Billing and Reimbursement for Learning Health Networks

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Contents

Introduction

Payment Calculations: 2023 Medicare Physician Fee Schedule

2023 Non-Facility Pricing Amount = [(Work RVU * Work GPCI) + (Non-Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor (CF)

2023 Facility Pricing Amount = [(Work RVU * Work GPCI) + (Facility PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * Conversion Factor

GCPI = Geographic Practice Cost Index
PE = Practice Expense
MP = Multiple Procedures
CF = Conversion Factor (33.8872 for 2023)

Eligible providers of Medicare services
Physicians (any specialty)
QHP = Qualified Healthcare Provider (able to bill Medicare)

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

CPT = Current Procedural Terminology
HCPCS = Healthcare Common Procedure Coding System; standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes

Traditional Evaluation/Management Codes (E/M)

Coding depends on:

- Levels of medical decision making applied during the service
    - Two out of three of:
    - Number and complexity of problems addressed
    - Amount and/or complexity of data to be reviewed and analyzed
    - Risk of complications and/or morbidity or mortality of patient management

OR

- Total time spent on the date of the visit (whether or not counseling or coordination of care dominates the service).
    - Time is calculated as the total time spent personally by the provider on the date of the encounter, including both face-to-face and non-face-to-face time.
    - **Preparing to see the patient (review of tests, outside records)**
    - Obtaining and/or reviewing a separately obtained history
    - Performing a medically necessary appropriate examination and/or evaluation
    - **Counseling and educating the patient/family/caregiver**
    - Ordering medications, tests, or procedures
    - Referring and communicating with other health care professionals (when not reported separately)
    - **Documenting** clinical information in the electronic or **other health record**
    - Independently interpreting results (not reported separately) and **communicating results to the patient/family/caregiver**
    - **Care coordination** (not reported separately)

RVU	Description	Time	wRVU	$
99202	New patient, straightforward	15-29 min	0.93	72.86
99203	New patient, low complexity	30-44 min	1.60	112.84
99204	New patient, moderate complexity	45-59 min	2.60	167.40
99205	New patient, high complexity	60-74 min	3.50	220.95
99212	Established patient, straightforward	10-19 min	0.70	46.13
99213	Established patient, low complexity	20-29 min	1.30	68.10
99214	Established patient, moderate complexity	30-39 min	1.92	110.43
99215	Established patient, high complexity	40-54 min	2.80	148.33
99417	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes	each 15 min	0.61	65.00

Suggested documentation: A total of X minutes was spent on this visit reviewing previous notes and **the pre-visit planning form**, providing **education about seizure types and use of a seizure calender**, counseling the patient **using the ELHS barriers to medication adherence module**, ordering tests (), adjusting meds, and documenting the findings in the note **and the patient registry**.

Online Digital E/M

- For physicians and QHP (not clinical staff)
- Brief online E/M via a secure HIPAA compliant platform
- Requires verbal consent of patient annually (for all communication-based technology services)
- Must be initiated by the patient (established only) by electronic platform
- No other E/M service within past 7 days or scheduled for next 7 days
- May be reported once in 7 day period
- The seven-day period begins with the physician's or other QHP's initial, personal review of the patient-generated inquiry
- Service time includes:
    - Review of the initial inquiry
    - Review of patient records or data pertinent to assessment of the patient's problem
    - Personal physician or other QHP interaction with clinical staff focused on the patient's problem
    - Development of management plans, including physician or other QHP generation of prescriptions or ordering of tests
    - Subsequent communication with the patient through online, telephone, email, or other digitally supported communication, which does not otherwise represent separately reported E/M
- Time does not include time spent on non-evaluative electronic communications

RVU	Description	wRVU	$
99421	Online digital E/M service, for an established patient, for up to seven days, **cumulative time during the seven** days; **5-10 minutes**	0.25	15
99422	Online digital E/M service, for an established patient, for up to seven days, **cumulative time during the seven days**; **11-20 minutes**	0.5	31
99423	Online digital E/M service, for an established patient, for up to seven days, **cumulative time during the seven days**; **21 or more minutes**	0.8	50
98970 G2061	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	0.25	
98971 G2062	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	0.44	
98972 G2063	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	0.69	

Phone E/M

- Provided to a patient, parent, or guardian
- Do not originate from a related E/M service within the previous seven days and do not lead to an E/M service or procedure within the next 24 hours or soonest available appointment

RVU	Description	wRVU	$
99441	Telephone E/M service; 5-10 minutes of medical discussion	0.70	46
99442	Telephone E/M service; 11-20 minutes of medical discussion	1.30	76
99443	Telephone E/M service, 21-30 minutes of medical discussion	1.92	110

