Integrated Healthcare Services

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1 General Information

All underlined words contained in this document should serve as hyperlinks to the appropriate internet resource. Email dmhfmedicalpolicy@utah.gov if any of the links do not function properly, noting the specific link that is not working and the page number where the link is found.

For general information regarding Utah Medicaid, refer to Section I: General Information, Chapter 1, General Information.

2 Health Plans

Information specific to Managed Care Entities can be found in Section I: General Information, Chapter 2, *Managed Care Entities*.

Refer to Section I: General Information Chapter 1-7, Fee-for-Service and Managed Care for information regarding how to verify if a Medicaid member is enrolled in managed care.

3 Provider Participation and Requirements

To enroll as a Medicaid Home Health Provider refer to Section I: General Information Chapter 3, Provider Participation and Requirements.

4 Record Keeping

Refer to Section I: General Information, Chapter 4, *Record Keeping*.

5 Provider Sanctions

Refer to Section I: General Information, Chapter 5, *Provider Sanctions*.

6 Member Eligibility

It is the responsibility of the provider to verify the member's eligibility prior to every rendered service. For additional information regarding member eligibility refer to Section I: General Information Chapter 6, Member Eligibility.

7 Member Responsibilities

For information on member responsibilities including establishing eligibility and co-payment.

8 Program Coverage

8-1 Definitions

Advanced Care Planning (ACP) a form of integrated healthcare that empowers members to make informed decisions about healthcare preferences and end-of-life care. By facilitating discussions and documenting preferences in advance, healthcare providers can honor members' wishes and ensure care aligns with their values and goals.

Behavioral health care manager (BHCM) - A designated provider with formal education or specialized training in behavioral health (including social work, counseling, nursing, or psychology), working under the oversight and direction of the treating provider.

Behavioral Health Integration (BHI) - a form of integrated healthcare that addresses a member's medical and behavioral health needs, reducing stigma and ensuring holistic care. BHI recognizes the intricate connection between behavioral and physical health.

Chronic Care Management (CCM) – a form of integrated healthcare that focuses on providing continuous, coordinated care for individuals with persistent conditions. By proactively managing a member's health and medical conditions such as diabetes, hypertension, and asthma, providers can establish treatment plans that lead to the prevention of exacerbations and complications, ultimately improving the member's quality of life.

Clinical Staff - are healthcare employees who work under the supervision of a physician or other QHP to perform, or assist in the performance of, a specified professional medical service as allowed by law, regulation, and facility policy. These individuals do not bill the professional service.

Health Behavior Assessments and Interventions (HBAI) a form of integrated healthcare that identifies and addresses the psychological, behavioral, emotional, cognitive, and interpersonal factors critical to the assessment, treatment, or management of specific physical disease-related problems.

Mental health therapist - As defined in the Mental Health Professional Practice Act, Utah Code 58-60-1-102

Nurse practitioner – As defined in the Nurse Practice Act, Utah Code 58-31b.

Physician assistant- As defined in the Physician Assistant Practice Act, Utah Code 58-70a.

Principal Care Management (PCM) - A form of integrated healthcare that delivers care management for members with a single chronic condition or with multiple chronic conditions but focuses on a single high-risk condition.

Psychiatric consultant - A medical provider trained in psychiatry and qualified to prescribe a full range of medications.

Qualified Healthcare Professional (QHP) – An individual who is qualified by education, training, licensure and regulation who performs a professional medical service within their scope of practice and is enrolled with Medicaid as a provider. Medicaid will only reimburse covered services performed by a QHP as indicated in the PRISM Coverage and Reimbursement Code Lookup for their specific provider enrollment type.

Social Determinant of Health (SDOH) - Are the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age. These forces and systems include a wide set of forces and systems that shape daily life such as economic policies and systems, development agendas, social norms, social policies, and political systems.

The Collaborative Care Model (CoCM) - A form of integrated healthcare that fosters collaboration between primary care providers, behavioral health specialists, and care managers. This team-based approach ensures that members receive comprehensive support tailored to their distinct circumstances, leading to more effective management of complex health conditions.

Transitional Care Management a form of integrated healthcare that facilitates smooth transitions between different healthcare settings, such as hospitals, nursing facilities, and home care. By coordinating follow-up care and providing support during critical transitions, members experience fewer gaps in care and have a reduced risk of readmission.

Treating provider - A physician or non-physician provider (NPP) who is typically a primary care provider but may be of another specialty.

8-2 Integrated Healthcare and Care Management

Integrated Healthcare is a comprehensive approach designed to prioritize the well-being of individuals by integrating various aspects of healthcare to meet their diverse needs. At its core, integrated healthcare aims to enhance member outcomes, improve access to quality care, and promote cost-effective strategies within the Medicaid population.

Included within the umbrella of integrated healthcare are various approaches to the management of each member's unique medical needs. These strategies include:

- **Chronic Care Management (CCM)** focuses on providing continuous coordinated care for individuals with persistent conditions. By proactively managing a member's health and medical conditions such as diabetes, hypertension, and asthma, providers can establish treatment plans that lead to the prevention of exacerbations and complications, ultimately improving the member's quality of life.
- **Principal Care Management (PCM)** services provide care for a single chronic condition or individuals with multiple chronic conditions but focuses on a single high-risk condition.
- **Behavioral Health Integration (BHI)** recognizes the intricate connection between behavioral and physical health. Through BHI, members have access to integrated services that address both their medical and behavioral health needs, reducing stigma and ensuring holistic care.
- **The Psychiatric Collaborative Care Model (CoCM)** strengthens integrated healthcare and BHI by fostering collaboration between primary care providers, behavioral health specialists, and care managers. This team-based approach ensures that members receive comprehensive support tailored to their distinct circumstances, leading to more effective management of complex health conditions.
- **Health Behavior Assessments and Interventions (HBAI)** identifies and addresses the psychological, behavioral, emotional, cognitive, and interpersonal factors critical to the assessment, treatment, or management of specific physical disease-related problems.
- **Transitional Care Management** plays a vital role in integrated healthcare by facilitating smooth transitions between different healthcare settings, such as hospitals, nursing facilities, and home care. By coordinating follow-up care and providing support during critical transitions, members experience fewer gaps in care and have a reduced risk of readmission.
- **Advanced Care Planning (ACP)** is also integral to integrated healthcare, empowering members to make informed decisions about their healthcare preferences and end-of-life care. By facilitating discussions and documenting preferences in advance, healthcare providers can honor a members' wishes and ensure care aligns with their values and goals.

Integrated healthcare encompasses all components of healthcare, including preventive services, care coordination, member education, and community resources. By prioritizing a member's needs and leveraging a collaborative, multidisciplinary approach, integrated healthcare can enhance the overall health and well-being of Medicaid members.

This manual serves as a resource for understanding how to report (code and bill) time and resources utilized as a part of integrated healthcare. The subsequent chapters of this manual will further outline the Medicaid recognized care models and offer guidance toward best practices for reporting and to help ensure payment for time and care provided to Medicaid members.

Many of these services are eligible to be performed via telehealth when clinically appropriate and the medical needs of the member can be met. Providers are responsible for ensuring that each service meets the Medicaid policy requirements for telehealth services prior to rendering the service. Additional information related to the coverage of telehealth services can be found in Chapter 8-4.2 Telehealth of the Section I: General Information provider manual.

The specific requirements for coverage of services, limitations, non-covered services, prior authorizations, supporting documentation, and reporting are outlined in each chapter based on the care model. Please refer to related chapters for specific policies.

