Maryland Department of Health
Maryland Primary Care Program
Billing Resource Guide

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September 2019

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Introduction

The goal of this white paper is to provide guidance on the selection of billing codes to help primary care practices achieve the appropriate financial benefits of participation in the Maryland Primary Care Program (MDPCP) while highlighting the Medicare billing codes that are excluded for attributed beneficiaries. The MDPCP provides primary care providers financial incentives in the form of Care Management Fees (CMFs) that effectively replace the Medicare Chronic Care Management Fees (CCMs) that exist outside of the MDPCP. The MDPCP also provides for a Performance Based Incentive Payment and, for Track 2 practices, a Comprehensive Primary Care Payment (CPCP). The details regarding of each of these payments can be found in the Financial Methodology document posted on Connect.

The following document provides MDPCP practices with information on both current and newly approved billing codes that are permitted within the framework of the MDPCP. This document is intended to serve as a summary of the most relevant codes and is not meant to be a comprehensive billing guide. Even as Maryland has created a climate that promotes the movement from volume to value in the delivery of healthcare, so have many insurance payers. The following information highlights movement toward payment for non-face-to-face visits and for various delegated activities within the framework of team-based care.

The MDPCP is an unprecedented opportunity for primary care practices to participate in care transformation that supports the delivery of high quality, advanced primary care throughout the State of Maryland. The Program is focused on improving health outcomes and the overall experience of healthcare for patients and their caregivers, while controlling total healthcare costs. The MDPCP Program Management Office team hope that the information provide herein supports you in that work. Attached to this narrative is a detailed spreadsheet containing the following information: CPT/HCPC II level codes, full CPT/HCPC descriptions, check marks for which codes can be performed via Telemedicine, the required licensure of the rendering provider, and the associated reimbursements for

Medicare, Medicaid and, where applicable, a crosswalk to the commercial payers, including Medicare Advantage plans. The codes are grouped into the following nine sections:

1. **Wellness and Preventive Services:** This code section includes the Medicare benefits for Wellness Visits. There is an initial 'Welcome to Medicare' Wellness Visit (IPPE) which may be reported with a separately billable ECG, followed by initial and subsequent Annual Wellness Visits (AWV). These benefits are limited by timing and frequency. The IPPE is covered once in a beneficiary's lifetime within the first 12 months of Medicare Part B enrollment. The initial AWV is also a once in a lifetime benefit eligible 12 months following the IPPE. Subsequent AWV's are covered every 12 months thereafter. The purpose of these visits is to identify health and social risk factors by means of a review of medical and social histories, screening tests and risk assessments resulting in the referral of treatment and a written personal prevention plan. Depression screening and health risk assessment services that are separately covered by Medicare are not reported on the same day as the AWV. These visits do not include comprehensive routine physical exams (99391-99397). Routine physicals are not covered by Medicare but may be billed to supplementary insurance, Medicare Advantage plans, commercial payers or directly to the patient as their coverage allows. Many Medicare Advantage plans cover the Medicare wellness codes and the routine physicals separately. These codes may be reported on the same day as problem-oriented visits, if performed. Additional AWV billing guidance can be found at:

   https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AWV_Chart_ICN905706.pdf
   https://www.cdc.gov/policy/hst/HRA/FrameworkForHRA.pdf

   A complete interactive tool for all additional preventive services covered by Medicare can be found at:

   https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html

2. **Transitional Care Management (TCM) Services:** This section includes the codes that are reported to obtain significant reimbursement for managing a patient's transition following discharge from an acute care facility. This includes an interactive contact and a face-to-face

visit during the 30 day transition period. Acute care facilities include but are not limited to hospitals, rehabilitation facilities and skilled nursing facilities as the patient is being discharged back to the community setting, e.g., home, domiciliary care, rest home or assisted living. TCM benefits are based on timing and the sequence of services performed and documented. The provider or a clinical staff member must initiate the interactive contact (telephone, email or in person) with the patient or caregiver within two (2) business days following the discharge date. Medication reconciliation should be documented during that communication and/or an attempt made to reconcile medications. Reimbursement levels are based on the timing of the face-to-face visit and the level of medical decision-making. This service may be billed on the date of the face-to-face visit and need not wait until the end of the 30-day transition period. Only one provider may bill the service per patient, and it is excluded from a surgeon's postoperative care (all surgical patients should be followed by their primary care provider). Do not bill for home health care plan oversite during this time period as it will cause the TCM care to deny as "duplicative." Clinical staff under the direction of the provider may furnish additional non-face-to-face services such as:

- Communicate with agencies and community services the beneficiary uses
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living
- Assess and support treatment adherence and medication management
- Identify available community and health resources
- Assist the beneficiary and family in accessing needed care and services

A complete guide to documentation and billing for transitional care service can be found at:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

3. **Complex and Noncomplex Chronic Care Management (CCM):** This section contains the codes that are *excluded* from reporting to Medicare while enrolled in the MDPCP program. However, they are billable to Medicare Advantage and commercial payers. They are not

covered under the Maryland Medicaid program. These codes provide reimbursement for non-face-to-face time spent by clinical staff and/or physicians and QHCPs for managing the care of patients with two or more chronic conditions. These conditions are expected to last at least 12 months and place the patient at significant risk of death, acute exacerbation/decompensation or functional decline. The work includes establishing, implementing, revising or monitoring a comprehensive care plan. The benefit is based on the amount of time accumulated during a calendar month spent on the CCM activities for the patient. The levels of reimbursement correspond to the amount of time spent and the level of complexity of medical decision making. Examples of chronic conditions include but are not limited to the following:

- Alzheimer's disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer Cardiovascular Disease
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Hypertension
- Infectious disease
- Substance abuse

CCM services include INR management, self-management education, telephone assessment and management discussions and other patient care supervision that is often not separately reimbursable. Do not report CCM services in the same calendar month as TCM services. Patient consent is required for billing including informing the patient that only one practitioner can furnish and be paid for the service. Obtaining the patient's signature to consent to the plan of care increases patient compliance. A complete guide to CCM services and additional resources can be found at:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

CareFirst provides significant reimbursement and support to providers in Patient Centered Medical Homes (PCMH) who activate an eligible patient's care plan through the CareFirst Provider Portal.
Additional CareFirst PCMH details can be found at:
https://provider.carefirst.com/carefirst-resources/provider/pdf/pcmh-care-plan-development-pcm1028.pdf

4. **Behavioral Health Intervention/Assessmen**t: This section includes the codes that are used to describe services that are intended to assess factors that may affect the recovery or progression of a diagnosed physical health problem or illness. These procedures identify the psychological and social factors that influence the patient's physical health problem. *The focus is not mental health and should not be reported if the patient has a mental health diagnosis*. *These services are payable under Medicare to a clinical psychologist*. These codes are not to be used by physicians, non-physician providers (NPP) or clinical social workers. Physicians and NPPs should report this type of service with evaluation and management (E/M) codes.
   Additional information regarding these codes can be found at:

   https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/30514_1/l30514_031610_cbg.pdf

5. **Chronic Care Remote Patient Monitoring (RPM)** – This section includes the codes that are used to report non-face-to-face evaluation and management services and health data monitoring. Medicare now covers a 'virtual check-in' which can be a telephone call. Because these services are inherently non face-to-face they are not classified as telehealth services. G2012 is reported to obtain reimbursement for a telephone call to evaluate and manage a patient's condition(s) in lieu of an office visit. G2010 is reported to obtain reimbursement for evaluation of recorded video and/or still images submitted by an established patient (i.e., store and forward), including interpretation and follow-up with the patient. Both codes are payable when the service does not arise from a face-to-face

visit in the last 7 days or results in the need to schedule an office visit at the soonest availability.