Screening

RVU	Description	wRVU	$
G0396	Alcohol or substance intervention, 15-30 min	0.65	29.42
G0397	Alcohol or substance intervention, > 30 min	1.30	65.51
G0442	Annual alcohol screen, 15 min	0.18	17.32
G0443	Brief alcohol misuse counsel	0.45	25.14
G0444	Depression screen, annual	0.18	18.00
G0447	Behavioral counseling, obesity, 15 min	0.45	26.00

Transitional Care Management (TCM)

- New or established patients whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to patient's community setting (home, group home, nursing facility, or assisted living facility)
- Reduce the number of unnecessary patient readmissions and prepare for a successful patient transition back into their place of residence in the community
- Commences upon the date of discharge and continues for the next 29 days
- Providers may bill TCM services if they have primary responsibility for post-discharge care coordination
- Only one health care professional may report TCM services for the 30-day post discharge period
- Required face-to-face visit should not take place on the same day in which the discharge day management services are reported
- TCM services may not be reported within the same month as reporting care plan oversight services; home health or hospice supervision; end-stage renal disease services; chronic care management services; prolonged evaluation and management services without direct patient contact

TCM services consist of three segments with TCM-specific timeframes

- Interactive contact (within 2 business days of discharge; phone, email, in person; clinical staff); can bill if try twice and document, even if patient not reached
- Provision of non-face-to-face services
- Office visit within 1 to 2 weeks, depending on complexity of medical decision making; physician

RVU	Description	wRVU	$
99495	TCM services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least **moderate complexity** during the service period; and face-to-face visit **within 14 calendar days of discharge**	2.78	176.50
99496	TCM services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of **high complexity** during the service period; and face-to-face visit **within seven calendar days of discharge**	3.79	236.77

Chronic Care Management (CCM) and Complex Care Management (CCCM)

- Comprehensive assessment of the patient's medical, functional, environmental, and psychosocial needs
- Provides ongoing treatment to patients between regular appointments delivered through remote interactions
- Two or more chronic conditions expected to last a minimum of 12 months (2+ ICD-10s); must note any chronic issues 12 months prior to CCM enrollment
    - Chronic conditions must pose a significant risk of death, acute decompensation, or functional decline
- Delivered through remote interactions
- Patient residing at home or in a domiciliary, rest home, or assisted living facility
- Patient written or verbal consent required (including cost sharing, right to stop)
- Only 1 physician/QHP can bill for CCM or CCCM per calander month
    - Requires initiating E/M visit within 1 year (must discuss CCM)
    - Must use certified EHR
    - Provide 24/7 access and continuity of care
    - Enhanced communication opportunities (i.e. email, patient portal)
- Establishment or revision of an electronic comprehensive care plan
    - Addresses all health issues, focus on managing chronic conditions
    - Copy to patient / family / other caregivers
- Comprehensive Care Plan must be established, implemented, revised, or monitored
- Provide Comprehensive Care Management
    - Assess the patient's medical, functional, and psychosocial needs
    - Make sure the patient receives timely recommended preventive services
    - Oversee the patient's medication self-management
    - Facilitate access to care and services
    - Assess and support patient compliance with treatment plan and medication adherence
    - Provide patient/caregiver education
    - Identify resources
    - Communicate with home health agencies
    - Communicate aspects of care with patients and caregivers
    - Collect health outcomes data and registry documentation

RVU	Description	wRVU	$
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; **first 20 minutes of clinical staff time** directed by a physician or other qualified health care professional, **per calendar month**	1.00	62.00
99439	Chronic care management services, **each additional 20 minutes of clinical staff time** directed by a physician or other qualified health care professional, **per calendar month**	0.70	61.00

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 comprehensive care plan, moderate or high complexity medical decision making; **first 60 minutes of clinical staff time** directed by a physician or other qualified health care professional, **per calendar month**	1.81	130.00
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 significant revision of 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)	1.00	69.00
99491	Chronic care management services, **provided personally by a physician or other qualified healthcare professional**, **at least 30 minutes** of physician or other qualified healthcare 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	1.50	86.17
99437	Chronic care management services, **provided personally by a physician or other qualified health care professional**, 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; **each additional 30 minutes** by a physician or other qualified health care professional, **per calendar month** (List separately in addition to code for primary procedure)	1.00	61.25
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	0.87	62.04

Principal Care Management (PCM)