It should be noted that each of these services is timed based and have time thresholds that must be met prior to a provider being able to bill for them. The time and resources of administrative and clerical staff cannot be included as part of the care team reporting requirements and should not be considered when determining time thresholds for billing.

8-3 Chronic Care Management

Chronic Care Management (CCM) is a primary care service that contributes to improved outcomes within healthcare. Medicaid covers CCM services for members with multiple chronic conditions. The elements required as a part of CCM include:

- Structured recording of member health information using electronic health record (EHR).
    - member demographics
    - problems
    - assessment of physical and behavioral health needs
    - medications
    - allergies
- Developing and maintaining comprehensive care plans
    - create, revise, or monitor the member-centered care plan based on physical, mental, cognitive, psychosocial, functional, environmental, and social determinants of health.
- Member education or motivational counseling.
- Manage care transitions between healthcare providers and clinical settings.
    - This includes referrals to other clinicians, follow-up care after an emergency department visit, and discharges from hospitals, skilled nursing facilities, or other health care facilities.
- Coordination of community-based services as needed based on assessment and care plan.
- Coordinating and sharing member health information promptly within and outside of the primary provider's practice.

CCM services provide members with a clear and simplified pathway to access their primary care providers (PCPs) or the clinical staff to address their chronic condition(s). These services offer continuity of care with a designated provider or member of the care team with whom the member may schedule successive routine appointments.

The goal of CCM is to empower members to better manage their health and work towards improved quality of life. By developing a comprehensive care plan, CCM supports member

health goals, presents pathways for ongoing communication and support between visits, and provides the member with resources, community services, and other educational information.

8-3.1 Provider Participation

Providers wanting to furnish CCM services must meet certain criteria to report and bill for this service. This criterion includes:

- The ability to provide continuity of care with the same provider or another member of the care team, with which the member can successfully schedule routine appointments.
- Utilize an EHR capable of exchanging health information with other providers.
- The ability to deliver comprehensive care management, including:
    - Manage care between different specialty providers and settings.
    - Exchange and receive medical records promptly with relevant providers and within federal regulations and guidelines to ensure thorough member care.
    - Offer pathways for members to communicate their care needs through phone, messaging, member portals, emails, or other asynchronous non-face-to-face methods.
        - Providers are responsible for ensuring all forms of communication are compliant with all privacy and security regulatory requirements.
- Obtain and maintain the member's consent in the medical record. The consent must:
    - Acknowledge that CCM services are available and the member's willingness to engage in CCM.
    - Indicate that the member may discontinue participation of CCM services at any time.
        - Termination of CCM services is effective at the end of the calendar month in which it was ended (i.e., providers can still report CCM services delivered for that month).
    - Document if the member accepted or declined CCM services.

Members need only provide informed consent for CCM services once, unless they switch to a different CCM provider. Acquiring consent helps to ensure member engagement and prevent duplicate billing by another provider.

8-3.2 Eligible Members

Members eligible for CCM services must have multiple (two or more) chronic conditions expected to last at least 12 months. These chronic conditions may place the member at a significant risk of death, have acute exacerbation or decompensation, or result in a functional decline and a decreased quality of life. Examples of chronic conditions include, but are not limited to:

- Alzheimer's disease and related dementias (AD/ADRD)
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Behavioral health conditions
- Cancer
- Cardiovascular disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Intellectual and developmental disabilities (IDDs) or developmental delays
- Diabetes
- Hypertension
- Infectious diseases like HIV and AIDS

The services provided under CCM apply to complex and non-complex chronic medical conditions.

8-3.3 Initiating Visit

Prior to initiating CCM services, an initial visit with the provider must occur. This visit is for members that have not participated in CCM before or who have not been seen for one year. An initial visit can occur during a comprehensive face-to-face Evaluation and Management (E/M) visit, Annual Wellness Visit (AWV), or Initial Preventive Physical Exam (IPPE). If the practitioner does not discuss CCM and receive member acceptance of CCM services, the provider may not begin billing for CCM services.

8-3.4 Comprehensive Care Plan

A comprehensive care plan is member-centered and based on the member's status of physical, mental, cognitive, psychosocial, functional, and social determinants of health. It should support the care and improvement of the member's identified health issues and focus on managing their chronic conditions and addressing social determinants of health.

Elements of a comprehensive care plan typically include:

- A problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medication management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources, practitioners, and providers
- Periodic review of the care plan with revision as needed

8-3.5 Coding and Billing CCM Services

CCM services are typically billed by the PCP, but some specialty providers may furnish and report these services. CCM services are not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists. CCM providers may, however, refer or consult with these practitioners to coordinate and manage a member's care.

CCM services are not typically face-to-face. CCM services require a minimum of 20 minutes of time spent furnishing the service before it can be billed.

Complex CCM and prolonged E/M services are not reportable in the same calendar month.

If a provider does not perform an initiating visit, they cannot report CCM services.

8-3.5.1 Clinical Staff

Clinical staff are employees who do not individually report their services. Clinical staff includes medical assistants, licensed practical nurses, registered nurses, and others. CCM codes describing clinical staff activities are provided under the overall direction and control of the PCP. Medicaid does not require the provider's physical presence while clinical staff deliver a service.

8-3.5.2 Complex and Non-complex CCM

Complex CCM services require and include moderate to high complexity medical decision-making by the treating provider. These services are directly delivered by the provider

Complex CCM billing requires:

- Two or more chronic conditions, expected to last at least 12 months, that place the member at significant risk of death or significant harm
- At least one of the chronic conditions has a history of ongoing severe exacerbation or decompensation, functional decline, or side effects of treatment, and
- The establishment of a comprehensive care plan or substantially revised.

Non-complex CCM may be provided by clinical staff under the supervision of the provider. For the purposes of CCM, the supervision is done under the providers overall direction and control, which does not require they be directly present while services are being delivered. These services are subject to applicable state law, licensure, and scope of practice parameters.

These services may not require the same level of medical decision making or meet all the requirements to be considered complex.

Non-complex CCM billing requires:

- Two or more chronic conditions expected to last at least 12 months that place the member at significant risk of death, acute exacerbation or decompensation, or functional decline, and
- The comprehensive care plan is already established and does not require ongoing significant changes.

8-3.5.3 Time

Time spent during the initial visit discussing CCM during an E/M, AWV, or IPPE cannot be counted towards the monthly time requirements for reporting CCM services. Providers must not count time and effort towards CCM to support the reporting of other codes. An example of this would be the review of diagnostic results that have a professional component.

Most time spent towards CCM will be non-face-to-face, however, face-to-face time may still count the activity as reportable time.

When counting time spent related to CCM services, the following actions are included in addition to those previously mentioned:

- Management of chronic conditions
- Management of referrals to other providers
- Management of prescriptions
- Ongoing review of member status

Non-complex CCM requires at least 20 minutes of clinical staff or provider time per calendar month spent on non-face-to-face CCM services.

Complex CCM services provided by a PCP require at least 30 minutes of personal time spent in care management activities.

CCM CPT codes are time-based codes and total time spent performing care management services during the calendar month must be documented in the member record. Failure to document time

spent performing CCM and what the activities were related to may result in denial of coverage for reported services, even when those services have been previously reimbursed.

Do not report CCM codes if all elements listed in the code description are not met.

When a provider performs face-to-face E/M visits in the same calendar month as CCM services, the services may be reported separately. The time of the clinical staff on the date the E/M was performed cannot be counted towards the CCM service time.

Time counted toward CCM service codes cannot be applied towards any other billed code.