There are four (4) additional codes for reimbursement when a physician or other QHCP orders an FDA-defined remote patient monitoring (RPM) device that is used by a patient for the purposes of collecting, monitoring, and reporting health-related data to the provider, including, but not limited to, weight, blood pressure, or pulse oximetry. This technology allows for the gathering of health data from the patient in one location and the electronic transmission of that data to a provider in a different location for review and subsequent recommendations, particularly for patients with ongoing and/or chronic disease processes. Code 99453 reports the work involved in orienting the patient to the RPM process, the initial device set-up, and the patient instruction and training for each episode of care. An episode of care is described as starting at the time the RPM device service begins and is complete when the established treatment goal has been reached. Code 99454 reports the supply of the actual device, including the daily recordings and program alert transmissions for a 30-day period. These codes should not be reported for monitoring if the duration is less than 16 days. Code 99457 is reported to identify time spent managing care when the patient or the practice does not meet requirements for reporting a more specific service. This code may be reported simultaneously with chronic care management, transitional care management, and behavioral health integration services. Time involved in performing this service should remain separate and distinct from other services and does not count toward the required time for both services in a single month. Live and interactive communication with the patient and/or caregiver is required with 20 minutes or more of clinician time per calendar month. Code 99457 should be reported only once per calendar month regardless of the number of physiologic monitoring modalities performed. Medicare has yet to issue guidance on specific types of telecommunications technology, data measurements and time frames for billing purposes and defers to CPT descriptors until further guidance is developed. Additional discussion of these codes can be found at:

https://www.foley.com/en/insights/publications/2018/11/medicareremote-patient-monitoring-reimbursement-fa

6. **Advance Care Planning (ACP):** This section includes the codes that provide reimbursement for time spent discussing advance directives with a patient, family member, or surrogate with or without completing relevant forms. This is a face-to-face visit with a physician or

QHCP. ACP may include discussion of goals and preferences for care, complex medical decision-making regarding life-threatening or life-limiting illness, explanation of relevant advance directives, including (but NOT requiring) completion of advance directives. An advance directive is a document in which a patient appoints an agent and/or records the wishes of a patient pertaining to their medical treatment at a future time if they cannot decide for themselves. This service is not limited to frequency as over time, directives may change or there is a need to engaging family members, and/or surrogate decision makers, as clinical situations arise. The level of benefit is based on the amount of time spent in discussion which should be separately documented. A minimum of 16 minutes must be documented to bill for the first 30 minutes. A minimum of 46 minutes must be documented to bill for an additional 30 minutes. Time may be documented as start and stop time or the total duration. This service may be reported on the same day as the AWV and when covered on that day there is no cost sharing to the patient. If the service is reported alone or on the same day as an E/M service, the patient should be informed that cost sharing will apply. Additional details may be found at:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AdvanceCarePlanning.pdf

7. **Behavioral Health Integration (BHI) Services:** This section includes the three (3) codes that provides separate reimbursement to physicians and NPPs for the BHI services they furnish to beneficiaries over a calendar month service period. There are two (2) models of care under which these services are provided. The first is the Psychiatric Collaborative Care Model (CoCM). Psychiatric collaborative care management services describe care reported by a qualified clinician overseeing a behavioral health care manager and psychiatric consultant who provides a behavioral health assessment, including establishing, starting, revising, or monitoring a plan of care as well as providing brief interventions to a patient diagnosed with a mental health disorder. The psychiatric consultant contracts directly with the qualified clinician to render the consultation portion of the service. Patients are generally referred to a behavioral health care manager for assistance in receiving treatment for newly diagnosed conditions that have been unresponsive to traditional or standard care provided in a non-psychiatric environment or who need additional

examination and evaluation before a referral to a psychiatric care setting. In 99492, the required elements include outreach and engagement, initial patient assessment that involves the administration of a validated rating scale, development of an individual patient care plan, psychiatric consultant review and modifications as needed, input of patient data into a registry and tracking of patient progress and follow up and provision of brief interventions using evidence-based techniques. In 99493, the required elements include tracking patient follow-up and progress via registry, weekly caseload participation with a psychiatric consultant, working together and coordinating with the qualified clinician on a regular basis, additional ongoing review of the patient's progress and recommendations for treatment changes, including medications with the psychiatric consultant, provision of brief interventions with the use of evidence-based techniques, monitoring patient outcomes using validated rating scales and relapse prevention planning. Episodes of care begin when the patient is first directed to the behavioral health care manager and ends when the treatment goals have been reached or the goals were not reached and the patient was referred to another provider for ongoing treatment, or no psychiatric collaborative care management was provided for a period of six consecutive months. These codes do not differentiate between new or established patient status. Report 99492 for 70 minutes of initial psychiatric collaborative care management in the first month; 99493 for 60 minutes of care in a subsequent month; and 99494 for each additional 30 minutes of initial or subsequent care in a calendar month.

