
Evaluation and Management (E&M)

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The *Current Procedural Terminology* (CPT®) book includes codes for billing Evaluation and Management (E&M) procedures. It is important that providers use the current version of the CPT and report E&M code definitions carefully.

General Information

The following paragraphs include general information about E&M procedures.

Levels of Care

Within each category and subcategory of E&M service, there are three to five levels of care available for billing purposes. These levels of care are not interchangeable among the different categories and subcategories of service. The components used to describe and define the various levels of care are listed in the “Evaluation and Management” section of the CPT book.

Unlisted E&M Services

CPT codes 99429 (unlisted preventive medicine service) and 99499 (unlisted evaluation and management service) require an approved *Treatment Authorization Request* (TAR) in order for these codes to be reimbursed.

Providers should include the following documentation when requesting the TAR:

- An adequate definition or description of the nature, extent and need for the procedure or service
- The time, effort and equipment necessary (if appropriate) to provide the service

Modifiers

Modifiers used to describe circumstances that modify a listed E&M code are listed with their descriptors in the *Modifiers: Approved List* and *Modifiers Used With Procedure Codes* sections of the appropriate Part 2 manual.

Psychotherapy Services

Refer to the *Psychiatry* section in the appropriate Part 2 manual for information about billing E&M services in conjunction with psychotherapy services.

Overriding Justification

Billing CPT codes 92002 thru 92014 (general ophthalmological services) and «99202» thru 99499 (E&M services) with modifier 24, 25 or 57 overrides the requirement of documenting medical justification when billed in conjunction with a surgical procedure as follows:

Overriding Justification Modifiers

Modifiers	Description	Application
24	Unrelated E&M service by the same physician or other qualified health care professional during a postoperative period	Minor (follow-up days of zero or 10) or major surgical procedures (follow-up days of 90)
25	Significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day of the procedure or other service	Minor (follow-up days of zero or 10) or major surgical procedures (follow-up days of 90)
57	Decision for surgery (major surgery only, day before or day of procedure)	Major surgical procedures only (follow-up days of 90)

Pregnancy-Related Services

When billing for any medically necessary service during pregnancy or the postpartum period, include a pregnancy diagnosis code on all claims. Claims submitted without a pregnancy diagnosis may be denied. Refer to the *Pregnancy: Early Care and Diagnostic Services* section of this manual for additional information.

New Patient Reimbursement

A new patient is one who has not received any professional services from the provider within the past three years. If a new patient visit has been paid, any subsequent claim for a new patient service by the same provider, for the same recipient received within three years will be paid at the level of the comparable established patient procedure.

RAD Reductions

The payment resulting from this change in the level of care will be made with a Remittance Advice Details (RAD) message defining the reduction as being in accordance with the service limit set for the procedure. «These codes are listed in the *Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations* spreadsheet in the *Remittance Advice Details (RAD) and Medi-Cal Financial Summary* section.» Providers who consider the service appropriate and the reduction inappropriate should submit a *Claims Inquiry Form (CIF)*.

Established Patient Reimbursement

An established patient is one who has received professional services from the provider within the past three years.

Providers on Call

If a provider is on call or covering for another provider, any service rendered must be classified as it would have been by the provider who is not available.

E&M Services Separately Reimbursable

The following CPT codes for E&M services are separately reimbursable if billed by the same provider, for the same recipient and same date of service, and if the required documentation is included in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment included with the claim.

- New patient, office or other outpatient visit (<<99202>> thru 99205) and new or established patient, office or other outpatient consultation (99241 thru 99245)

Claims for codes 99241 thru 99245 must document the following:

- Another provider requested the patient consultation;
 - Consultation was regarding a separate problem than that of the earlier initial patient visit; and
 - Medical necessity
- New or established patient, subsequent hospital care (99231 thru 99233) and new or established patient, initial inpatient consultation (99251 thru 99255)

Code combinations 99231 thru 99233 and 99251 thru 99255 may be reimbursed when:

- Two different physicians provide inpatient services to the same recipient on the same date with the same group provider number. Documentation must be submitted with the claim to medically justify two services on the same day.
- One physician provides inpatient services to a recipient twice on the same date of service. Documentation must be submitted with the claim to medically justify two services on the same day.

Frequency Restrictions

The frequency restriction for CPT codes 99211 thru 99214 may be exceeded with medical justification. Providers must submit the medical justification with the original claim when established E&M visits exceed six in 90 days. Providers must document that the patient's acute or chronic condition requires frequent visits in order to monitor their condition with the goal of decreasing hospitalizations.