- Treatment of single chronic condition or multiple chronic conditions but focused on single high-risk condition
    - Expected to last 6 months – 1 year or until the patient's death
    - Chronic condition is expected to last between, at minimum, 3 months to lifelong
    - Chronic condition must place the patient at significant risk of death, acute exacerbation or decompensation, or a state of functional decline, and/or be associated with a recent hospitalization
- Delivered through remote interactions
- Typically billed by a specialist; expected outcome is stabilization and return care to PCP
- Patient written or verbal consent required (including cost sharing, right to stop)
- Multiple providers can bill for PCM within a calendar month
    - Requires initiating E/M visit within 1 year (must discuss PCM)
    - Must use certified EHR
    - Provide 24/7 access and continuity of care
    - Enhanced communication opportunities (i.e. email, patient portal)
- Establishment or revision of an electronic disease-specific care plan
    - Addresses disease-specific health issues
    - Copy to patient / family / other caregivers
- Disease-specific Care Plan must be established, implemented, revised, or monitored
- Provide Disease-specific Care Management
    - Assess the patient's medical, functional, and psychosocial needs for 1 diagnosis
    - Make sure the patient receives timely recommended preventive services
    - Oversee the patient's medication self-management
    - Facilitate access to care and services
    - Assess and support patient compliance with treatment plan and medication adherence
    - Provide patient/caregiver education
    - Identify resources
    - Communicate with home health agencies
    - Communicate aspects of care with patients and caregivers
    - Collect health outcomes data and registry documentation
- Cannot deliver CCM and PCM to the same patient in the same month

RVU	Description	wRVU	$
99424	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; **first 30 minutes provided personally by a physician or other qualified health care professional**, **per calendar month**	1.45	83.40

99425	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; **each additional 30 minutes provided personally by a physician or other qualified health care professional**, **per calendar month** (List separately in addition to code for primary procedure)	1.00	58.00
99426	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; **first 30 minutes of clinical staff time** directed by physician or other qualified health care professional, **per calendar month**	1.00	61.00
99427	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; **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)	0.71	49.00

Care Plan Oversight (CPO)

- Physician spends at least 30 minutes per month
- Depend on whether the patient is under the care of a home health agency (HHA) or hospice, the time spent each month, and the payer class

RVU	Description	wRVU	$
99483	Assessment of and care planning for a patient **with cognitive impairment**, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., Basic and Instrumental Activities of Daily Living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., Functional Assessment Staging Test [FAST], Clinical Dementia Rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support; typically, **50 minutes** are spent face-to-face with the patient and/or family or caregiver	3.84	265
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	0.87	

Remote Physiologic Monitoring (RPM)

- Tracks patients' health issues through the transmission of clinical data via a digital device
- Devices must meet the Food and Drug Administration's (FDAs) criteria for a designated medical device, such as weight scales, blood pressure monitors, pulse oximeters, glucometers, heart rate monitors, thermometers, spirometers
- On a monthly basis, patients must receive at least 20 minutes of service and/or record 16 days of remote device readings for Medicare to offer reimbursement
- Providers must
    - Use a certified electronic health record (EHR) technology
    - Spend at least 20 minutes per month with the patient and/or record 16 days of remote device readings
    - Document time and device readings
    - Compile monthly reports and summary of RPM data
    - Have 24/7 access to care management services
    - Track readings from connected devices
    - Have RPM data available 24/7 for the entire staff
    - Share RPM data with the EHR and other providers
- Codes for devices and for care coordination
- Device must automatically collect data
- Care coordination by interactive virtual communication

RVU	Description	wRVU	$
99453	**Initial set-up & patient education** on equipment (one-time fee)	0.00	18.48
99454	Supply of devices, collection, transmission, and report/ summary of services to the clinician	0.00	54.10
99457	Remote physiologic monitoring services by **clinical staff/MD/QHCP first 20 cumulative minutes** of RPM services over a **30-day period**	0.61	48.72
99458	Remote physiologic monitoring services by clinical staff/MD/QHCP for an **additional cumulative 20 minutes** of RPM services over a **30-day period**	0.61	39.65
99091	Collection and interpretation of data by physician or QHCP, **30 minutes**	1.10	54.77

Remote Therapeutic Monitoring (RTM)

- Use of a medical device (as defined by the FDA) to monitor a patient's health or response to treatment using non-physiological data
- Medication adherence, response to therapy, musculoskeletal activity, and respiratory activity; allows for self-reported data from the patient
- Data around indicators such as therapy/medication adherence, therapy/medication response, and pain level can be collected and billed under the new RTM codes
- 16 days of readings every 30 days
- Cannot be combined with RPM