General behavioral health integration care management services (99484) are provided face-to-face by clinical staff under the direct supervision of a qualified clinician, to a patient with a diagnosed health care condition including substance abuse issues requiring care management services for a minimum of 20 minutes per month. Specific elements of a treatment plan must be provided and documented, including an initial assessment or follow-up monitoring involving the use of validated rating scales, behavioral health care planning relating to the patient's behavioral or mental health problems with revisions in cases where a patient is not responding to treatment or has a status change, organizing and coordinating all aspects of the patient's mental health care such as therapy, medications, counseling and/or psychiatric consultations and continuing ongoing care in conjunction with

a designated care team member. The clinician does not need to provide a comprehensive assessment and treatment plan nor is it required to have all chronic care management functions documented. The patient may receive these services in any outpatient setting once certain criteria are established, namely that the clinician maintains a relationship with the patient and clinical staff and that the clinical staff be available to provide the patient with face-to-face services.

8. **Screening and Brief Intervention for Referral to Treatment (SBIRT):** This section includes codes reimbursed by Medicare, Medicaid and commercial payers for changing behavior related to substance abuse. SBIRT services are counseling and/or intervention services directed at high-risk behaviors such as alcohol, and substance abuse (tobacco is not included in this section). These services can be reported as treatment of the condition or in relation to the condition that has the potential of causing illness or injury. Additionally, substance abuse screenings, utilizing instruments such as AUDIT and DAST, are used to determine the patient's opinion related to behavior change and provide input on a plan to change behavior with appropriate actions and motivation. These are time-based codes and time spent with the patient must be documented in the medical record separately from time spent performing an E/M service. When documentation supports that a significant, separately identifiable problem-oriented evaluation and management (E/M) service is rendered, the appropriate code for the E/M service may be reported separately. An intervention is performed when indicated by the score with the nature of the intervention recorded. If an intervention is not required on the basis of screening results, the survey may be reported with code 96160 or 96161 or the Medicare alcohol screening code (G0442). There are additional resources at:

   https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SBIRT_Factsheet_ICN904084.pdf

   For CY 2020, Medicare is proposing to add the following codes to the list of telehealth services: HCPCS codes GYYY1, GYYY2, and GYYY3, which describe a bundled episode of care for treatment of opioid use disorders.

9. **Miscellaneous Health Intervention Services:** This section contains miscellaneous CPT and HCPCII codes available for additional wellness services and behavioral screening and intervention services payable under Medicare, Medicaid and commercial payers. This section includes codes for smoking cessation, high risk behavior counseling and screening services that are separately reportable when not included in another service, e.g., depression screening or routine alcohol screening with a negative result.

   Telehealth/Telemedicine Medical Services: Telehealth services are described as the delivery of healthcare services normally provided in a face-to-face setting through the use of real-time, interactive two-way communication technology for the purpose of diagnosis, consultation, and/or treatment of a patient in a location separate from the servicing provider. Telehealth services do not include the use of audio-only telephone, facsimile machine, texting, or electronic mail. Telehealth services include a wide range of evaluation and management services, annual wellness visits, subsequent inpatient care, psychotherapy and substance abuse treatments. Telehealth services are used to support health care when the provider and the patient are physically separated. Typically, the patient communicates with the telehealth provider via interactive means that are sufficient to establish the necessary link to the telehealth provider who is working at a different location ("distant site") from the patient. Telehealth includes a wide range of services including but not limited to office visits, consultations, inpatient follow up care, nursing home visits and some health risk assessments including AWV's and SBIRT services. Medicare reimburses telehealth services when meeting the following criteria:

   - Must be furnished via an interactive telecommunications system
   - Must be furnished by a physician or authorized practitioner
   - Must be furnished to an eligible telehealth individual
   - The individual receiving the service must be located in a telehealth originating site