Dispensing of Hormonal Contraceptives

Refer to the *Family Planning* section in the appropriate Part 2 manual for information regarding E&M services and dispensing of hormonal contraceptives.

Prolonged E&M Services

Prolonged services include outpatient services CPT codes 99354, 99355, 99415, 99416 <<and 99417>> and inpatient services CPT codes 99356 and 99357.

Outpatient Services: Direct Patient Contact

Outpatient E&M CPT code 99354 («prolonged service[s] in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour») must be billed in conjunction with one of the following E&M codes: «99241 thru 99245, 99324 thru 99337 or 99341 thru 99350.»

Outpatient E&M CPT code 99355 («prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; each additional 30 minutes») must be billed in conjunction with code 99354.

Billing Calculations

CPT codes 99354 and 99355 are subject to the least restrictive frequency limitation as the required companion code. To calculate the amount of time that is payable for prolonged outpatient services, take the total face-to-face time and subtract the time of the primary E&M service. The following table may be used to calculate billing for prolonged outpatient E&M codes 99354 and 99355.

Prolonged Outpatient E&M Billing: Codes 99354 & 99355

Time of E&M Visit Code Not Included	First Hour	Each Additional 30 Minutes
Less than 30 minutes	Not reported	Not reported
30 to 74 minutes	99354	Not reported
75 to 104 minutes	99354	99355
105 or more minutes	99354	99355 (quantity of 2 or more for each additional 30 minutes)

«Outpatient Services: With or Without Direct Patient Contact

Outpatient E&M CPT code 99417 (prolonged office or other outpatient evaluation and management service(s) beyond the minimum required 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 of total time) must be billed in conjunction with one of the following E&M codes: 99205 or 99215. The maximum frequency limit for 99417 is 10 per day. Do not report 99417 for any time unit less than 15 minutes. »

«Billing Calculations

CPT code 99417 is subject to the least restrictive frequency limitation as the required companion code. The following table may be used to calculate billing for prolonged outpatient E&M code 99417.

Prolonged Outpatient E&M Billing: Code 99417

Total Duration of a New Patient Office or Other Outpatient Service (use with 99205)	Codes
Less than 75 minutes	Not reported
75-89 minutes	99205 and 99417 (1x)
90-104 minutes	99205 and 99417 (2x)
105 or more minutes	99205 and 99417 (3x or more for each additional 15 minutes)

Total Duration of an Established Patient Office or Other Outpatient Service (use with 99215)	Codes
Less than 55 minutes	Not reported
55-69 minutes	99215 and 99417 (1x)
70-84 minutes	99215 and 99417 (2x)
85 or more minutes	99215 and 99417 (3x or more for each additional 15 minutes)»

Outpatient Services: Supervision of Clinical Staff

Outpatient E&M CPT code 99415 (prolonged clinical staff service [the service beyond the «highest time in the range of total time of the service»] during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour) must be billed in conjunction with one of the following E&M CPT codes: «99202» thru 99215.

Outpatient E&M CPT code 99416 (prolonged clinical staff service [the service beyond the «highest time in the range of total time of the service»] during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes) must be billed in conjunction with code 99415.

Billing Calculations

CPT codes 99415 and 99416 are subject to the least restrictive frequency limitation as the required companion code. To calculate the amount of time that is payable for prolonged outpatient services, take the total face-to-face time and subtract the time of the primary E&M service. The following table may be used to calculate billing for prolonged outpatient E&M codes 99415 and 99416.

Prolonged Outpatient E&M Billing: Codes 99415 & 99416

Time of E&M Visit Code Not Included	First Hour	Each Additional 30 Minutes
Less than 45 minutes	Not reported	Not reported
45 to 74 minutes	99415	Not reported
75 to 104 minutes	99415	99416
105 or more minutes	99415	99416 (quantity of 2 or more for each additional 30 minutes)

Inpatient Services

Inpatient E&M CPT code 99356 (prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour) must be billed in conjunction with one of the following E&M service codes: 99221 thru 99223, 99231 thru 99233, 99251 thru 99255, or 99304 thru 99310.

Inpatient E&M services, CPT code 99357 (prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes) must be billed in conjunction with code 99356.

Billing Calculations

CPT codes 99356 and 99357 are subject to the least restrictive frequency limitation as the required companion code. To calculate the amount of time that is payable for prolonged inpatient services, take the total unit/floor time and subtract the time of the primary E&M service. The following table may be used to calculate billing for prolonged inpatient E&M codes 99356 and 99357

Prolonged Outpatient E&M Billing Codes: 99356 & 99357

Time of E&M Visit Code Not Included	First Hour	Each Additional 30 Minutes
Less than 30 minutes	Not reported	Not reported
30 to 74 minutes	99356	Not reported
75 to 104 minutes	99356	99357
105 or more minutes	99356	99357 (quantity of 2 or more for each additional 30 minutes)

Emergency Department Services

Claims for emergency department E&M services must be accompanied by an appropriate diagnosis code reflecting the need for the level of E&M services rendered. Inappropriate upcoding is subject to audit.

