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Arizona Telemedicine Program

The Southwest Telehealth Resource Center

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- Webinar is being recorded
- Recordings will be posted on the ATP website
    - http://telemedicine.arizona.edu/webinars/previous

CONTINUING MEDICAL EDUCATION

Outcome Objectives

- Differentiate between asynchronous care management services and telehealth services, and accurately classify at least three common scenarios (RPM, CCM, eVisit) as telehealth vs non-telehealth for billing/compliance.
- Apply Medicare and commercial payer coverage rules to see if asynchronous services are covered (CCM, RPM, RTM, eConsults) and what kind of documentation is needed.
- Develop at least one workflow or process improvement strategy to integrate asynchronous CM services into clinical practice, while maintaining compliance, improving patient engagement, and optimizing reimbursement.

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All Faculty, CME Planning Committee Members, and the CME Office Reviewers have disclosed that they do not have any relevant financial relationships with ineligible companies that could constitute a conflict of interest concerning this CME activity.

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Please participate in this brief evaluation and find the code number and instructions for today's session to log your attendance for CME credit.

Evaluation link will populate in separate URL and be posted in the chat.

This webinar is made possible through funding provided by Health Resources and Services Administration, Office for the Advancement of Telehealth (U1U42527).

Care Management Services: What's Telehealth VS Not Telehealth

Carol Yarbrough, MBA, CCA, CPC, OCS, CHC
Billing, Compliance & Reimbursement Advisor

Things to Remember

- The slides will be provided after the webinar is over, as well as a recording, on the SW TRC site: https://telemedicine.arizona.edu/webinars/previous
- Ask questions as we go along and I'll try to answer in context, but there will also be time at the end
- Enjoy the next hour – I'll try to keep it entertaining!

Agenda

- Care Management Services: what makes them *not* telehealth?
- Policy Extravaganza
- Clinical Examples

Care Management Services: what makes them *not* telehealth?

Care Management: a mixed bag

- Synchronous
  - The initiating visit must be face-to-face
  - Can be done during a telehealth or in-clinic visit
- Asynchronous
  - The behind-the-scenes activities that a provider and their staff do to take care of a patient's needs

Telehealth is Synchronous – *only*

- Social Security Act, 1834(m)
  - In general.—The term “telehealth service” means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241–99275, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.
- Medicare Telehealth List
  - Synchronous services are on the list; no asynchronous activities represented by CPTs and definitions are on it
  - https://www.cms.gov/medicare/coverage/telehealth/list-services

Billing Implications

- POS 02 and 10 are for telehealth services
- If somewhat telehealth shaped, why not telehealth?
  - Because it's not on the list!

Place of Service Codes

POS Code	Description	CCM Allowed?	Notes
11	Office	Yes	Most common; default for practitioners in office-based practice
22	Outpatient Hospital	Yes	Used when practitioner is hospital-based outpatient
19	Off-Campus Outpatient Hospital	Yes	Same as 22 but for off-campus site
31	Skilled Nursing Facility	Yes, with limits	Only when practitioner is **not employed by** the SNF (e.g., community physician managing care)

Place of Service Codes

POS Code	Description	CCM Allowed?	Notes
32	Nursing Facility	Yes	Same as above — must meet incident-to and supervision rules
49	Independent Clinic	Yes	Allowed if clinic maintains medical oversight
65	ESRD Facility	Conditional	If patient receives regular dialysis care, ensure it's medically distinct and not duplicative of dialysis CCM
02 / 10	Telehealth (patient home, respectively)	**No**	CCM is **not a telehealth service**; it's a **non-face-to-face** service, so 02/10 are inappropriate POS codes
12	Home	No	Even though the patient resides there, the **POS is where the billing practitioner practices**, not the patient's location

The CCM Code "Groups": From Easiest to Implement to Most Difficult

- Transitional Care Management
- General Behavioral Health Integration Care Management
- Principal Care Management
- Remote Physiological Monitoring
- Remote Therapeutic Monitoring
- Chronic Care Management
- Complex Chronic Care Management
- Psychiatric Collaborative Care Management

Coverage Policies

Transitional Care Management: the Codes

- 99495:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision-making of at least moderate complexity during the service period
  - Face-to-face visit within 14 calendar days of discharge.
- 99496:
  - Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  - Medical decision-making of at least high complexity during the service period
  - Face-to-face visit within 7 calendar days of discharge.