Beneficiaries are eligible for telehealth services only if they are treated at an originating site located either in a rural health professional shortage areas (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA).

https://mhealthintelligence.com/news/cms-gives-telehealth-a-nudge-with-coverage-for-virtual-check-ins

Health Resources and Services Administration (HRSA) provides a tool to determine the originating site's eligibility

Distant site practitioners payable under Medicare include:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Clinical psychologists (CPs) and clinical social workers (CSWs)
- Registered dietitians or nutrition professional

Commercial payers reimburse telehealth services per individual payer policies. CPT indicates all codes designated as Telemedicine with the preceding star symbol. *All codes that are listed in the attached spreadsheets with a check mark in Telehealth eligible column may be reported as a telehealth service.* Medicare publishes the list of covered codes each year as determined in the MPFS rule. Medicare reimburses a telehealth service at the non-facility fee schedule which is the same rate as the face-to-face service unless the provider assigns payment to a CAH. Medicare does limit the number of telemedicine services eligible for payment during the year. Medicare has eliminated the use of the telemedicine modifier and the service is identified as telehealth by the POS code (02). Physician offices in an eligible area may bill the originating site facility fee with HCPC code Q3014 with POS 11. Commercial payers issue other specific guidance relative to reporting a telehealth service by appending the appropriate (95, GQ, GT or GO as determined by the payer) and by reporting a place of service (POS) code 02 – Telehealth.

Additional Medicare billing and payment guidance including a list of telemedicine procedure codes can be found at:
https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027460

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10883.pdf

Due to wide availability and advances in technology, telemedicine has emerged as a critical health care component that is viewed by many payers as a tool to improve patients' access to timely and cost-effective care. Mandates to health plans governing provision of telemedicine under MD state law are:

- Requires coverage for health services "appropriately" delivered through telemedicine.
- Prohibits an insurer from excluding coverage solely because it is provided through telemedicine and not provided through an in-person consultation or contact between a provider and a patient.
- Prohibits distinguishing between patients in rural or urban locations in providing coverage for services through telemedicine.
- Does not require coverage of telemedicine if the decision is based on a finding that telemedicine is not medically necessary, appropriate, or efficient

Many large health insurers, including CareFirst, provide the software and education to connect their subscribers to their providers care via interactive telecommunication (Video Visits). More information about the CareFirst Telemedicine Program that is available at no charge to PCPs in PCMH practices can be found at:

https://provider.carefirst.com/providers/care-management/telemedicine.page

N.B. There are new codes that may impact this program which CMS will publish before the effective date of January 1, 2020.

Wellness and Preventive Services

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
1. Wellness and Preventive Services								
G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment. **(Welcome to Medicare Visit)**		$ 179.86	$ 189.96	$ 172.76		MD/DO NP/PA	99381-99412
G0403	Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report		$ 18.65	$ 19.91	$ 17.76		MD/DO NP/PA	93000
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	√	$ 185.85	$ 196.50	$ 178.37		MD/DO NP/PA or other Medical Professionals including an RN, Health Educator, RD, other licensed professionals under direct supervision of MD or DO	99381-99412
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	√	$ 126.27	$ 133.99	$ 120.99		MD/DO NP/PA or other Medical Professionals including an RN, Health Educator, RD, other licensed professionals under direct supervision of MD or DO	99381-99412

Wellness and Preventive Services

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
1. Wellness and Preventive Services								
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)	√	$ 69.83	$ 72.91	$ 67.27		MD/DO NP/PA	99381-99412
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)	√	$ 69.83	$ 72.91	$ 67.27		MD/DO NP/PA	99381-99412
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes - May be reported on same day as AWV	√	$ 28.25	$ 29.60	$ 27.21		MD/DO NP/PA	99381-99412

Transitional Care (TCM)

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
2. Transitional Care Management Services (TCM)								
99495	Transitional Care Management Services (TCM) with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge	√	$ 177.78	$ 188.75	$ 170.40	$ 165.88	Clinical Staff + MD/DO NP/PA	
99496	Transitional Care Management Services (TCM) with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge	√	$ 250.82	$ 265.96	$ 240.44	$ 234.84	Clinical Staff + MD/DO NP/PA	