CCM codes may be reported by the same providers for services furnished during the 30-day Transitional Care Management service period. See the transitional care management chapter for more information.

CCM services cannot be reported during the same service period by the same provider as certain end stage renal disease (ESRD) services. These include CPT codes 90951–90970.

Table 1 – Chronic Care Management Coding Tool

	CPT Code	Performed by		Time Requirements	Coding Note and Limitation
		Provider	Clinical Staff		
Non-Complex CCM	99490	X	X	first 20 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month. • Cannot report if less than 20 minutes are utilized.
	99439	X	X	each additional 20 minutes	• Time spent by billing provider is counted when 99491 is not billed in the same month. • Limited to 2 units per month. • Report in conjunction with 99490.
	99487	X	X	first 60-89 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month
	99489	X	X	each additional 30 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month
Complex CCM	99491	X		first 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Cannot report in same month as non-complex CCM codes. • Limited to 1 unit per month • Cannot report if less than 30 minutes are utilized.
	99437	X		each additional 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Reported in addition to 99491 when time threshold is met. • Cannot be reported without 99491. • Limited to 2 units per month

8-4 Principal Care Management

Principal Care Management (PCM) services are designed to furnish CCM services for members with a single chronic or with multiple chronic conditions but is focused on a single high-risk condition. In either case, the condition must be a high-risk condition. A high-risk condition is a

medical condition places the member at significant risk of hospitalization, nursing home placement, acute exacerbation or decompensation, functional decline, or death

PCM services may be expected to last at least three months or until the member's death. This differs from CCM in that the single high-risk condition must be expected to last at least three months instead of six.

PCM services are reported with separate CPT codes from other CCM services. Other than the distinction of only requiring management of a single chronic condition, PCM services have all the same policy requirements as CCM services.

Table 2 – Principal Care Management Coding Tool

	CPT Code	Performed by		Time Requirements	Coding Note and Limitation
		Provider	Clinical Staff		
Non-Complex PCM	99426	X	X	first 30 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99424 is not billed in the same month. • Limited to 1 unit per month. • Cannot report if less than 30 minutes are utilized. • Cannot be reported in the same month as CCM codes.
	99427	X	X	each additional 30 minutes	• Limited to 2 units per month. • Report in conjunction with 99426.
Complex PCM	99424	X		first 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Cannot report in same month as non-complex PCM codes. • Limited to 1 unit per month • Cannot report if less than 30 minutes are utilized. • Cannot be reported in the same months as CCM codes.
	99425	X		each additional 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Reported in addition to 99424 when time threshold is met. • Cannot be reported without 99424. • Limited to 2 units per month

8-5 Diabetes Prevention

Medicaid encourages providers to screen and refer members to the evidence-based diabetes prevention programs (DPPs) recognized by the Centers for Disease Control and Prevention (CDC) when the member is found to be at risk for the development of type 2 diabetes.

DPP services include behavioral counseling and lifestyle-change programs which are proven effective when delivered to prediabetic members at high risk for developing type 2 diabetes, specifically those with minimal physical activity, obesity, and genetic predisposition. Intensive behavioral counseling includes care management, lifestyle coaching, the facilitation of a peer support group, and the provision of clinically validated educational lessons based on a standardized curriculum focused on nutrition, exercise, stress, and weight management while allowing care plan oversight by a trained provider.

DPP services must be performed by trained lifestyle coaches who have completed a nationally recognized training program. Lifestyle coaches must be available to interact with the participants.

For a member to be considered eligible for coverage of these services, they must meet the following requirements:

- Receive DPP from a CDC-recognized diabetes prevention lifestyle change program
- Must be:
    - 18 years of age or older
    - Overweight – BMI of 25 or higher
    - Not diagnosed with diabetes type 1 or 2
    - Not currently pregnant
- Have at least one of the following:
    - A blood test result in the prediabetes range within the past year (includes any of these tests and results):
        - Hemoglobin A1C: 5.7–6.4%.
        - Fasting plasma glucose: 110–125 mg/dL.
        - 2-hour plasma glucose (after a 75 g glucose load): 140–199 mg/dL.
        - Previously diagnosed with gestational diabetes or high-risk results on prediabetes risk test
        - A score of 5 or higher on the CDC Prediabetes Risk Test

8-6 Diabetes Self-Management

Diabetes self-management training is a covered service when delivered by diabetes self-management programs.

Diabetic self-management training services are limited to an initial ten (10) sessions per year and must be provided through a:

- Nationally recognized *American Diabetes Association* (ADA) certified diabetes educator, or
- An educator certified by the *American Association of Diabetes Educators* (AADE)

Note: This program does not cover self-management training for the sole use of glucose monitoring or nutritional counseling.

For additional policies related to this service, refer to *Utah Administrative Code* R414-90 Diabetes Self-Management Training.

8-7 Behavioral Health Integration

Behavioral Health Integration (BHI) is a type of care management service that integrates behavioral health care services with primary care services, which are often detected and treated in a primary care setting. BHI recognizes there is an intricate connection between behavioral and physical health, because of this, providers may utilize resources to combine mental health and substance use services as a part of the primary healthcare setting. This approach ensures that members receive comprehensive care for both their physical, mental, and emotional well-being in one place.

The BHI care model involves collaboration between healthcare providers and establishes a care team dedicated towards the overall wellbeing of the member. There are two ways to perform BHI:

- General BHI services, and
- Psychiatric collaborative care model (CoCM)

For general BHI, the care team includes the treating provider, clinical staff, and the member. Under the psychiatric collaborative care model (CoCM) the care team consists of a treating provider, behavior health care manager, psychiatric consultant, and the member.

Providers can identify members that may benefit from BHI services by recognizing those individuals with behavioral health conditions that, in the clinical judgment of the provider, warrant further assessment and treatment.

Eligible conditions for BHI services are any behavioral health condition, pre-existing or newly diagnosed that are treated by the provider.

Some examples of conditions that may benefit from BHI are listed below. These conditions serve as examples; however, the list is not comprehensive.

- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Developmental Disorders
- Bipolar Disorder
- Depression and Anxiety Disorders
- Eating Disorders
- Post-Traumatic Stress Disorder (PTSD)
- Substance Use Disorders
- Suicidal Ideation
- Trauma-Related Disorders

8-7.1 Initiating Visit

An initiating visit is required for new members or members not seen within a year prior to the onset of BHI services. This initial visit establishes the member's relationship with the treating provider and allows the provider the opportunity to conduct a baseline assessment prior to initiating BHI services.

8-8 General BHI Services

General BHI services require a member to have a diagnosis of a behavioral health condition. General BHI is used to report time and resources used by a provider and their staff that go beyond the standard office visit.

8-8.1 Provider Participation

Medicaid has outlined the requirements that must be met for providers seeking coverage of general BHI services. These include:

- The member has a diagnosis of a behavioral health condition requiring care management.
- An initial assessment or follow-up monitoring including the use of applicable validated rating scales.
  - The reporting provider must furnish the initial evaluation and management service.
- Behavior health care planning in relation to behavioral or other psychiatric health conditions, including timely revisions for members who are not progressing or whose status changes.
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, or psychiatric consultation.
- Continuity of care with a designated member of the care team.
  - This will primarily be with the clinical staff but can be the treating provider.

The clinician is not required to provide a comprehensive assessment and treatment plan for the behavioral health condition, rather this is the responsibility of the treating provider. The provider is not required to address all chronic care management functions for a member with multiple comorbidities.