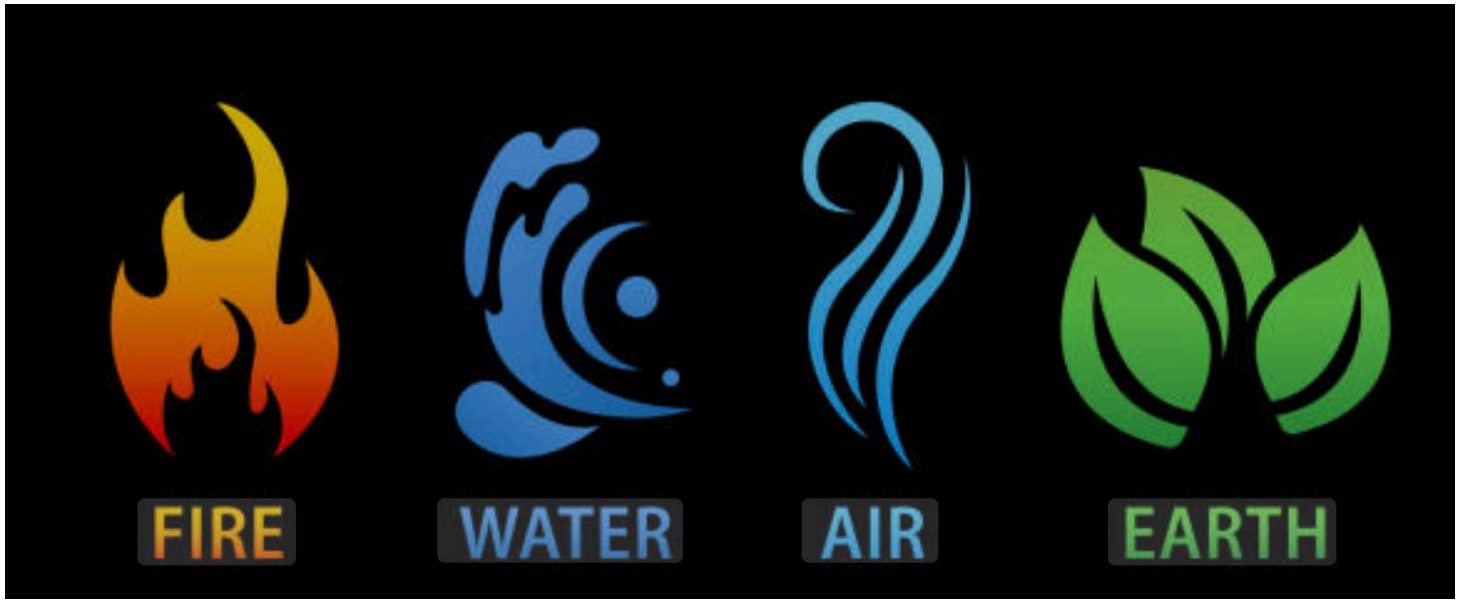
A Policy: UHC's Time-Based Codes

Only one individual may report these services and only once per patient **within 30 days of discharge**. Another TCM may not be reported by the same individual or group for any subsequent discharge(s). The same individual may report hospital or observation discharge services and TCM. However, the discharge service may not constitute the required face-to-face visit. The same individual should not report TCM services provided in the postoperative period of a service that the individual reported

- https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-reimbursement/MEDADV-Time-Span-Codes-Policy.pdf

General Behavioral Health Integration Care Management, 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, per calendar month, with the following required elements:



- initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, and/or psychiatric consultation;
- and continuity of care with a designated member of the care team.

