoCM

Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and that the treating physician or other qualified health care professional directs (list separately from the code for the primary procedure)

HCPCS Code G0323: Care Management Services for Behavioral Health Conditions

Care management services for behavioral health conditions cover at least 20 minutes of clinical psychologist or clinical social worker time per calendar month, including:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning for behavioral or psychiatric health problems, with revision for patients who aren't progressing or whose status changes
- Facilitating and coordinating treatment, such as psychotherapy; coordination with and referral to physicians and practitioners who Medicare authorizes to prescribe medications and furnish Evaluation and Management (E/M) services; counseling or psychiatric consultation; and continuity of care with an appointed care team member

Expanded Interprofessional Consultation Services

We added 6 new G-codes, G0546 through G0551, for interprofessional consultation services. These codes allow billing by specialists who diagnose and treat mental illness, including:

- Clinical Psychologists
- Clinical Social Workers
- Marriage and Family Therapists
- Mental Health Counselors

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These codes mirror existing CPT interprofessional consultation codes used by providers eligible for E/M visits. The codes are:

- G0546 – 5 to 10 minute assessment
- G0547 – 11 to 20 minute assessment
- G0548 – 21 to 30 minute assessment
- G0549 – 31 or more minute assessment
- G0550 – Assessment with written report for 5 or more minutes
- G0551 – Referral service for 30 minutes

HCPCS Code G2214: Initial & Subsequent Psychiatric CoCM

Initial or subsequent psychiatric collaborative care management covers the first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional:

- Tracking patient follow-up and progress using the registry, with proper documentation; participation in weekly caseload consultation with the psychiatric consultant
- Coordinating mental health care with the treating physician or other qualified health care professional and any other treating mental health providers
- Reviewing progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations supplied by the psychiatric consultant
- Provision of brief interventions using evidence-based techniques like behavioral activation, motivational interviewing, and other focused treatment strategies
- Monitoring patient outcomes using validated rating scales
- Planning for relapse prevention with patients as they achieve remission of symptoms, or other treatment goals and prepare for discharge from active treatment

Need More Information?

Find your [MAC's website](#) for details.

Resources

- [Agency for Healthcare Research and Quality-Develop a Shared Care Plan](#)
- [BHI FAQs](#)
- [CoCM Implementation Resources](#)
- [CY 2025 Medicare Physician Fee Schedule \(MPFS\) Final Rule](#)

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