No distinction is made between new and established patients in the emergency department. Providers must use CPT codes 99281 thru 99285 when billing for emergency department services, whether the patient is new or established.

If a recipient visits the emergency department more than once on the same date of service, the provider should use the recipient's records from the first visit instead of completing a new evaluation. Claims for E&M services rendered more than once in the emergency department by the same provider, for the same recipient and date of service are reimbursable only if they contain medical justification or an indication from the provider that the recipient came to the emergency department more than once in the same day.

Note: Evaluation and Management (E&M) CPT codes 99281 thru 99285 are physician service codes and under most circumstances, only physicians may submit claims for these codes. The treating physician and the emergency department services may not submit separate claims using these codes for the same recipient and date of service.

E&M codes 99284 and 99285 are not reimbursable together or more than once to the same provider, for the same recipient and date of service. Instead, providers should use code 99283 to bill for second and subsequent recipient visits on the same date of service.

E&M: Place of Service/Facility Type Codes

The CPT codes listed below are restricted to the following facility type/Place of Service codes:

Place of Service/Facility Type Codes Table

CPT Code	Description	Facility Type <i>UB-04</i>	Place of Service Code <i>CMS-1500</i>
<<99202>> thru 99215, <<99417>>	Office Services	13, 71, 72, 73, 74, 75, 76, 79, 83	11, 20, 22, 24, 25, 53, 65, 71, 72
99221 thru 99223, 99231 thru 99233, 99238, 99239	Hospital Services	11, 12	21, 51
99221 thru 99223, 99231 thru 99233, 99238, 99239, 99241 thru 99245, 99251 thru 99255	Subacute Care ^o	Not Applicable	Not Applicable
99234 thru 99236	Observation Hospital, Same Day	Not Applicable	25
99241 thru 99245	Office Consultation	13, 14, 20, 24, 33, 34, 44, 54, 64, 71, 72, 73, 74, 75, 76, 79, 83, 89	11, 12, 20, 22, 23, 24, 25, 53, 55, 62, 65, 71, 81, 99
99251 thru 99255	Initial Inpatient Consultation	11, 12, 25, 26, 27, 65, 71, 73, 74, 75, 76, 86, 89	21, 31, 32, 53, 54, 99
99281 thru 99285	Emergency Department Services	14*	23

Place of Service/Facility Type Codes Table (continued)

CPT Code	Description	Facility Type <i>UB-04</i>	Place of Service Code <i>CMS-1500</i>
99354, 99355	Outpatient Prolonged Services	13, 71, 72, 73	11, 22, 24, 25
99356, 99357	Inpatient Prolonged Services	11, 12, 25, 26, 27, 65, 71, 73, 74, 75, 76, 86, 89	21, 31, 32, 53, 54, 99
«99406, 99407	Tobacco Cessation Counseling	11, 12, 13, 14, 24, 25, 26, 27, 33, 34, 44, 54, 64, 65, 71, 72, 73, 74, 75, 76, 79, 83, 86, 89	11, 12, 20, 21, 22, 23, 24, 31, 32, 53, 54, 62, 65, 71, 72, 99»
99415, 99416	Outpatient Prolonged Services	74, 75, 76, 79, 83	53, 65, 71, 72
99460, 99462	Newborn Care	11, 12	21
99477	Neonate Intensive E&M	13, 14, 24, 34, 44, 54 or 64	21
99492, 99493, 99494	Psychiatric Collaborative Care Management	13, 33, 71, 73, 74, 75, 79	11, 12, 22, 62, 71, 72, 99

Refer to the *CMS-1500 Completion* or *UB-04 Completion – Outpatient Services* section of the appropriate Part 2 manual for facility type/Place of Service codes and descriptions. Refer to the end of these sections to see the correspondence between local and national codes.

Claims for services rendered in an inappropriate facility type/Place of Service will be denied with RAD code 062, “The facility type/Place of Service is not acceptable for this procedure.”

Routine or Standing Orders – Hospitals and Nursing Facilities Level B (NF-B)

Services billed to Medi-Cal that are the result of routine or standing orders for admission to a hospital or Nursing Facility Level B (NF-B) are not reimbursable when applied indiscriminately to all patients. All patient orders, including standing orders for particular types of cases, must be specific to the patient and must represent necessary medical care for the diagnosis or treatment of a particular condition. Claims for routine orders will be subject to audit for medical necessity and will be denied if not justified by the facts relating to the case or if in excess of current patient needs.