IMPORTANT TO NOTE:

- MD, NP or PA must bill or supervise (facilities can bill out on UB-04)
- 20 min at least
- Need a treatment plan
- Staff does not need to be a behavioral health practitioner

Aetna: March 2025 OfficeLink Updates

- States that the service is a covered benefit (page 46)
- "We expect collaborative care and reimburse for it."

- https://www.aetna.com/content/dam/aetna/pdfs/olu/officelink-updates-march-2025-olu.pdf

99484 is distinct from CoCM services

Element	99484 (General BHI)	99492–99494 (CoCM)
Psychiatric consultant	Not required	Required
Designated behavioral health care manager	Not required (but you need clinical staff time)	Required
Minimum time per month	≥ 20 minutes	70–120 minutes (varies by code)
Supervision	General supervision by billing practitioner	General supervision
Payment	Lower reimbursement	Higher (multiple-tiered)
Example setting	Primary care practice managing anxiety, depression, or SUD with check-ins	Fully integrated behavioral health collaborative model with psychiatrist consult

Alert! What follows is out of (my) Sequence!

Going into CoCM just for a bit to stay on the behavioral health care topic

Code	Description	Time Requirement (per calendar month)	Who Performs the Work	When to Use	Approx. 2025 Medicare Pmt. (natl. avg, non-facility)
99492	Initial psychiatric collaborative care management, **first 70 minutes** in the first calendar month	≥70 minutes total staff time (directed by the billing practitioner)	Behavioral health care manager (BHCM) under general supervision; psychiatrist or psychiatric consultant involved	First month	~$161
99493	Subsequent psychiatric collaborative care management, **first 60 minutes** in a subsequent month	≥60 minutes	BHCM + psychiatric consultant	Ongoing	~$127
99494	**Each additional 30 minutes** of CoCM services (add-on to 99492 or 99493)	≥30 minutes beyond the base time	BHCM under general supervision	Add-on	~$65 per 30 min

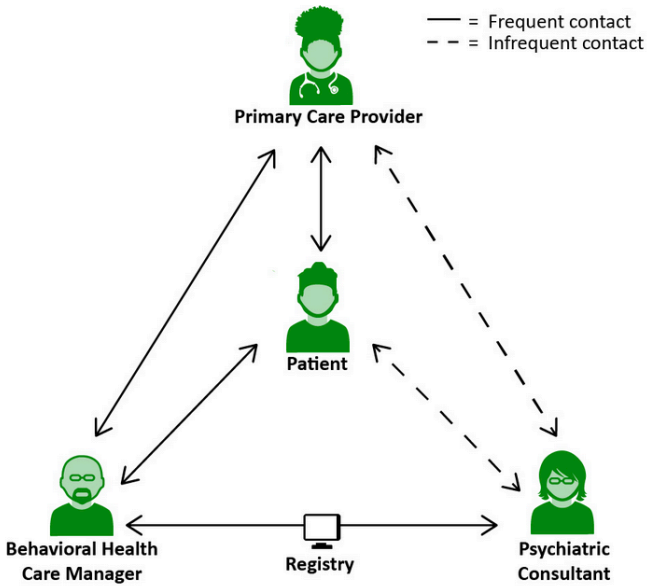
One more code:

Code	Description	Time Requirement (per calendar month)	Who Performs the Work	When to Use	Approx. 2025 Medicare Pmt (natl. avg, non-facility)
G2214	**Initial or subsequent month, at least 30 minutes** of CoCM (short month)	≥30 but <70 minutes in first month, or ≥30 but <60 minutes in subsequent month	BHCM under general supervision	Used instead of 99492/99493 when total time is below base threshold but ≥30 minutes	~$74

Univ of WA and the APA have training and resources

Collaborative Care Team

CoCM requires a team of providers. Trained Primary Care Providers (PCP) work with embedded Behavioral Health Care Managers (BHCM) to provide evidence-based medication or psychosocial treatments. The PCP and BHCM are supported by a Psychiatric Consultant who meets regularly with the BHCM for Systematic Caseload Review (SCR), where they consult on patients and adjusts treatment for those who are not improving as expected.



