PriorityHealth

Expanded services: Contracted billable codes

The advanced medical home model is transforming the delivery of personal, cost-effective health care. Care managers are an integral part of the value-added care team along with pharmacists, behavioral health providers and social workers. We recognize the value of these additional services and reimburse for many of them across multiple plan types.

As you expand the services you deliver in your practice, use this guide to understand what you can bill us.

Outpatient behavioral health

Code	Description	Plans				Providers		
		HMO/ POS/ PPO	Medicare	Medicaid	HealthyMI	Physician	Fully-licensed psychologist	LMSW, MA LLP, LPC
90849	Multiple family group psychotherapy	•	•	•	•	•	•	•
90853	Group psychotherapy	•	•	•	•	•	•	•
90863	Pharmacologic management with psychotherapy	•			•	•		
96150	Health and behavioral initial evaluation Health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires 15 minutes face-to-face with patient	•	•	•	•		•	•*
96151	Health and behavioral reassessment. Health focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires 15 minutes face-to-face with patient	•	•	•	•		•	•*
96152	Health and behavioral intervention 15 minutes face-to-face individual	•	•	•	•		•	•*
96153	Health and behavioral intervention 15 minutes face-to-face group Two or more patients	•	•	•	•		•	•*
96154	Health and behavioral intervention 15 minutes face-to-face group Family with patient present	•	•	•	•		•	•*
96155	Health and behavioral intervention 15 minutes face-to-face group Family without patient present	•			•		•	•

**No LMSW 96150, 96151, 96152, 96153, 96154*
The provider manual on priorityhealth.com offers updates and details regarding coding and coverage.
Note: *99444 is a covered benefit for telepsych as an E&M service. See code details on pg. 5 of this document.*

Advance care planning

These preventive health services are not subject to copays, deductibles or coinsurance.
There are no limits on the number of times these codes can be billed per year.

Code	Description	Plans					Providers	
		HMO/ POS/PPO	Medicare	Medicaid	HealthyMI	MIChild	Physician	Non-physician
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed) by the physician or other qualified health care professional First 30 minutes face-to-face with the patient, family members and/or surrogate	•	•				•	•
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed) by the physician or other qualified health care professional Each additional 30 minutes (List separately in addition to code for primary procedure)	•	•				•	•

Care management

Self-funded plans have various coverage.

Code	Description	Plans				Providers	
		HMO/POS/ PPO	Medicare	Medicaid	HealthyMI	Physician	Non-physician
99492	Initial psychiatric collaborative care management for the first 70 minutes in the first calendar month.	•	•			•	
99493	Subsequent psychiatric collaborative care management for the first 60 minutes in a subsequent month.	•	•			•	
99494	Additional 30 minutes of behavioral health care manager activities in a calendar month, in consultation with a psychiatric consultant and directed by the treating physician.	•	•			•	
99483	Assessment and care planning for patients with cognitive impairment.	•	•			•	
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service).		•			•	
99484	Covering care management services of behavioral health conditions for at least 20 minutes of clinical staff time per month.	•	•			•	

Care management (continued)

Self-funded plans have various coverage.

Code	Description	Plans				Providers	
		HMO/POS/ PPO	Medicare	Medicaid	HealthyMI	Physician	Non-physician
G9001*	Coordinated care fee, initial assessment	•	•	•	•		•
G9002*	Coordinated care fee, individual face-to-face visit	•	•	•	•		•
G9007*	Coordinated care fee, scheduled team conference	•	•	•	•	•	
G9008*	Coordinated care fee, scheduled conference, physician oversight service	•	•	•	•	•	
98966*	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent or guardian 5-10 minutes of medical discussion	•	•	•	•		•
98967*	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent or guardian 11-20 minutes of medical discussion	•	•	•	•		•
98968*	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent or guardian 21-30 minutes of medical discussion	•	•	•	•		•
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 place the patient at significant risk of death, acute exacerbation/decompensation or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	•	•			•	

Care management (continued)

Self-funded plans have various coverage.

Code	Description	Plans				Providers	
		HMO/POS/ PPO	Medicare	Medicaid	HealthyMI	Physician	Non-physician
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 place the patient at significant risk of death, acute exacerbation/decompensation or functional decline, establishment or substantial revision of a comprehensive care plan, 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		•	•	•	•	
G0511**	*Rural health clinic (RHC) or federally qualified health center (FQHC) use only.* General care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by a RHC or FQHC practitioner. Once per calendar month.		•			•	•
G0512**	*Rural health clinic (RHC) or federally qualified health center (FQHC) use only.* Psychiatric collaborative care model (CoCM), 60 minutes or more of clinical staff time for psychiatric CoCM services directed by a RHC or FQHC practitioner, including services furnished by a behavioral health care manager and consultation with a psychiatric consultant. Once per calendar month.		•			•	•
99495	Transitional care management: moderate complexity, patient contact within two business days of discharge and face-to-face within 14 calendar days of discharge	•	•	•	•	•	
99496	Transitional care management: high complexity, patient contact within two business days of discharge and a face-to face within seven calendar days of discharge	•	•	•	•	•	

**Code processes without member liability.*

***These codes apply to RHCs and FQHCs only and should be billed on a facility claim (UB) form.*

Tobacco cessation

Code	Description	Plans				Providers	
		HMO/POS/ PPO	Medicare	Medicaid	HealthyMI	Physician	Non-physician
99406	Smoking and tobacco use cessation counseling visit; intermediate Greater than 3 minutes up to 10 minutes	•	•	•	•	•	•
99407	Smoking and tobacco use cessation counseling visit; intensive Greater than 10 minutes	•	•	•	•	•	•
4000F**	Tobacco use cessation intervention, counseling (COPD, CAP, CAD, Asthma) (DM) (PV)					•	
4001F**	Tobacco use cessation intervention, pharmacologic therapy (COPD, CAP, CAD, Asthma) (DM) (PV)					•	
4004F**	Patient screened for tobacco use and has received tobacco cessation intervention (counseling, pharmacotherapy or both) if identified as a tobacco user (PV, CAD)					•	