The use of routine or standing orders is discouraged by the American College of Surgeons, the California Medical Association, the California Association of Hospitals and Health Systems, the Joint Commission on Accreditation of Healthcare Organizations and the American Medical Association.

Board and Care Facility Services and Home Visit Codes

California Code of Regulations, Title 22, Section 51145 defines “home” as any place of residence of a recipient other than a hospital, Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B) where the recipient is a registered inpatient.

Since board and care facilities can be considered “home” for Medi-Cal patients, home visit CPT codes 99341 thru 99350 may be used to bill Medi-Cal for visits to patients in these facilities. Procedure codes 99304 thru 99316 or 99334 thru 99336, used for visits to board and care facilities, are not acceptable and may lead to claim denial. For services rendered in a board and care facility, use the “home” facility type code “33” on the *UB-04* or Place of Service code “12” on the *CMS-1500* for proper reimbursement.

Nursing Facilities: Frequency of Physician Visits

Reimbursement for physician visits to patients in Nursing Facilities is limited to once a month in NF Level B (NF-B) facilities, and once every two months in NF Level A facilities (NF-A). Medi-Cal regulations mandate visits no less often than once every 30 days for the first 90 days following admission to an NF-B and no less often than once every 60 days for an NF-A patient. To allow flexibility in scheduling NF visits and also to meet medical requirements, Medi-Cal reimburses for visits once a month for NF-B patients and 55 to 60 days for NF-A patients.

Billing Instructions Additional Visits:

In those unusual circumstances that require physician visits in excess of the frequencies above, providers must include justification for the additional visits in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment included with the claim.

Hospital Visits

Physicians submitting claims to Medi-Cal for hospital visits and consultations are reminded that each physician is limited to one initial hospital visit (CPT codes 99221 thru 99223) during the recipient’s hospital stay.

Cutback Reimbursement Rates

Reimbursement for initial inpatient consultation services billed in excess of one per month is cut back as follows:

Initial Inpatient Consultation Cutback Codes

Billed Code	Cutback Code
99251	99231
99252	99231
99253	99232
99254	99232
99255	99232

When any of the following procedure codes have been reimbursed within a previous period of three years to the same provider, for the same recipient, any new patient office visit or home visit codes billed by the provider will be reduced to the reimbursement rate of the corresponding, established visit procedure codes.

Visit Procedure Codes

CPT Code Range	Description
99211 thru 99215	Established patient; office or other outpatient visit
99221 thru 99223	New or established patient; initial hospital care
99231 thru 99233	New or established patient; subsequent hospital care
99241 thru 99245	New or established patient; office consultation
99251 thru 99255	New or established patient; initial inpatient consultation
99347 thru 99350	Established patient; home visit
99354 thru 99357	Prolonged physician service with direct (face to face) patient contact

These restrictions do not apply to California Children's Services (CCS) or the Genetically Handicapped Persons Program (GHPP).

Hospital Visit/Discharge Services Rendered on Same Date of Service

A hospital visit (CPT codes 99221 thru 99223 and 99231 thru 99233) is not separately reimbursable when billed with a hospital discharge service (codes 99238 thru 99239) for the same date of service, for the same provider. However, reimbursement will be allowed for both services when different rendering providers are billing using the same group provider number.

Outpatient Visits: Reimbursement Based on Recipient's Age

Medi-Cal reimburses codes 99205 (new patient visit, level five), 99215 (established patient visit, office or other outpatient visit, level five) «and 99417 (prolonged evaluation and management service, each 15 minutes)» at different levels based on the patient's age. Therefore, payment reflected on the RAD will vary depending on the age of the patient.

Additional E&M Home Visits Require Justification

Only one E&M home visit (CPT codes 99341 thru 99350) is reimbursable when submitted by the same provider, for the same recipient and date of service. Additional home visits billed on the same day, and home visits billed on the same day in conjunction with office visit codes «99202» thru 99215, «99417,» and 99241 thru 99245 and select surgical procedure codes, require medical justification that must be documented in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) or on an attachment to the claim.

Pre-Operative Exam Billing by Outpatient Surgery Clinics

Outpatient surgery clinics may not bill Medi-Cal for E&M of a new patient in addition to the surgical procedure performed because this service has already been provided by an attending physician who may bill for this service under his/her own National Provider Identifier (NPI). Outpatient surgery clinics' claims for initial office visit procedure codes (CPT codes «99202» thru 99205) will be denied.