Free Coaching Available

As an added benefit to licensing the AIMS Caseload Tracker, our team of experts will offer two-hours of FREE clinical and/or implementation coaching to help your team with questions or challenges you may be facing with your CoCM program. We can help regardless of whether you are just launching CoCM or have years of experience.

Commonalities of the CoCM Codes

Element	CMS Definition
Behavioral Health Care Manager (BHCM)	Provides ongoing assessment, care planning, and coordination
Psychiatric Consultant	Reviews cases weekly, recommends treatment adjustments
Billing Practitioner	Oversees the team, bills for the service (e.g., PCP, NP, PA)
Structured Care Plan	Documented and available to patient and treating team
Validated Rating Scales	Used to monitor clinical outcomes (e.g., PHQ-9, GAD-7)
Monthly Time Tracking	Cumulative minutes of BHCM and consultant activities logged each calendar month

Who Pays for It?

State Medicaid Coverage for Collaborative Care Management Codes

State	Coverage*	Rates Listed on Medicaid Fee Schedule	Medicare Rate Comparison (Non-Facility)	Written Guidelines Published
Alabama	No			
Alaska	No			
Arizona	Yes	Yes	Below	No
Arkansas	Yes	No	Undetermined	No
California	Yes	Yes	Below	No
Colorado	No			
Connecticut	Yes	Yes	Above	Yes

https://mmhpi.org/wp-content/uploads/2025/04/Medicaid-Coverage_Collaborative-Care-Management-Codes.pdf

APA video of how to manage and get reimbursed with clinical examples:
https://vimeo.com/440768429/a32276f6fe

Arizona Specific Payers

Payer	CoCM coverage (99492 / 99493 / 99494 / G2214)	Key billing / documentation notes	Source
AHCCCS (AMPM / Covered Behavioral Health Services Manual)	Yes — AHCCCS explicitly includes the Psychiatric Collaborative Care Model (CoCM) in its Covered Behavioral Health Services Manual and references use of CPT 99492/99493/99494 (and related guidance).	Manual describes elements (behavioral health care manager, psychiatric consultant, PCP duties), time-tracking, and that 99494 is an add-on to 99492/99493. Verify MCO contract rules for local implementation.	AHCCCS Covered Behavioral Health Services Manual (AMPM). (AHCCCS)
Mercy Care (AZ MCO) — Provider Manual / Provider Resources	Yes / Implemented — Mercy Care provider materials reference Psychiatric Collaborative Care Management and list the CoCM CPT codes (99492–99494) in program/clinical materials and coding/gap-closure guides.	Mercy Care's provider manual and gap-closure/ref guides show use of CoCM codes and program activities; verify Mercy Care-specific billing rules	Mercy Care Provider Manual & provider resources / gap-closure guide. (Mercy Care Arizona)

Where are we? How can you combine virtual modalities and "on-ground" services?

- Transitional Care Management ☑
- General Behavioral Health Integration Care Management ☑
- Principal Care Management
- Remote Physiological Monitoring
- Remote Therapeutic Monitoring
- Chronic Care Management
- Complex Chronic Care Management
- Psychiatric Collaborative Care Management ☑

Principal Care Management – QHP

CPT	Time / Description	Who Bills	Who Performs	Key Requirements
99424	*First 30 min/mo* – QHP time managing **one high-risk condition**	Physician, NP, PA, CNS, CNM	**QHP only** (not staff)	- ≥3 mo expected duration- Frequent adjustments- 30 min of provider time- Care plan created / updated- Document patient consent
99425	*+ Each add'l 30 min/mo*(add-on to 99424)	Same as 99424	Same as 99424	- ≥60 min total QHP time- Separate time documentation

Principal Care Management - Staff

CPT	Time / Description	Who Bills	Who Performs	Key Requirements
99426	*First 30 min/mo* – **clinical staff** time under QHP direction	Physician, NP, PA, CNS, CNM	**Clinical staff** under **general supervision**	- One condition, ≥3 mo- Active care plan- ≥30 min staff time- Consent required- Only one provider bills per pt/mo
99427	*+ Each add'l 30 min/mo*(add-on to 99426)	Same as 99426	Same as 99426	- ≥60 min total staff time- Add in 30-min increments- Fully document time & activity

How should this be done?