Chronic Care

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
3. Complex and Non-Complex Chronic Care Services (CCM) - These services are excluded from the MDPCP program but may be reported to Medicare Advantage health plans and commercial payers								
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 *****		$ 99.65	$ 106.40	$ 95.29	NC	Clinical Staff under QHCP direction,	
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)		$ 49.83	$ 53.20	$ 47.65	NC	Clinical Staff under QHCP direction	

Chronic Care

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
3. Complex and Non-Complex Chronic Care Services (CCM) - These services are excluded from the MDPCP program but may be reported to Medicare Advantage health plans and commercial payers								
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, 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; comprehensive care plan established, implemented, revised, or monitored		$ 44.88	$ 47.37	$ 43.10	NC	Clinical Staff under QHCP direction	
99491	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, 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; comprehensive care plan established, implemented, revised, or monitored		$ 88.83	$ 93.01	$ 85.65	NC	MD/DO NP/PA	
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service) - Add on code to IPPE, AWV or E/M code when chronic care planning is initiated	√	$ 67.63	$ 71.54	$ 64.88		MD/DO NP/PA	99487-99491

Chronic Care

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
3. Complex and Non-Complex Chronic Care Services (CCM) - These services are excluded from the MDPCP program but may be reported to Medicare Advantage health plans and commercial payers								
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour ǂ		$ 119.94	$124.99	$115.72	NC	MD/DO NP/PA	
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) ǂ		$ 57.89	$ 63.08	$ 55.85	NC	MD/DO NP/PA	
	**In addition to CCM services, CareFirst allows reimbursement for activating a care plan with the payer. S0280 is reimbursed at $200.00 for the activation and S0281 is reimbursed when substantial changes are made to the plan (usually quarterly)*							
	ǂ This non-face to face service for complex care is covered by some payers. Time and activities must be documented separately from the face to face visit.							

Behavioral Health

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
4. Behavioral Health Interventions - Health and behavior assessment and/or intervention services performed by a QHCP other than a clinical psychologist must be reported with the appropriate Evaluation and Management (E/M) codes.								
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	√	$ 27.86	$ 29.17	$ 26.84		MD/DO NP/PA or RD's under Incident to	99401
96150	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	√	$ 24.50	$ 25.38	$ 23.80	$ 28.98	Clinical Psychologist	
96151	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment	√	$ 24.23	$ 25.09	$ 23.46	$ 27.25	Clinical Psychologist	
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	√	$ 22.23	$ 23.01	$ 21.60		Clinical Psychologist	
96153	Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)	√	$ 5.34	$ 5.52	$ 5.14	NC	Clinical Psychologist	
96154	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)	√	$ 21.86	$ 22.63	21.24	NC	Clinical Psychologist	

Technology Based Services and Remote Patient Monitoring (RPM)

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
5. Technology Based Services and Remote Patient Monitoring (RPM)								
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., **store and forward**), including interpretation, with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment		$ 13.42	$ 14.81	$ 12.81		MD/DO NP/PA	
G2012	Brief communication technology-based service, e.g. **"virtual check-in"** by a physician or other qualified health care professional who can report evaluation and management E/M services provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; **5-10 minutes of medical discussion**		$ 15.68	$ 16.40	$ 15.08		MD/DO NP/PA	99441
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment		$ 21.38	$ 23.47	$ 20.12	NC	MD/DO NP/PA	

Technology Based Services and Remote Patient Monitoring (RPM)

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
5. Technology Based Services and Remote Patient Monitoring (RPM)								
99454	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days		$ 70.32	$ 77.32	$ 66.28	NC	MD/DO NP/PA	
99457	Remote physiologic monitoring treatment management services, **20 minutes or more** of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month *****		$ 55.14	$ 58.66	$ 52.78	NC	MD/DO NP/PA	
	*******The MPFS rule - CPT Code 99457 describes only professional time and "therefore cannot be furnished by auxiliary personnel incident to a practitioner's professional services."*							
99091	Collection and interpretation of physiologic data (e.g., 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		$ 61.58	$ 64.15	$ 59.48	NC	MD/DO NP/PA	

Advance Care (ACP)