Pre-Operative Exam Not Separately Reimbursable From Surgery

Under most circumstances, including ordinary referrals, the pre-operative examination by the operating surgeon or assistant surgeon in the emergency room, hospital or elsewhere on the day of surgery, or one day prior to the day of surgery, is considered a part of the surgical procedure and is not separately reimbursable by Medi-Cal.

Note: CPT codes <<99202>> thru 99215 <<and 99417>> rendered by the primary or assistant surgeon are not separately reimbursable unless medical justification is attached to the claim. He/she must document medical justification in the remarks section of the claim when a pre-operative visit is performed on the day before or day of surgery.

Billing Exceptions to Pre-Operative Policy

Exceptions to this policy may be made when the pre-operative visit is an initial emergency visit requiring extended evaluation or detention (for example, to prepare the patient or establish the need for the surgery).

Procedures (for example, bronchoscopy prior to thoracic surgery) that are not normally an integral part of the basic surgical procedure may be reimbursed separately.

Post-Operative Services Not Separately Reimbursable When Billed Within Surgery Follow-Up Period

Office visits, hospital visits, consultations and ophthalmological exams (CPT codes 92002 thru 92014, <<99202>> thru 99215, <<99417,>> 99221 thru 99233, 99238, 99239 and 99241 thru 99275) related to a surgery and billed during the follow-up period of the surgery, are not separately reimbursable if billed by the surgeon or assistant surgeon.

These claims will be denied with RAD code 074: "This service is included in the surgical fee." Surgical follow-up periods (referred to as global days) are listed in the relative value (RVU) files of the latest quarterly physician fee schedule on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov).

Tips: To locate files containing surgical procedure codes and associated follow-up (global) time periods, providers should enter "PPRVU" in the search box on the CMS website home page. PPRVU spreadsheets are released quarterly. Quarter one files end in the letter A, quarter two files end in the letter B and so on. Within the PPRVU spreadsheet, providers should refer to the "Glob Days" column for follow-up (global) time frames.

Emergency Room Visits and Critical Care Not Separately Reimbursable

Emergency room E&M CPT codes 99281 thru 99285 and critical care and E&M codes 99291 and 99292 are not separately reimbursable if billed by the same provider for the same recipient and date of service. Because emergency room services and critical care E&M require the same three key components (a patient history, examination of the patient and medical decision-making), submitting claims for both constitutes double billing.

If emergency room and critical care E&M services are both billed, Medi-Cal will reimburse only up to the allowed amount of the higher-priced service.

Initial Inpatient Consultations

Claims billed with CPT code 99253 thru 99255 (initial inpatient consultation visits) are reimbursable more than once every six months when billed by the same provider, for the same recipient, when medically necessary. Justification must be documented in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) or on an attachment included with the claim.

Note: This policy also applies to claims billed with a group provider number.

Physician Office/Outpatient Consultations

A physician consultation billed with CPT code 99243 thru 99245 performed within six months of a previous consultation (CPT codes 99241 thru 99245) by the same group or rendering provider are reimbursed at the rate for CPT code 99241.

Note: This policy also applies if the claims for the initial and subsequent consultations have the same group number but different rendering provider numbers.

Physician Visits: “State” Hospitals

Physicians treating patients at State hospitals must use home visit CPT codes 99341 thru 99350 with the appropriate Place of Service “Other” code. Providers billing on the *UB-04* claim should use facility type code “14,” “24,” “34,” “44,” “54” or “64.” Providers billing on the *CMS-1500* claim should use Place of Service code “55” or “99.” Enter in the *Additional Claim Information field* (Box 19) of the claim the reason for the visit when billing with Place of Service code “55.” Facility type/Place of Service code “14,” “24,” “34,” “44,” “54,” “64,” “55” or “99” must be used for visits to State hospitals under the home visit procedure code to ensure proper reimbursement. Claims submitted with an inappropriate facility type/Place of Service code will be denied.

Physician Standby/ Detention Time

Standby physician services are billed under CPT code 99360 for detention time. This procedure must be billed “By Report.”

CPT Code 99360: Documentation Requirements

When billing for these services, providers must include the following documentation:

- The procedure requiring the physician’s full-time attendance
- The medical necessity for the physician’s immediate presence
- A detailed report of the tasks performed
- The duration of the actual time spent with the patient

Physician standby (detention) time during anesthesia administered by a nurse anesthetist for either podiatric or dental surgery will be reimbursed when a supervising anesthesiologist is not available. The standby physician must be immediately available and in close proximity to the operating room but not necessarily in the operating room.