8-8.2 Documentation

General BHI is a time-based service. As such, providers and clinical staff are required to document the amount of time spent performing various functions related to the service to receive coverage of the service. Documentation that does not support the time spent performing these functions does not support the reporting of this service for reimbursement.

8-8.3 Eligible Members

The provider may deliver general BHI services to members who have a behavioral health diagnosis.

8-8.4 Coding and Billing General Behavioral Health Integration

Coding of general BHI is recorded using CPT code 99484. This code represents the time spent by clinical staff coordinating a member's behavioral health care plan. For a provider to code for general BHI services they must meet all the requirements outlined within the *General BHI* chapter and the code description. For a full description of CPT code 99484 please see the table listed at the end of this manual.

As a time-based service, providers count the time spent by clinical staff performing BHI related functions. General BHI requires a minimum of 20 minutes spent towards performing functions of the service in a calendar month before it can be considered as reportable. Time spent by the treating provider can be applied towards meeting the time threshold of this service if that time is not counted towards another service.

Billing of general BHI is limited to:

- Meeting the general BHI criteria
- 1 unit per calendar month, and
- Cannot be reported in the same month as Psychiatric collaborative care (CoCM).

The following services are separately reportable on the same day or calendar month as general BHI services:

- Preventive services
- Evaluation and management (E/M)
- Chronic care management (CCM)
- Principal care management (PCM)
- Psychotherapy services
- Transitional care management
- Advanced care planning (ACP)

8-9 Psychiatric Collaborative Care Model

When providers have determined that general BHI services will not meet the behavioral needs of the member, they may determine that psychiatric collaborative care model (CoCM) is an appropriate care management methodology. As a type of BHI, CoCM continues to address

members' behavioral health needs along with physical health needs, however, these needs may require additional resources not provided through general BHI.

Medicaid covers CoCM when all the criteria policies have been met, including those outlined throughout this manual. CoCM services are available to providers to report in order to receive reimbursement for time and resources spent on the management of members with eligible conditions.

Member consent for CoCM services is required in order to be considered for coverage, which can be given in writing or verbally. In either case, providers must document that consent was obtained in the member's medical record. The consent enables the provider to consult with relevant specialists and care team members including the psychiatric consultant.

Psychiatric CoCM typically is provided by a primary care team consisting of a primary care provider and a care manager who works in collaboration with a psychiatric consultant, such as a psychiatrist. Care is directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of members and to make treatment recommendations.

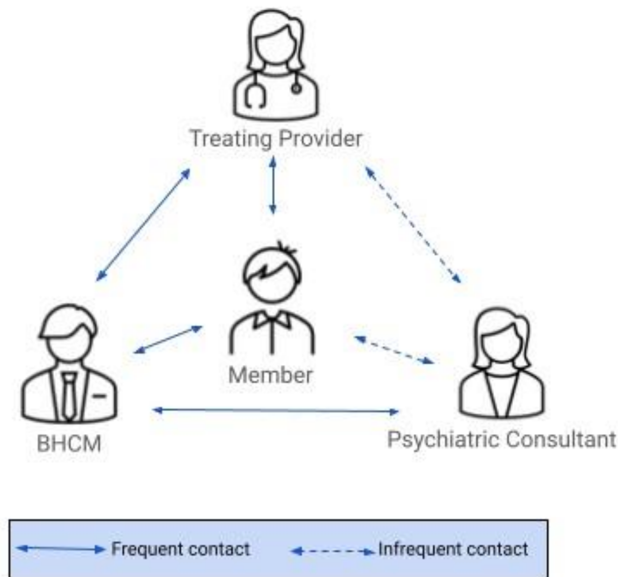
8-9.1 Care Team

The CoCM care team members include:

- Treating provider
- Behavioral health case manager
- Psychiatric consultant
- Member

Collaborative Care Model –

The diagram below demonstrates collaboration between the CoCM care team.



8-9.1.2 Treating Provider

The treating provider has primary oversight of the member's care as they would in any primary care setting. In most instances, the treating provider is a primary care provider (PCP) but may be of another specialty if they have primary oversight of the member's care as previously mentioned. They are responsible for directing the behavioral healthcare manager and other clinical staff. This direction is generally performed under the general supervision of staff through established and well-defined care plans. As part of treating a member using the CoCM model, they are additionally responsible for:

- Ongoing oversight of their member's care, including:
    - prescribing medications
    - providing treatments for both physical and behavioral medical conditions
    - referrals to specialty care when needed
- Establishing comprehensive care plans through collaboration with a psychiatric consultant.
- Maintain communication with the behavioral healthcare manager and psychiatric consultant.

8-9.1.3 Behavioral Healthcare Manager

The behavioral healthcare manager (BHM) is a part of the member's ongoing care and supports the treating provider through various tasks and responsibilities. They are consistently available to meet with the member through scheduled visits whether in person or by means of telehealth. These services include:

- Administering assessment and providing care management services, including:
    - utilizing evidence-based behavioral health rating scales,
    - behavioral healthcare planning that addresses the member's behavioral health condition(s),
    - provider care plan revisions as needed,

    - furnishing brief psychosocial interventions, and
    - continuous collaboration with the treating provider and conferring with the psychiatric consultant.
- Maintaining a continuous relationship with the member,
- Maintaining a collaborative, integrated relationship with the rest of the care team,
- Referring members to appropriate community resources to address social determinants of health and increase access to needed services, and
- Have a clinical license, formal education, or specialized training in behavioral health.
    - Examples include social workers, nurses, and psychologists.

8-9.1.4 Psychiatric Consultant

The psychiatric consultant is an integral part of CoCM services in addition to the BHM. These individuals are medical providers trained in psychiatry and qualified to prescribe the full range of medications to meet the member's medical needs. The psychiatric consultant advises and makes recommendations as needed. Their responsibilities and oversight include:

- assess and diagnose behavioral health disorder(s),
- collaborate in developing treatment strategies including appropriate therapies,
- coordination of medication management,
- medical management of complications associated with treatment,
- referral for direct provision of psychiatric care when clinically indicated,
- take part in regular review of clinical status of members getting BHI services,
- advise ways for resolving issues with treatment adherence and development of medication tolerances,
- adjusts treatment and care plan for members who aren’t progressing, and
- manages adverse interactions between members’ behavioral health and medical treatments.

8-9.2 Provider Participation

Only the treating provider is responsible for being enrolled with Utah Medicaid. While the BH care manager and psychiatric consultant can also be enrolled with Medicaid, it is not necessary that they are for the delivery and coverage of this service.

8-9.3 Reporting – Coding and Billing

Billing of CoCM is reported using time-based codes. These codes represent the time spent by the care team when performing CoCM services during a calendar month.

Reporting of CoCM services is limited to the treating practitioner. The psychiatric consultant and the BH care manager are subsequently paid through whatever remunerable arrangements have been made through the treating providers business model. These are often established through contract or employment agreements; however, Medicaid does not dictate how these arrangements are made.

In instances where a psychiatric consultant or BH care manager are enrolled as Medicaid providers and have delivered additional services beyond those that are considered part of CoCM, these providers may bill for those services separately. Please see the “NOTE” below for additional details.

The following services are separately reportable on the same day or calendar month as CoCM services:

- Preventive services
- Evaluation and management (E/M)
- Chronic care management (CCM)
- Principal care management (PCM)
- Psychotherapy services
- Transitional care management
- Advanced care planning (ACP)

8-9.4 Coding

Providers can use the following when determining code assignment of CoCM services for billing purposes. Documentation in the member's medical record must support services billed to Medicaid.