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
6. Advance Care Planning (ACP)								
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 member(s), and/or surrogate	√	$ 91.54	$ 95.78	$ 88.23	NC	MD/DO NP/PA	
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)	√	$ 80.28	$ 83.74	$ 77.50	NC	MD/DO NP/PA	

Behavioral Health Integration (BHI)/Collaborative Care

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
7. Behavioral Health Integration (BHI)/Collaborative Care Services								
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar 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, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of 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 appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies		$ 173.96	$ 185.84	$162.18	$ 161.28	PCP, Health Care Manager, NP, PA, LCSW, including Medical Assistant under PCP	

Behavioral Health Integration (BHI)/Collaborative Care

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
7. Behavioral Health Integration (BHI)/Collaborative Care Services								
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent 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, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; 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; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; 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.		$ 138.42	$ 147.28	$132.50	$ 128.88	PCP, Health care manager, NP, PA, LCSW, including MA under PCP	
99494	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 directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure).		$ 71.63	$ 76.15	$ 68.62	$ 66.60	PCP, NP, PA, LCSW, including MA under PCP	

Behavioral Health Integration (BHI)/Collaborative Care

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
7. Behavioral Health Integration (BHI)/Collaborative Care Services								
99484	BHI- Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with 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, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team *		$ 51.98	$ 55.19	$ 49.80	$ 32.76	PCP, Health Care Manager, NP, PA, LCSW, including Medical Assistant under PCP	
	*This code is reported for behavioral health management outside of the CoCM model where there is not a formal team manager.							

SBIRT

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
8. Screening, Brief Intervention, and Referral to Treatment (SBIRT).								
G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST) and brief intervention. **5-14 minutes**		$ 17.84	$ 18.55	$ 17.25		MD/DO NP/PA, LCSW, Clinical Psychologist	
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes	√	$ 38.53	$ 40.21	$ 37.13		MD/DO NP/PA, LCSW, Clinical Psychologist	99408
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g. AUDIT, DAST), and intervention, greater than **30 minutes**	√	$ 71.86	$ 74.76	$ 69.40		MD/DO NP/PA, LCSW, Clinical Psychologist	99409
G0443	Brief face-to-face behavioral counseling for alcohol misuse, **15 minutes**	√	$ 28.25	$ 29.60	$ 27.21		MD/DO NP/PA, LCSW, Clinical Psychologist	Add time to E/M
G0442	Annual alcohol misuse screening, **15 minutes**	√	$ 19.73	$ 21.13	$ 18.85		MD/DO NP/PA, LCSW, Clinical Psychologist	99408
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; **15 to 30 minutes.**	√					MD/DO NP/PA/ LCSW/ Clinical Psychologist	
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; **greater than 30 minutes**	√					MD/DO NP/PA/ LCSW/ Clinical Psychologist	
W7000	Alcohol and/or substance (other than tobacco) use disorder screening; self-administered		NA	NA	NA	$ 5.14	MD/DO NP/PA/ LCSW/ Clinical Psychologist	NA

SBIRT

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
8. Screening, Brief Intervention, and Referral to Treatment (SBIRT).								
W7010	Alcohol and/or substance (other than tobacco) use disorder screening; provider-administered structured screening (e.g., AUDIT, DAST)		NA	NA	NA	$ 17.13	MD/DO NP/PA/ LCSW/ Clinical Psychologist	NA
W7020	Alcohol and/or substance (other than tobacco) use disorder intervention; greater **than 3 minutes up to 10 minutes**		NA	NA	NA	$ 5.71	MD/DO NP/PA/ LCSW/ Clinical Psychologist	NA
W7021	Alcohol and/or substance (other than tobacco) use disorder intervention; **greater than 10 minutes up to 20 minutes**		NA	NA	NA	$ 11.42	MD/DO NP/PA/ LCSW/ Clinical Psychologist	NA
W7022	Alcohol and/or substance (other than tobacco) use disorder intervention**; greater than 20 minutes**		NA	NA	NA	$ 22.36	MD/DO NP/PA/ LCSW/ Clinical Psychologist	NA