The claim must contain a statement explaining that an anesthesiologist was not available to supervise the anesthesia, and that the standby physician was immediately available to the operating room. The statement must be signed by the attending or standby physician.

Critical Care Codes 99291 and 99292

Services rendered and billed with code 99360 must not include services provided during the time period when CPT code 99291 or 99292 is billed.

Pediatric Critical Care Patient Transport Codes 99466 and 99467, 99485 and 99486

These codes are used to report the physical attendance and direct face-to-face care by a physician during the inter-facility transport of a critically ill or critically injured pediatric patient. Reimbursable time begins when the physician assumes primary responsibility for the pediatric patient at the referring hospital/facility and ends when the receiving hospital/facility accepts responsibility for the care of the patient. Providers should report only the time spent in direct face-to-face contact with the patient during the transport. Code 99466 covers the first 30 to 74 minutes of hands-on care during transport. Code 99467 covers the same service for each additional 30 minutes.

Services rendered and billed with code 99467 must only be billed in conjunction with code 99466. Reimbursement is restricted to recipients 24 months of age or less. Providers must document medical justification when billing code 99467 for a quantity greater than one.

CPT codes 99485 and 99486 are used to report the control physician's non-face-to-face supervision of interfacility pediatric critical care transport. Code 99486 must be billed in conjunction with code 99485.

Codes 99485 and 99486

CPT Code	Description
99485	Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 month of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report, first 30 minutes
99486	Supervision by a control physician of interfacility transport care of the critically ill or critically injured pediatric patient, 24 month of age or younger, includes two-way communication with transport team before transport, at the referring facility and during the transport, including data interpretation and report, each additional 30 minutes

Preventive Medicine Services for Children

Office visits for preventive medical care for children must be billed using CPT codes 99381 thru 99385 and 99391 thru 99395, as appropriate. CPT codes 99385 and 99395 are only to be used with recipients 18 «through 20» years of age. Refer to the *Preventive Services* section of the appropriate provider manual for more information on preventive medicine services for children.

New Patients

New patient CPT codes 99381 thru 99385 may only be billed when the patient has not received any professional services from the provider within the past three years. If a new patient visit has been paid, any subsequent claim for a new patient service by the same provider, for the same recipient received within three years, will be paid at the level of the comparable established patient procedure code (99391 thru 99395).

Newborn Care

Normal newborn care should be billed with CPT code 99460 for the first day of care when the service is provided in a hospital or a birthing care center. CPT code 99462 should be billed on a separate claim line if there is subsequent hospital care. When a newborn is admitted and discharged on the same date, neither CPT code 99238 nor code 99239 can be billed with code 99460 for the same date of service, any provider.

The following policies apply to billing procedures for newborn care:

- CPT code 99460 (history and examination of the normal newborn infant) may be reimbursed only once to any provider for the same recipient. Code 99460 will not be reimbursed if it is billed subsequent to any other initial hospital inpatient services (99221 thru 99223).
- CPT code 99462 (subsequent hospital care, for the evaluation and management of a normal newborn, per day) may be reimbursed for up to two days of hospital care for the same recipient, any provider when the diagnosis code indicates a vaginal delivery. CPT code 99462 may be reimbursed for up to four days of hospital care for the same recipient, any provider when the diagnosis code indicates a cesarean section delivery.
- Reimbursement for CPT codes 99222 and 99223 is reduced to the same rate as 99460 if the ICD-10-CM diagnosis code indicates a healthy newborn (Z38.00 thru Z38.8).
- Reimbursement for CPT codes 99231 thru 99233 is reduced to the rate of 99462 if the ICD-10-CM diagnosis indicates a healthy newborn (Z38.00 thru Z38.8). All other hospital visit codes billed by the same provider, for the same recipient and date of service will be denied.
- CPT code 96110 (developmental screening, with scoring and documentation, per standardized instrument) is not reimbursable if billed within one month of code 99460 or 99462 (normal newborn care services) by the same provider for the same recipient.

Neonatal and Pediatric Intensive Care Guidelines

The following information describes the billing guidelines for neonatal and pediatric intensive care services.

Neonate, Intensive E&M

CPT code 99477 (initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care services) has the following policy:

- Another initial hospital visit(s) may not be reimbursed on the same day as code 99477.
- If billed with an ICD-10-CM diagnosis code of Z38.00 thru Z38.8, reimbursement will be cut back to the rate of CPT code 99460.

Neonatal, Hypothermia

Hypothermia for critically ill neonates is reimbursed with CPT code 99184 (initiation of selective head or total body hypothermia in the critically ill neonate, includes appropriate patient selection by review of clinical, imaging and laboratory data, confirmation of esophageal temperature probe location, evaluation of amplitude EEG, supervision of controlled hypothermia, and assessment of patient tolerance of cooling) when initiated within the first six hours of birth and discontinued after 72 hours.