Category	Requirement / Policy Summary
Qualifying condition	One chronic, complex condition (≥3 months, ongoing management) — e.g., CHF, COPD, diabetes, substance use disorder
Distinct from CCM	Cannot bill for same condition in same month; allowed concurrently if addressing *different* conditions
Supervision	99426–99427: **General supervision** allowed (42 CFR §410.26)
Care plan	Required — includes problem list, goals, medication, follow-up
Consent	Verbal or written consent documented prior to service
Frequency	Once per calendar month per patient per billing provider

RPM / RTM

- Past webinar available:
  - https://telemedicine.arizona.edu/sites/default/files/webinar_files/Open.Close%20slide%20CME%20Webinar%203.30.2023.pdf
  - Video: https://www.youtube.com/watch?v=lPW_PzHjVP8 (4 views, only! – let's drive up the usage and everyone go watch it ;-))
- Remember!
  - 2026 Final Medicare Physician Fee Schedule due in mid-November to early December 2025
  - New RPM codes to allow for 2-15 days of data collected
  - Webinar w 2026 Final Rule Updates: TBD

Chronic Care Management - QHP

CPT	Time / Description	Who Bills	Who Performs	Key Requirements
99491	*First 30 min/mo* of **QHP** (physician/NP/PA) time personally spent	Same as above	**QHP only** (not staff)	– ≥2 chronic conditions– Direct provider time ≥ 30 min– Separate note and time statement
99437	*Each add'l 30 min/mo* (add-on to 99491)	Same as 99491	Same as 99491	– Used when QHP time ≥ 60 min– Must document add'l time

Chronic Care Management - Staff

CPT	Time / Description	Who Bills	Who Performs	Key Requirements
99490	*First 20 min/mo* of **clini cal staff** time for ≥2 chronic conditions	Physicia n, NP, PA, CNS, CNM	Clinical staff under **gen'l supervision**	– ≥2 chronic conditions (≥12 mo or risk of death/decompensation)– Comprehensive care plan– Patient consent (doc.)– Structured recording in EHR (shared access)
99439	*Each add'l 20 min/mo*(add-on to 99490)	Same as 99490	Same as 99490	– Used when staff time ≥ 40 min/mo– Add 20-min increments– Document all time & activity

How should this be done?

Category	Requirement / Policy Summary
Qualifying conditions	≥2 chronic conditions lasting ≥12 months or risk of death/decompensation
Distinct from PCM	CCM manages ≥2 conditions; PCM is for 1 condition only — can bill together if different conditions
Supervision level	General supervision allowed under 42 CFR §410.26
Care plan	Comprehensive electronic care plan — problem list, medications, goals, follow-up

How should this be done?

Category	Requirement / Policy Summary
Patient consent	Verbal or written consent documented in chart before service
Frequency / limit	Once per calendar month per patient per provider TIN
Non-overlap rule	Only one provider can bill CCM per month for the same patient
Documentation tips	Record total minutes, care plan activities, and coordination notes
Care Team Access	Care plan must be available electronically to all team members
Time thresholds	99490 = 20 min; 99439 +20 min increments; 99491 = 30 min QHP; 99437 +30 min increments

Complex CCM - QHP

CPT Code	Descriptor	Who Performs	Minimum Time / Month	Supervision Level
99491	CCM personally provided by physician/QHP — first 30 min	QHP only	≥30 min	Direct (provider personal time)
99437	Each additional 30 min of CCM personally provided by QHP	QHP only	+30 min	Direct (provider personal time)

Complex CCM - Staff

CPT Code	Descriptor	Who Performs	Minimum Time / Month	Supervision Level
99487	Complex CCM — first 60 min clinical staff time directed by QHP, *moderate or high complexity* MDM	Clinical staff under QHP	≥60 min	General
99489	Each additional 30 min of Complex CCM	Clinical staff under QHP	+30 min	General

Complex v Basic – what fits your patient pop?