Initial psychiatric collaborative care management – CPT Code 99492

- Used to report the first month of time spent on CoCM services coordinating an individual's behavioral health care plan.
- This code is based on the amount of time the BH care manager spends doing clinical work, both face-to-face and non-face-to-face with the member.
- Represents first 70 minutes.
  - This code requires a minimum of 36 minutes of documented BH care manager time.
  - The treating practitioner's time can be included in meeting if that time isn't used to support the coding of another service. E.g., evaluation and management visits.
  - The psychiatric consultant's time can be applied towards the time spent on CoCM services.
    - Cannot apply consultation time if reported by another member of the care team.
    - Cannot use the time spent to support the coding of another service.
- Requires BH care manager:
  - outreach to and engagement in treatment of a member directed by the treating provider,
  - initial assessment of the member, including administration of validated rating scales, with the development of an individualized treatment plan,
  - review of treatment plan by the psychiatric consultant with modifications as needed,
  - tracking member care and progress through documentation,
  - participation in weekly caseload consultation with the psychiatric consultant, and
  - providing brief interventions to the member using evidence-based techniques.
- Cannot be billed again until CoCM services have not been provided for at least 6 consecutive months.
- Cannot be billed in the same month as the general BHI code 99484.

Subsequent psychiatric collaborative care management - CPT Code 99493

- This code is used to report subsequent months of time spent on CoCM services coordinating an individual's behavioral health care plan after the initial month of care has been completed.
- This code is based on the amount of time the BH care manager spends doing clinical work, both face-to-face and non-face-to-face with the member.
- Represents first 60 minutes.
    - This code requires a minimum of 31 minutes of documented BH care manager time.
    - The treating practitioner time can be included in meeting this requirement when the time isn't used to support the coding of another service, e.g., evaluation and management visits.
    - The psychiatric consultant's time can be applied towards the time spent on CoCM services.
        - Cannot apply consultation time if reported by another member of the care team.
        - Cannot use time used to support the coding of another service.
- BH care manager requirements:
    - Tracking member care and progress through documentation,
    - Participation in weekly caseload consultation with the psychiatric consultant,
    - Ongoing collaboration with member care team,
    - Review of progress and recommendations for changes in treatment as necessary,
    - Provision of brief interventions using evidence-based techniques,
    - Monitoring of member outcomes using validated rating scales,
    - Relapse prevention planning with members as they achieve remission of symptoms,
    - Establishing treatment goals and preparing for discharge from active treatment.
- Cannot be billed in the same month as the general BHI code 99484.

Initial or subsequent psychiatric collaborative care management - CPT code 99494

- This CPT is used to report time beyond what is covered under CPT codes 99492 and 99493.
- This code represents each additional 30 minutes beyond what the primary code covers.
- Requires a minimum of 16 minutes past the primary codes time.
    - Allowable after 85 minutes for CPT code 99492
    - Allowable after 75 minutes for CPT code 99493
- All other criteria for the applicable primary code apply to this code.
- Providers are limited to reporting this code up to 2 times in a calendar month.
- Documentation must support the reported code requirements.

Initial or subsequent psychiatric collaborative care management – CPT code G2214

- Represents first 30 minutes of CoCM services in a calendar month.
- This code is reportable when CoCM services are discontinued due to either referral to specialized care for ongoing treatment of the behavioral health condition or an inpatient admission.

- Not permitted if billed with other CoCM codes.
- Requires a minimum of 16 minutes of CoCM related service time.
- All other requirements for CPT codes 99492 and 99493 respectively apply to this code.

Table – Quick CoCM Reference

Code	Brief Description	Time Requirement	Limitations and Notes
99492	Initial Psychiatric CoCM	70 minutes	1 unit per month
99493	Subsequent Psychiatric CoCM	60 minutes	1 unit per month
99494	Initial & Subsequent Psychiatric CoCM	30 minutes	2 units per month This is an add on code to 99492 and 99493.
G2214	Initial & Subsequent Psychiatric CoCM	30 minutes	1 unit per month

8-10 Transitional Care Management

Medicaid covers transitional care management services as part of the 30-day period following a member's discharge from an inpatient facility. These services allow the inpatient attending provider to assist the members in their transition back into the community. Transitional care management includes referrals to other clinicians, follow-up after an emergency department visit, and discharges from hospitals, skilled nursing facilities, or other health care facilities. To facilitate the transition of care providers should ensure prompt sharing of medical records, especially with the primary care provider.

Eligible inpatient settings for the reporting of transitional care management services include:

- inpatient acute care hospital,
- inpatient psychiatric hospital,
- inpatient rehabilitation facility,
- long-term care hospital, or
- skilled nursing facility.

When a member discharges from an eligible inpatient setting transitional care management services must be provided during the 30-day period following discharge. As a part of this service, providers must establish face-to-face contact with the member. This requires contacting the member or their caregiver by means of phone, an audio-video virtual visit, or directly in-person within two business days after the member's discharge. If this is not completed within two business days, then the service is non-covered, and reimbursement is prohibited.

This initial action may be performed by the provider or clinical staff. Medicaid recognizes an individual as a clinical staff member when they are 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 clinical service but does not individually report that professional service.

When first contacting the member, providers or their staff must be able to manage and reconcile the member's medications. Additionally, they must also address member status and needs beyond scheduling follow-up care.

Transitional care management has multiple requirements and some optional components that can be used in supporting the billing of this service:

- Supporting a member's transition to their place of residence. Examples of the community setting include:
    - Home
    - Domiciliary
    - Nursing facility
    - Assisted living facility
- The provider furnishes transitional care management at the time of post-facility discharge, without a service gap.
    - This is completed within two business days of discharge.
- Moderate or high complexity medical decision making (MDM) is needed to address the members medical needs. The member's medical record must support a diagnosis and severity of illness to justify this level of MDM.

Beyond the established transitional care management requirement, the delivery of face-to-face and non-face-to-face time establishes the medical need for this service. As previously described, the face-to-face criteria needs to be performed within two business days of discharge from a facility.

When providing non-face-to-face transitional care management, providers may support billing this service with time spent in:

- reviewing discharge documentation (for example, discharge summary or continuity-of-care documents),
- reviewing the member's need for or follow up on, diagnostic tests and treatments,
- interacting with other health care professionals who may assume or reassume care of the member's medical care,
- educating the member, family, guardian, or caregiver,
- establishing or re-establishing referrals and arrange needed community resources, and
- aiding with scheduling required community providers and services follow-up

Clinical staff may perform certain non-face-to-face service tasks under the general supervision of the provider, these include:

- communicating with the member,
- coordinating with agencies and community service providers the member uses,
- educating the member or caregiver to support self-management, independent living, and activities of daily living (ADLs),
- assessing and support treatment adherence,
- identifying available community and health resources, and
- helping the member and family access needed care and services

8-10.1 Transitional Care Management Reporting – Coding and Billing

When reporting transitional care management services providers are required to only bill for those services that meet the criteria established throughout this manual and when coding requirements are met for each service reported. There are both time thresholds and limitations regarding the billing of concurrent services provided in conjunction with transitional care management.

Providers may not report transitional care management when the member is under the post-operative global surgery period. The global period payment of a surgery includes the transitional care management services and would be considered double billed under those circumstances.

The member's medical record must reflect and support any reporting of transitional care management. The reporting of transitional care management is limited to the following providers overseeing the discharge of the member:

- Physicians
- Certified nurse-midwives (CNMs)
- Clinical nurse specialists (CNSs)
- Nurse practitioners (NPs)
- Physician assistants (PAs)

Only one provider may report transitional care management services during the 30-day period following the discharge of a member from an eligible inpatient facility. transitional care management may be reported by the same provider that oversees and bills for discharge observation, however, the provider may not perform the transitional care management face-to-face on the same day as the reported discharge management services.