Reimbursement is limited to three times in a recipient's lifetime for any provider.

Intensive Care in a CCS Approved NICU or PICU

Neonatal and Pediatric Intensive Care Unit (NICU/PICU) global CPT codes (99222, 99223, 99232, 99233, 99291, 99292 with modifiers TG and/or HA, 99468, 99469, 99471, 99472, 99475 thru 99480) are reimbursed only for physician services provided in a facility approved by California Children's Services (CCS) as a regional, community or intermediate NICU or as a PICU.

Codes 99222, 99223, 99232, 99233, 99291, 99292 with modifiers TG and/or HA, 99468, 99469, 99471, 99472, 99475 thru 99480 are used to bill for 24 hours of care and only one code is reimbursable for the same recipient and date of service. If the recipient dies, or is transferred or discharged before midnight, a full day of care may be billed by the physician for that date.

“From-Through” Billing

Physicians may bill CPT codes 99232, 99233, 99291 and 99292 with modifiers TG and/or HA, 99469, 99472, 99476, 99478 thru 99480 using the “from-through” method.

Other Services Covered

Each intensive care code covers all services rendered by a physician including umbilical catheterization, venipunctures, intubations, blood cultures, blood gas interpretations and delivery/birthing room resuscitation. Only exchange transfusions (36450 and 36456), chest tube insertions (32002) bronchoscopy services (31622 thru 31654), and resuscitation (99465) are reimbursed if billed separately. Exchange transfusions (36450 and 36456) are reimbursable for newborns up to one month old.

Physician standby service requiring prolonged physician attendance, each 30 minutes (99360), is reimbursable only when billed in conjunction with CPT codes 99222, 99223, 99291 and 99292 with modifiers TG and/or HA, 99468, 99471, 99475, 99477. Physician billing codes 99222, 99223, 99232, 99233, 99291, 99292 with modifiers TG and/or HA, 99468, 99469, 99471, 99472, 99475 thru 99480 will not be reimbursed for any other physician service for the same recipient and date of service except as noted above. No other physician is reimbursed for NICU/PICU services for the same recipient and date of service. Other physicians may be reimbursed for essential services that are not included in the NICU/PICU codes. Physicians who bill services under a group provider number must enter their rendering provider number on the claim in the appropriate area.

Note: The neonatal intensive care form used when billing NICU services is not required.

Critical Care and Initial Neonatal and Pediatric Intensive Care Codes

Providers may bill critical care codes (99291 or 99292) for services rendered before the child is admitted to the NICU/PICU when the global NICU/PICU codes 99222, 99223, 99468, 99471, 99475, 99477 are not billed by the same provider, for the same recipient and date of service. Providers billing code 99291 or 99292 may be reimbursed for services rendered to infants and children prior to the transfer to a PICU even if the global NICU/PICU codes are billed by another provider for the same date of service. Enter in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim that the service was rendered prior to transferring the recipient to a NICU or PICU.

Note: Claims billed with codes 99232, 99233, 99291 and 99292 with modifiers TG and/or HA, 99469, 99472, 99476, 99478 thru 99480 (neonatal and pediatric intensive care) or Z3012 (extracorporeal membrane oxygenation) will not be reimbursed if critical care code 99291 or 99292 has been previously paid to any provider on the same date of service. Also, claims billed with critical care code 99291 or 99292 will not be reimbursed if codes 99232, 99233, 99291 and 99292 with modifiers TG and/or HA, 99469, 99472, 99476, 99478 thru 99480 or Z3012 have been previously paid to any provider for the same date of service.

Initial Neonatal and Pediatric Intensive Care

Providers should use CPT codes 99222, 99223, 99291, 99292, 99468, 99471, 99475 and 99477 to bill for initial neonatal or pediatric intensive care (first or partial 24 hours). These codes may be billed only once using an individual claim line, a quantity of one, and the date of admission to the NICU/PICU as the date of service.

Note: Initial NICU/PICU care codes may be billed when the medical conditions of the child require repeated readmission to the NICU or PICU.

Critical (CPT Codes 99291 [TG/HA], 99292 [TG/HA], 99468, 99471 and 99475)

Critical level of care: Children receiving ventilatory support (including continuous positive airway pressure [CPAP]), invasive monitoring, and/or intravenous pharmacological support of the circulatory system.

Intensive (CPT Codes 99477)

Intensive level of care: Cardiorespiratory monitoring for unstable physiology, for example, apnea or hypoglycemia.