RVU	Description	wRVU	$
98975	Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); **initial set-up and patient education** on use of equipment	0.00 PE 0.55	18.82
98976	Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); **device(s) supply** with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor **respiratory** system, each 30 days	0.00 PE 1.47	54.10
98977	Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); **device(s) supply** with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor **musculoskeletal** system, each 30 days	0.00 PE 1.47	54.10
98978	Remote therapeutic monitoring (e.g. respiratory system status, musculoskeletal system status, therapy adherence, therapy response); **device(s) supply** with scheduled (e.g. daily) recording(s) and/or programmed alert(s) transmission to monitor **cognitive behavioral treatment,** each 30 days	0.00 PE 0.00	0
98980	RTM treatment management services, time over a calendar month requiring at least **one interactive communication** with the patient/caregiver; **first 20 minutes** of E/M	0.62	48.72
98981	RTM treatment management services, time over a calendar month requiring at least **one interactive communication** with the patient/caregiver; **each additional 20 minutes** of E/M services	0.61	30.57

Psychiatric Collaborative Care Management (PCCM)

- Collaborative Care team is led by a primary care provider (PCP) and includes behavioral health care managers, psychiatrists and frequently other mental health professionals
- Primary care provider or specialty treating practitioner
- Psychiatric consultant
- Care management support for patients receiving behavioral health treatment
- Regular (weekly) psychiatric inter-specialty consultation
- Use of validated rating scales
- Tracking patient follow-up and progress using a registry
- Brief evidence-based interventions

RVU	Description	wRVU	$
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	1.88	162.18
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	2.05	129.38

	relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment		
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.	0.82	67.03

General Behavioral Health Integration (BHI)

- Patient must have a behavioral health or psychiatric condition, including substance use disorders, that, in the clinical judgment of the physician/QHP, warrants psychiatric services
- Patient must have received a visit furnished by a physician/QHP no more than one-year prior to commencing PCCM or BHICM
- Can be billed once per month by the physician or QHP supervising the clinical staff rendering the BHICM
- Coordinating care with the emergency department may be reported using 99484, but time spent while the patient is inpatient or admitted to observation status may not be reported using 99484

RVU	Description	wRVU	$
99484	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 time, 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 or psychiatric health problems, including revision for patients not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling or psychiatric consultation; Continuity of care with a designated member of the care team	0.61	48.65
G2214	Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional: Tracking patient follow-up and progress using the registry, with 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; other review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations supplied by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment)	0.77	60.13

Advanced Care Planning (ACP)

RVU	Description	wRVU	$
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	1.50	85.93
99498	**each additional 30 minutes** (List separately in addition to code for primary procedure)	1.40	74.83

Chronic Pain Management (CPM)

- Diagnosis
- Assessment and monitoring
- Administration of a validated pain rating scale or tool
- Development, implementation, revision, and/or maintenance of a patient-centered care plan that includes strengths, goals, clinical needs, and desired outcomes
- Overall treatment management
- Facilitation and coordination of any necessary behavioral health treatment
- Medication management
- Pain and health literacy counseling
- Any necessary chronic pain related crisis care
- Ongoing communication and care coordination between relevant practitioners furnishing care

RVU	Description	wRVU	$
G3002	Initial face-to-face visit for at least 30 minutes provided by a physician or other qualified health professional per calendar month	1.45	79.02
G3003	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional per calendar month (listed separately and in addition to code G3002)	0.50	28.76

Patient Education

- Use a standardized curriculum that is consistent with guidelines or standards established or recognized by a health care professional society or association
- The patient must be present and actively engaged in the education and training
- Don't report these codes for patient or caregiver education that occurs as part of another evaluation or treatment service
- Follow established guidelines for meeting minimum time requirements for time-based codes
- Not billable for < 15 minutes

RVU	Description	wRVU	$
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) **each 30 minutes; individual patient**	0.00 PE 0.85	38
98961	2-4 patients	0.00 PE 0.41	
98962	5-8 patients	0.00 PE 0.30	

Medical Team Conferences

- A minimum of three qualified health care professionals from different specialties or disciplines who provide direct care to the patient must participate in the reported team conference
- No more than one individual from the same specialty may report 99366-99368 at the same encounter
- Reporting participants must be present for the entire team conference
- Reporting participants shall have performed face-to face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days
- Follow established guidelines for meeting minimum time requirements for time-based codes
- The time for the team conference starts at the beginning of the case review and ends at the conclusion of the review. Record keeping or report generation time is not included.
- Reporting participants should record their role in the conference, contributed information, and subsequent treatment recommendations

RVU	Description	wRVU	$
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by nonphysician qualified health care professional	0.82	
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional	1.10	