If a member is readmitted during the 30 days after discharge, a provider may report transitional care management services if the criteria have been met.

8-10.1.1 Transitional Care Management Coding

Use the table below to determine which code to report when the criteria for transitional care management have been met.

8-10.1.2 Transitional Care Management Concurrent Billing

Certain other care management services may be reported concurrently with transitional care management services, when medically necessary, and if the time and effort of each are not counted more than once. These services include:

- Monitoring of End-stage renal disease (ESRD)
- Training for home international normalized ratio (INR) monitoring and anticoagulation management
- Collection and interpretation of physiologic data
- Prolonged evaluation and management (E/M) services
- Chronic care management (complex and non-complex)
- Hospice
- Home Health requiring complex and multidisciplinary care modalities

Providers must meet the coding and policy requirements of the above services as applicable prior to reporting.

8-11 Health Behavioral Assessment and Interventions (HBAI)

Health Behavior Assessment and Intervention (HBAI) are covered services for members when used to improve the physical health of the member through psychological assessments and interventions. These services are offered to members with physical illnesses, diagnoses, or symptoms that require psychological interventions designed to ameliorate the specific physical disease-related problems.

HBAI services include the following services used to identify factors important to the prevention, treatment, and management of physical health problems:

- Behavioral
- Cognitive
- Emotional
- Psychological
- Social

8-11.1 Health Behavior Assessment

A health behavior assessment is conducted using health-focused interviews, behavioral observation, and clinical decision-making. Health behavior assessments include evaluating the member's responses to disease, illness or injury, outlook concerning disease prognosis, coping strategies, motivation, and adherence to medical treatment. The assessment is conducted through health-focused clinical interviews, observation, and clinical decision making.

The coverage of a health behavior assessment and reassessment requires a health focused clinical interview, behavioral observations, and clinical decision making.

As part of the health-focused clinical interview the QHP conducts a face-to-face interview with the member while assessing multiple behavioral domains. Collateral interviews are conducted as appropriate. When it precedes a health behavior intervention, the clinical assessment would determine the type(s) of intervention that would best benefit the member.

When performing the health-focused clinical interview the QHP evaluates how the member is responding through direct behavioral observation. These observations will direct the clinical decision-making process and support the medical necessity of the service being provided.

The information gained during the health-focused clinical interview and behavior observations help to conceptualize the QHPs clinical impressions and treatment recommendations.

Health behavior assessment and re-assessment evaluate multiple domains and their degree of impact. These assessments may include the following as they are relevant to the member:

- Academic and vocational histories
- Adjustment to the medical illness or injury
- Coping strategies, member strengths
- Daily activities, level of behavioral activation, and functional impairment
- Health beliefs, perception, and outlook
- Health care decision-making skills
- Mental health and substance use (including tobacco and alcohol use)—current and past
- Mood
- Motivation and self-efficacy beliefs
- Psychological and environmental factors affecting management of the medical condition
- Quality of life
- Relevant medical history
- Sleep, diet, physical activity, and other health risk behaviors
- Social support, family and interpersonal relations
- Treatment adherence and expectations
- Understanding of treatment plan, benefits and risks of procedures

8-11.2 Assessment Medical Necessity Requirements

For Medicaid to cover these health behavioral assessments, the member must meet the following criteria:

- there is an established physical condition, and the purpose of the assessment is not for the diagnosis or treatment of mental illness,
- there are indications that psychological, behavioral, and/or psychosocial factors may be affecting the treatment or medical management of an illness or an injury,
- the member is alert, oriented, and has the capacity to understand and to respond meaningfully during a face-to-face encounter,
- the health behavior evaluation or intervention will contribute to the successful management of the member's activities of daily living (ADLs), and
- the member can be referred from a medical or mental health care provider, or self-referred to seek assistance in addressing the role of psychological and/or behavioral factors affecting an underlying physical health condition.

8-11.3 Re-assessment Requirements

In addition to meeting the criteria stated above, medical necessity for re-assessment must be further established through documentation of one of the following:

- change in the mental or medical status warranting re-evaluation,
- specific concern from the primary medical provider or member of medical team,
- need for re-assessment as part of the standard of care,
- change in providers, or
- at least a 6-month period has elapsed since the last assessment.

8-11.4 Documentation Requirements for Assessments

Health behavior assessment or re-assessment are required to be medically necessary for Medicaid to cover the services. In order to support the medical necessity of services billed the documentation must support the following:

- assess psychological and/or behavioral factors that impact the management of a member's acute or chronic physical health condition (e.g., assessment of stress and its impact on diabetes management),
- assess member's responses to disease, illness or injury, outlook (e.g. health beliefs and attitudes), coping strategies, motivation, and adherence to medical treatment,
- assess behavioral and contextual factors that impact disease management in scenarios that include, but are not limited to:
    - pre-surgical evaluation to identify psychological factors that may potentially affect or complicate the outcome of surgical procedures and/or aftercare (e.g., spinal surgery, bariatric surgery, implantable therapies, organ transplant),
    - assessment of emotional/personality factors impacting physical disease management and ability to comply with and/or benefit from medical interventions, or
    - assessment of psychosocial and/or environmental factors that can impact a member's ability to comply with and/or benefit from medical interventions,
- assess psychological barriers and strengths to aid in treatment planning, including but not limited to:

    - the selection of treatment options when several evidence-based approaches may be indicated,
    - determining treatment prognosis and outcomes, or
    - identifying reasons for poor response to medical treatment,
- assess and monitor psychological factors and impact on medical condition and management over time (repeated assessments), or
- assess health related risk behaviors (e.g., sleep, diet, physical activity, tobacco use) and their impact on the medical condition and management.

8-11.5 Health Behavioral Intervention

Health behavior intervention emphasizes active member and family engagement and involvement. Interventions may be provided individually, to a group of two or more members, and/or to the family, with or without the member present. Interventions include:

- promoting functional improvement,
- minimizing psychological and/or psychosocial barriers to recovery, or
- managing and improving coping methods associated with medical conditions

Health behavior intervention services are considered medically necessary when one or more of the following needs are present:

- manage psychological and behavioral factors that are impacting the management of a member's physical medical condition (e.g., improve stress management to improve diabetes management),
- improve a member's cognitive or emotional responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment,
- improve psychological and/or behavioral factors that impact disease management in scenarios that include but are not limited to:
    - psychological factors affecting or complicating the outcome of surgical procedures and/or aftercare (e.g., spinal surgery, bariatric surgery, implantable therapies).
    - The emotional/personality impacts on physical disease management and/or the ability to comply with and benefit from medical interventions,
- improve a member's adherence to medical treatment and/or health risk-related behaviors,
- improve a member's engagement in self-management and participation in treatment, and
- improve a member's understanding of the medical condition, its treatment, and the psychological, behavioral, emotional, cognitive, or social factors related to the prevention, treatment or management of the medical condition.

These intervention services may be provided to:

- The individual member
- A group of members receiving similar interventions for HBAI
- The member's family or caregiver(s), with or without the member present
    - These intervention services involve face-to-face interaction with the family or caregiver(s) present.

Health behavior intervention includes promotion of functional improvement, minimization of psychological or psychosocial barriers to recovery, and management of and improved coping

with medical conditions. These services emphasize active member/family engagement and involvement.