Miscellaneous Health

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
9. Miscellaneous Health Intervention Services								
G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (ldct) (service is for eligibility determination and shared decision making) Can be billed in addition to AW services and/or E/M service	√	$ 30.83	$ 32.24	$29.76	$ 30.13	MD/DO NP/PA	99401
G0444	Annual depression screening, 15 minutes	√	$ 19.73	$ 21.13	$18.85		MD/DO NP/PA LCSW, RN may do screening	96127
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	√	$ 29.83	$ 31.34	$ 27.70		MD/DO NP/PA	99402
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	√	$ 16.10	$ 16.90	$ 15.46	$ 15.48	MD/DO NP/PA	
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	√	$ 30.56	$ 31.94	$ 29.42	$ 28.02	MD/DO NP/PA	
96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument	√	$ 3.55	$ 3.91	$ 3.85	$ 4.06	Can be administered by auxiliary staff	
96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	√	$ 3.55	$ 3.91	$ 3.35	$ 4.06	Can be administered by auxiliary staff	

Miscellaneous Health

Code	Description	Telehealth Eligible	Maryland Jurisdictions			MD Medicaid Fee	Licensure of Rendering Provider	Commercial Payers Crosswalk
			Baltimore Counties	DC Suburbs	Rest of MD			
9. Miscellaneous Health Intervention Services								
96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument		$ 5.99	$ 6.53	$ 5.60	$ 4.71	Can be administered by auxiliary staff	

Telehealth/Telemedicine Medical Services
Modifiers and Place of Service Codes

Telehealth/Telemedicine Medical Services: Telehealth services are described as the delivery of healthcare services normally provided in a face-to-face setting through the use of real-time, interactive two-way communication technology for the purpose of diagnosis, consultation, and/or treatment of a patient in a location separate from the servicing provider. Telehealth services do not include the use of audio-only telephone, facsimile machine, texting, or electronic mail. Telehealth services include a wide range of evaluation and management services, annual wellness visits, subsequent inpatient care, and psychotherapy and substance abuse treatments. Telehealth services are used to support health care when the provider and the patient are physically separated. Typically, the patient communicates with the telehealth provider via interactive means that are sufficient to establish the necessary link to the telehealth provider who is working at a different location ("distant site") from the patient. Telehealth includes a wide range of services including but not limited to office visits, consultations, inpatient follow up care, nursing home visits and some health risk assessments including AWV and SBIRT services. Medicare reimburses telehealth services when meeting the following criteria:

- Must be furnished via an interactive telecommunications system
- Must be furnished by a physician or authorized practitioner
- Must be furnished to an eligible telehealth individual
- The individual receiving the service must be located in a telehealth originating site

Beneficiaries are eligible for telehealth services only if they are treated at an originating site located either in a rural health professional shortage areas (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA).

https://mhealthintelligence.com/news/cms-gives-telehealth-a-nudge-with-coverage-for-virtual-check- ins

Health Resources and Services Administration (HRSA) provides a tool to determine the originating site's eligibility

Distant site practitioners payable under Medicare include:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Clinical psychologists (CPs) and clinical social workers (CSWs)
- Registered dietitians or nutrition professional

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Commercial payers reimburse telehealth services per individual payer policies. CPT indicates all codes designated as Telemedicine with the preceding star symbol. *All codes that are listed in the attached spreadsheets with a check mark in Telehealth eligible column may be reported as a telehealth service*. Medicare publishes the list of covered codes each year as determined in the MPFS rule. Medicare reimburses a telehealth service at the non-facility fee schedule which is the same rate as the face-to-face service unless the provider assigns payment to a CAH. Medicare does limit the number of telemedicine services eligible for payment during the year. Medicare has eliminated the use of the telemedicine modifier and the service is identified as telehealth by the POS code (02). Physician offices in an eligible area may bill the originating site facility fee with HCPC code Q3014 with POS 11. Commercial payers issue other specific guidance relative to reporting a telehealth service by appending the appropriate (95, GQ, GT or GO as determined by the payer) and by reporting a place of service (POS) code 02 – Telehealth.

Additional Medicare billing and payment guidance including a list of telemedicine procedure codes can be found at:
https://www.novitas- solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027460

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