***Reporting only codes — developed for CMS' PQRS program*

Telephone services, virtual visits and hosted visits

Code	Description	Plans				Providers	
		HMO/POS/ PPO	Medicare	Medicaid	HealthyMI	Physician	Non-physician
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report E&M services provided to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment 5-10 minutes of medical discussion	•	•	•	•	•	•
99442	Telephone services (see above) 11-20 minutes of medical discussion	•	•	•	•	•	•
99443	Telephone services (see above) 21-30 minutes of medical discussion	•	•	•	•	•	•
99444	Online medical evaluation — physician non-face-to-face E&M service to patient, guardian or health care provider not originating from a related E&M service provided within the previous seven days	•	•	•	•	•	•
98966*	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent or guardian 5-10 minutes of medical discussion	•	•	•	•		•

Telephone services, virtual visits and hosted visits (continued)

Code	Description	Plans				Providers	
		HMO/POS/ PPO	Medicare	Medicaid	HealthyMI	Physician	Non-physician
98967*	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent or guardian 11-20 minutes of medical discussion	•	•	•	•		•
98968*	Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent or guardian 21-30 minutes of medical discussion	•	•	•	•		•
98969	Online assessment and management services provided by a Qualified Health Professional	•	•	•	•		•
G0406	Follow-up inpatient consultation, limited, physician typically spends 15 minutes communicating with the patient via telehealth	•	•	•	•	•	•
G0407	Follow-up inpatient consultation, limited, physician typically spends 25 minutes communicating with the patient via telehealth	•	•	•	•	•	•
G0408	Follow-up inpatient consultation, limited, physician typically spends 35 minutes communicating with the patient via telehealth	•	•	•	•	•	•
G0425	Telehealth consultation, emergency department or initial inpatient, physician typically spends 30 minutes communicating with the patient via telehealth	•	•	•	•	•	•
G0426	Telehealth consultation, emergency department or initial inpatient, physician typically spends 50 minutes communicating with the patient via telehealth	•	•	•	•	•	•
G0427	Telehealth consultation, emergency department or initial inpatient, physician typically spends 70 minutes communicating with the patient via telehealth	•	•	•	•	•	•
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth.	•	•			•	
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth.	•	•			•	

Note: *Virtual visits must be fully documented in the member's record by the performing provider. Provider must share documentation with member's primary care provider and/or other plan provider specified by the member.*

Do not report 99444 when using 99339-99340, 99374-99380 for the same communication or for anticoagulation management when reporting 99363, 99364. You must use encrypted or authenticated email for online medical evaluation visits. Standard email is not acceptable since it is not secure, has no "terms of use" or legal disclaimers in place to protect the provider and can easily expose patient PHI including email addresses to unintended third parties. Copayments will apply.

**Code processes without member liability.*

Telemonitoring

Services must include:

- A mechanism for monitoring, tracking and responding to changes in a member's clinical condition
- A mechanism for monitoring weight, blood pressure and pulse daily
- A standard of acceptable parameters for a member's clinical parameters which can be adjusted based upon the member's condition
- A process for physician identification of acceptable and unacceptable parameters for a member's weight, blood pressure and pulse
- Policies and procedures which address how monitoring staff will respond to member values outside of identified parameters
- A process for dealing with defective equipment in a manner that protects the safety of Priority Health members
- A process for notifying the physician of significant changes in the member's clinical signs and symptoms

		Plans				Providers	
Code	**Description**	**HMO/POS/ PPO/EPO**	**Medicare**	**Medicaid**	**HealthyMI**	**Physician**	**Non-physician**
Q3014	Telehealth originating site facility fee — clinic or facility hosting patient	•	•	•	•	**N/A**	**N/A**
Rev 0590[1]	Home health placement and removal of equipment placed for telemonitoring	•	•	•	•	**N/A**	**N/A**
S9110[2]	Telemonitoring of patient in home, per month	•	•	•	•	**N/A**	**N/A**
T5999[3]	Supply not specified — download of smart phone app for telemonitoring	•	•	•	•	**N/A**	**N/A**
T2023[4]	Targeted case management — monthly fee for using the smart phone app	•	•	•	•	**N/A**	**N/A**

[1]Report revenue code only (no CPT), one time only, for combined payment of installation and removal of telemedicine equipment — for home health agency
[2]Report with revenue code 0590 for 1/2 month monitoring — for home health agency
[3]Report with revenue code 0590 for set-up of smart phone application — for home health agency
[4]Report with revenue code 0590 for set-up of smart phone application, second month — for home health agency

Medication Therapy Management (MTM)

	Plans			
Description	**HMO/ POS/PPO**	**Medicare**	**Medicaid**	**HealthyMI**
Service to help members who take multiple medications for several chronic conditions. Pharmacists will consult with the members face-to-face and engage with the providers to resolve drug-related problems and gaps in care such as medication non-adherence, drug interactions and drug duplication.*	•	•		

**Processes without member liability.*
There is no copay, coinsurance, deductible or other out-of-pocket expense for MTM services. The service is available through most large chain and many independent pharmacies. Some accountable care networks have embedded pharmacists in patient centered/advanced medical homes. Pharmacists must contract with Priority Health's vendor, OutcomesMTM, to provide MTM services and receive reimbursement based upon a fee schedule.