Feature	Complex CCM (99487 / 99489)	Basic CCM (99490 / 99439 / 99491 / 99437)
# of Conditions	≥ 2 chronic conditions (same as CCM)	≥ 2 chronic conditions
Time Threshold	99487 = first 60 min99489 = each additional 30 min	99490 = 20 min (staff)99439 = +20 min99491 = 30 min (provider)99437 = +30 min
Complexity Level	**Moderate or High** MDM (E/M 2023 guidelines)	Low to Moderate MDM
Supervision Level	General supervision	General supervision
Who Performs	Clinical staff or QHP	Clinical staff or QHP

Complex v Basic

Feature	Complex CCM (99487 / 99489)	Basic CCM (99490 / 99439 / 99491 / 99437)
Who Performs	Clinical staff or QHP	Clinical staff or QHP
Care Plan	Required – must document *complex*coordination and medication management	Required – may be less intensive
Consent	Verbal or written, documented	Verbal or written, documented
Typical Monthly Work	Medication titration, frequent updates, multiple specialists	Routine follow-up, stable condition monitoring
Billing Limitations	1 provider per patient/month	1 provider per patient/month
Medicare Payment (Approx.)	$93–$145 (varies by MAC/locality)	$62–$140 (varies by MAC/locality)

Example 1: Mr. Lopez, 72, has Type 2 Diabetes and Hypertension.

- Summary:
- Both conditions are well-controlled with stable medications.
- The care team (MA and RN) conducts monthly phone outreach to review glucose readings and blood pressure logs.
- RN updates the electronic care plan and coordinates with the PCP about an overdue eye exam and medication refill.
- No medication changes or new complications this month.

Example 1: Activities and Billing

- Monthly Care Management Activities:
  - 25 minutes of staff time logged (phone check-in, documentation, care coordination).
  - Care plan reviewed and updated in the EHR.
  - Verbal consent for CCM on file.
- Billing:
  - CPT 99490 (20 minutes, clinical staff time)
  - Meets basic CCM requirements — ≥2 chronic conditions, low complexity, routine coordination.

Example 2: Ms. Thompson, 68, has CHF, COPD, and CKD stage 3

- Summary:
- Over the past month, she experienced two medication adjustments (diuretics and inhaler regimen).
- The RN and pharmacist conducted multiple follow-ups (three phone calls and one telehealth check-in).
- The care team coordinated among cardiology, nephrology, and pulmonology.
- The care plan required updates weekly as her weight fluctuated and renal function declined slightly.
- The physician personally reviewed notes and authorized changes.

Example 2: Activities and Billing

- Monthly Care Management Activities:
  - 75 minutes of clinical staff time under general supervision (RN and pharmacist).
  - Documented moderate-complexity medical decision-making due to multi-system risk and frequent medication titrations.
  - Updated shared electronic care plan accessible to all specialists.
- Billing:
  - CPT 99487 (first 60 min)
  - CPT 99489 (additional 30 min)
  - Meets complex CCM due to both time (≥60 min) and MDM complexity (moderate to high).

Questions

Resources

- SSA 1834(m): https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
- UHC RPM Policy: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/index/mamp/remote-physiologic-monitoring-mamp-01012026.pdf
- https://aims.uw.edu/collaborative-care/
- https://www.psychiatry.org/Psychiatrists/Practice/Professional-Interests/Collaborative-Care
- https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/AHCCCSCoveredBHServicesManual.pdf
- https://www.cms.gov/files/document/chroniccaremanagement.pdf