Evidence-based health behavior interventions address behavioral factors that influence a person's medical condition and consist of various types of treatment interventions, including but not limited to:

- Cognitive restructuring
- Communication skills training
- Coping skills training
- Emotional awareness and management
- Functional and structural family treatment
- Graded activation, behavioral activation, and pacing techniques
- Mindfulness techniques
- Motivational interviewing
- Operant behavior therapy and contingency management
- Problem solving training
- Psychoeducation related to the psychological, behavioral, and/or psychosocial aspects of the member's illness or presenting problem
- Relaxation techniques and skills training
- Stimulus control

8-11.6 Documentation Supporting Medical Necessity of Interventions

The health behavioral intervention services may be considered reasonable and necessary for the member who meets all of the following criteria:

- The member has an underlying physical illness or injury
- Specific psychological intervention(s) and member outcome goal(s) have been clearly identified and documented
- Psychological intervention is necessary to address:
  - Non-adherence with the medical treatment plan, or
  - The psychological and/or psychosocial factors associated with a newly diagnosed physical illness, or an exacerbation of an established physical illness, when such factors affect:
    - symptom management and expression
    - health-promoting behaviors
    - health-related risk-taking behaviors
    - overall adjustment to medical illness.
- There are indications that psychological, behavioral, and/or psychosocial factors may be affecting the treatment or medical management of an illness or an injury
- The member is alert, oriented and has the capacity to understand and to respond meaningfully during the intervention service

When providing these services to the member's family or caregiver(s) the documentation must additionally support:

- The family representative or caregiver who directly participates in the overall care of the member, and
- The psychological intervention with the member and family is necessary to address psychological or psychosocial factors that affect adherence with the plan of care,

symptom management, health-promoting behaviors, health-related risk-taking behaviors, and overall adjustment to medical illness.

8-11.7 Provider Participation

Only qualified healthcare professionals may provide HBAI services in accordance with their licensing, training, and scope of practice. Examples of professionals licensed to provide HBAI services include:

- Physicians
- Advanced Practicing Nurse Practitioners (APRN)
- Physician Assistants (PA)
- Psychologist
- Mental Health Therapist

8-11.8 Limitations and Non-Covered HBAI Services

HBAI Services do not include:

- Adaptive behavior services
- E/M services on the same date of service
- Preventive medicine counseling services
- Psychotherapy services

In addition, HBAI is not considered medically necessary when the member:

- Does not have a suspected or established underlying physical illness or injury; or
- There is no indication that psychological and/or psychosocial factors may be significantly affecting the treatment, or medical management of an illness or injury (i.e., screening medical member for psychological problems); or
- Does not have the capacity to understand and to respond meaningfully during the face-to-face encounter for reasons such as, but not limited to:
    - Cognitive status indicates inability to actively participate and benefit from services.
    - Severe dementia that has produced a severe enough cognitive defect for the psychological intervention to be ineffective.
    - Severe or profound intellectual disability.
    - Persistent inability to engage in meaningful interpersonal interactions including inability to respond to cues and directions.
- Updating or educating the family about the member's condition
- Educating individuals who are not direct family members or legally responsible guardians and other members of the treatment team (e.g., health aides, nurses, physical or occupational therapists, home health aides, personal care attendants, and co-workers) about the member's care plan.
- Treatment-planning with staff
- Mediating between family members or providing family psychotherapy
- Education that does not include the psychological, behavioral, and/or psychosocial aspects of the member's illness or presenting problem
- Delivering Medical Nutrition Therapy
- Retraining cognition due to dementia or memory enhancement training
- Provision of support services, not requiring the skills of an individual with health psychology training.
- Provide personal, social, recreational, and general support services, including:
    - Stress management for support staff
    - Replacement for expected nursing home staff functions
    - Recreational services, including dance, play, or art

- Music appreciation
- Craft skill training
- Cooking classes
- Individual or group social activities
- General conversation
- Consciousness raising
- Vocational or religious advice
- General educational activities
- Visits for loneliness relief
- Sensory stimulation
- Games, such as bingo
- Projects, such as shopping outings, even when used to reduce a dysphoric state
- Teaching grooming skills
- Grooming services
- Monitoring activities of daily living
- Teaching the member simple self-care
- Teaching the member to follow simple directives
- Wheeling the member around the facility
- Orienting the member to name, date, and place
- In-vivo exercise programs
- Activities principally for diversion
- Planning for milieu modifications
- Contributions to member care plans
- Maintenance of behavioral logs

8-11.9 Reporting: Coding and Billing Health Behavioral Assessments and Interventions

A provider reporting an Evaluation and Management (E/M) service code cannot report HBAI services on the same day by the same health care professional or another clinician practicing in the same facility under the same specialty.

HBAI services are not used for reporting mental health services provided as part of the treatment of a primary physical health diagnosis.

Do not report health behavior intervention services with psychiatric services on the same date. Instead, report the predominant service performed. It is typical for psychological testing and health behavior assessment, re-assessment, or intervention services to be provided on the same date of service.

Psychological testing performed in addition to a health assessment should be reported separately, based on the type of testing performed.

- HBAI services performed on the same date of service as psychological services should follow NCCI guidelines for reporting these services using an appropriate modifier:
  - Modifier XE for separate encounters on the same DOS; or
  - Modifier 59 for services provided in the same encounter)

Providers reporting HBAI assessments/re-assessments and interventions must maintain clinical documentation that supports the requirements and the medical necessity of the service being delivered. These records are not required as a part of the claim's submission process; however, they may be requested per the Medicaid post-payment review and claims evaluation processes.

Table -Assessments and Re-assessments

Code	Description	Limitations and Notes
96156	Health behavior assessment, or re-assessment	• Limited to one unit per date of service. • Reassessments can only be billed every six months from either the date of the initial assessment or the previous reassessment.

Table - Interventions

Health Behavioral Intervention Reporting			
	Code	**Description**	**Limitations and Notes**

Individual	96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to being reportable
	96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96158 • Limited to 4 units per date of service ○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time ○ 3 units require at least 68 minutes of individual time ○ 4 units require at least 83 minutes of individual time
Group	96164	Health behavior intervention, group (2 or more members), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting
	96165	Health behavior intervention, group (2 or more members), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96164 • Limited to 6 units per date of service ○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time ○ 3 units require at least 68 minutes of individual time ○ 4 units require at least 83 minutes of individual time ○ 5 units require at least 98 minutes of individual time ○ 6 units require at least 113 minutes of individual time
Family or Caregiver, with member present	96167	Health behavior intervention, family (with the member present), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting
	96168	Health behavior intervention, family (with the member present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96167 • Limited to 6 units per date of service ○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time ○ 3 units require at least 68 minutes of individual time ○ 4 units require at least 83 minutes of individual time ○ 5 units require at least 98 minutes of individual time

			○ 6 units require at least 113 minutes of individual time
Family or Caregiver, without member present	96170	Health behavior intervention, family (without the member present), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting.
	96171	Health behavior intervention, family (without the member present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96170 • Limited to 2 units per date of service ○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time

When coding and billing for interventions providers must report the most appropriate CPT code as supported through clinical documentation. The intervention codes are time-based services and are therefore supported through clinical documentation supporting start and stop times. These are outlined in the following table.

8-12 Advanced Care Planning

Advance care planning (ACP) is a voluntary, face-to-face service between a physician or other QHP and a member, family member, or caregiver to discuss the member's health care wishes if they become unable to make their own medical decisions. The primary goal of ACP is to facilitate people receiving medical care that is consistent with their personal values, goals, and preferences.

Examples of ACP services may include, but are not limited to the following content:

- Introducing and discussing the value and importance of basic ACP,
- Exploring current and past experiences of loved ones who have been seriously ill or have died,
- Exploring goals of care in the event of sudden injury or illness,
- Exploring goals of care when there would be little chance for members to recover or to have the ability to know who they are or who they are with,
- Identifying and/or preparing a healthcare agent,
- Completing or updating an advance directive document, and
- Transferring members' preferences into actionable medical orders.

An advance directive is described as a written document that a member uses to appoint a representative and/or to record his or her wishes as they relate to future medical treatment in the event the member is incapacitated and unable to make decisions on his or her own. Types of written advance directives include, but are not limited to:

- Healthcare proxy
- Durable power of attorney for healthcare
- Living will
- Provider orders for life-sustaining treatment (POLST)

Such formal written documents are not required, but may be included, in the provision and reporting of these services.

8-12.1 Reporting – Coding and Billing

ACP services are time based. No other active management of the member's affairs should be undertaken for the time reported when ACP codes are billed. Brief conversations of just a few minutes (done in the course of an E/M service) related to wishes concerning potential emergent resuscitation do not represent ACP services.

ACP is limited to up to two hours per date of service. Services reported on separate dates of service must include documentation of change in existing ACP or the addition of new written advance directives. Documentation must support the medical necessity of the services as evidenced by the following:

- The content and the medical necessity of the ACP related discussion,
- Voluntary participation in ACP by the member, or in the case of absent decision-making capacity, by the family member or surrogate,
- A change in health status or advance care wishes in order to support repetitive provision of ACP services,
- The scenario for the service: face to face, by phone, as a telehealth service including audio and/or video communication,
- The time spent solely for provision of ACP services, and
- The names of participants involved in the discussion.

ACP codes describe counseling and discussion of advance care directives with the member, family members, or authorized representatives. Such services may or may not include completion of pertinent legal documents.

Table - Coding and Billing for Advanced Care Planning

CPT Code	Description	Limitations and Notes
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 member, family member(s), and/or surrogate.	• Initial 30 minutes • Requires a face-to-face visit.
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)	• Each additional 30 minutes • Requires a face-to-face visit.

These codes can be separately reported when performed on the same date of service in conjunction with the following E/M services:

- Office or another outpatient visit
- Initial hospital inpatient or observational care
- Subsequent hospital or observational care
- Discharge day management
- Office or other outpatient consultations for new or established member
- Hospital inpatient or observational care for new or established member
- Emergency department visits
- Initial nursing facility care

- Nursing facility discharge management
- Home or residence visits for new or established member
- Initial comprehensive preventive medicine evaluation
- Transitional care management services

Codes 99497 and 99498 *should not* be reported on the same date of service as the critical care E/M services.

To ensure you are able to report these services for reimbursement please see the PRISM Coverage and Reimbursement Code Lookup Tool.

Reference Tables

Chronic Care Management

	CPT Code	Performed by		Time Requirements	Coding Note and Limitation
		Provider	Clinical Staff		
Non-Complex CCM	99490	X	X	first 20 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month. • Cannot report if less than 20 minutes are utilized.
	99439	X	X	each additional 20 minutes	• Time spent by billing provider is counted when 99491 is not billed in the same month. • Limited to 2 units per month. • Report in conjunction with 99490.
	99487	X	X	first 60-89 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month
	99489	X	X	each additional 30 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99491 is not billed in the same month. • Limited to 1 unit per month
Complex CCM	99491	X		first 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Cannot report in same month as non-complex CCM codes. • Limited to 1 unit per month • Cannot report if less than 30 minutes are utilized.
	99437	X		each additional 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Reported in addition to 99491 when time threshold is met. • Cannot be reported without 99491. • Limited to 2 units per month

Principal Care Management

	CPT Code	Performed by		Time Requirements	Coding Note and Limitation
		Provider	Clinical Staff		
Non-Complex PCM	99426	X	X	first 30 minutes	• Time spent by billing provider can be counted in addition to clinical staff time when 99424 is not billed in the same month. • Limited to 1 unit per month. • Cannot report if less than 30 minutes are utilized. • Cannot be reported in the same month as CCM codes.

	99427	X	X	each additional 30 minutes	• Limited to 2 units per month. • Report in conjunction with 99426.
Complex PCM	99424	X		first 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Cannot report in same month as non-complex PCM codes. • Limited to 1 unit per month • Cannot report if less than 30 minutes are utilized. • Cannot be reported in the same months as CCM codes.
	99425	X		each additional 30 minutes	• Clinical staff time cannot be used towards meeting time requirements. • Reported in addition to 99424 when time threshold is met. • Cannot be reported without 99424. • Limited to 2 units per month

Psychiatric Collaborative Care Model

Code	Brief Description	Time Requirement	Limitations and Notes
99492	Initial Psychiatric CoCM	70 minutes	1 unit per month
99493	Subsequent Psychiatric CoCM	60 minutes	1 unit per month
99494	Initial & Subsequent Psychiatric CoCM	30 minutes	2 units per month This is an add on code to 99492 and 99493.
G2214	Initial & Subsequent Psychiatric CoCM	30 minutes	1 unit per month

Health Behavior Assessments and Interventions

Health Behavioral Assessment Reporting		
Code	**Brief Description**	**Limitations and Notes**
96156	Health behavior assessment, or re-assessment	• Limited to one unit per date of service. • Reassessments can only be billed every six months from either the date of the initial assessment or the previous reassessment.

Health Behavioral Intervention Reporting			
	Code	**Brief Description**	**Limitations and Notes**
Individual	96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to being reportable
	96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96158 • Limited to 4 units per date of service ○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time ○ 3 units require at least 68 minutes of individual time ○ 4 units require at least 83 minutes of individual time
Group	96164	Health behavior intervention, group (2 or more members), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting
	96165	Health behavior intervention, group (2 or more members), face-to-face;	• Must be reported as an add on service to 96164 • Limited to 6 units per date of service

		each additional 15 minutes (List separately in addition to code for primary service)	○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time ○ 3 units require at least 68 minutes of individual time ○ 4 units require at least 83 minutes of individual time ○ 5 units require at least 98 minutes of individual time ○ 6 units require at least 113 minutes of individual time
Family or Caregiver, with member present	96167	Health behavior intervention, family (with the member present), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting
	96168	Health behavior intervention, family (with the member present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96167 • Limited to 6 units per date of service ○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time ○ 3 units require at least 68 minutes of individual time ○ 4 units require at least 83 minutes of individual time ○ 5 units require at least 98 minutes of individual time ○ 6 units require at least 113 minutes of individual time
Family or Caregiver, without member present	96170	Health behavior intervention, family (without the member present), face-to-face; initial 30 minutes	Requires at least 16 minutes of provider time prior to reporting.
	96171	Health behavior intervention, family (without the member present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	• Must be reported as an add on service to 96170 • Limited to 2 units per date of service ○ 1 unit requires at least 38 minutes of individual time ○ 2 units requires at least 53 minutes of individual time

Transitional Care Management

Complexity of MDM	Code	Description
Moderate	99495	Transitional care management services with communication with the patient 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.
High	99496	Transitional care management services with communication with the patient 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.

Advanced Care Planning

CPT Code	Description	Limitations and Notes
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 member, family member(s), and/or surrogate.	• Initial 30 minutes • Requires a face-to-face visit.
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)	• Each additional 30 minutes • Requires a face-to-face visit.