Non-Critical, Non-Intensive (CPT Codes 99222 and 99223)

Non-Critical, Non-Intensive level of care: Physiologic stability but requires support such as tube feeding, I.V. medicine or fluid covered.

Subsequent Neonatal and Pediatric Intensive Care

Subsequent days of physician NICU/PICU care are billed using CPT codes 99232, 99233, 99291, 99292, 99469, 99472, 99476 and 99478 thru 99480 for each date of service, depending on the level of care (as listed below) provided to the patient at 2400 hours (midnight) on the date of service.

Critical (CPT Codes 99291 [TG/HA], 99292 [TG/HA], 99469, 99472 and 99476)

Critical level of care: Children receiving ventilatory support (including continuous positive airway pressure [CPAP]), invasive monitoring, and/or intravenous pharmacological support of the circulatory system.

Intensive (CPT Codes 99478 thru 99480)

Intensive level of care: Cardiorespiratory monitoring for unstable physiology; for example, apnea or hypoglycemia.

Non-Critical, Non-Intensive (CPT Codes 99232 and 99233)

Non-Critical, Non-Intensive level of care: Physiologic stability but requires support such as tube feeding, I.V. medicine or fluid covered.

Extracorporeal Membrane Oxygenation (ECMO)

Neonatologists are reimbursed for ECMO services only when provided to newborns in CCS-approved ECMO centers. CPT codes 33946, 33947, 33948, 33949, 33951, 33953, 33955, 33957, 33959, 33963, 33965, 33969, 33985, 33987, 33988 and 33989 cover all examinations and procedures performed during each 24-hour period of ECMO treatment of an infant by a neonatologist. Daily overall management of the patient may be separately reported using the relevant hospital inpatient services or critical care evaluation and management codes 99221, 99222, 99223, 99231, 99232, 99233, 99291, 99292 and 99477 and may be reimbursed to any provider for the same recipient and same date of service.

Billing for Services to Multiple Newborns

When billing for care of multiple newborns, complete Boxes 2, 3, 4 and 6 on the *CMS-1500* claim or Boxes 12, 14, 15, 58 and 59 on the *UB-04 claim*. Refer to the appropriate claim form completion section in this manual for specific instructions on completing these boxes.

Note: When billing for a birth occurring to the same mother within six months of a previous birth, identify the second birth with the alpha or numeric indicator “B” or “2” (for example, Jones, Baby Girl, B).

NICU and PICU Care in Non-CCS Approved Facilities

Physician services provided in a NICU/PICU facility not certified by California Children’s Services (CCS), or not having CCS-equivalent resources, services and equipment, must be billed using the appropriate critical care visit codes (code 99291 or 99292), hospital admission codes (codes 99221 thru 99223, 99460) or hospital visit codes (99231 thru 99233, 99462).

Critical Care: Services Not Separately Reimbursable

The following services are included in CPT codes 99291 (critical care, first hour) and 99292 (critical care, each additional 30 minutes) and are not separately reimbursable when billed by the same provider, for the same recipient and date of service.

Services Not Separately Reimbursable

CPT Code	Description
36000	Introduction of needle or intracatheter, vein
36410	Venipuncture, age 3 years or older, necessitating physician’s skill (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36415	Collection of venous blood by venipuncture
36600	Arterial puncture, withdrawal of blood for diagnosis

Services Not Separately Reimbursable (continued)

CPT Code	Description
71045	Radiologic examination, chest; single view
71046	Radiologic examination, chest; two views
91105	Gastric intubation, and aspiration or lavage for treatment (e.g., for ingested poisons)
92953	Temporary transcutaneous pacing
93561 ¹	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement
93562 ¹	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; first day
94003	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; subsequent days
94660	Continuous positive airway pressure ventilation (CPAP), initiation and management
94662	Continuous negative pressure ventilation (CNP), initiation and management

Services Separately Reimbursable

Providers may be reimbursed separately only for the technical components of the following services. The professional components are included in codes 99291 and 99292 and are not separately reimbursable when billed by the same provider, for the same recipient and date of service.

Services Separately Reimbursable

CPT Code	Description
71010	Radiologic examination, chest; single view
71020	Radiologic examination, chest; two views
93561	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement
93562	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output

Pulse Oximetry

CPT code 94760 (non-invasive ear or pulse oximetry saturation; single determination) is reimbursable only to physicians when no other services are billed for the same recipient, by the same provider on the same date of service.

Cardiopulmonary Resuscitation

CPT code 92950 (cardiopulmonary resuscitation [e.g., in cardiac arrest]) is reimbursable with codes 99291 and 99292.

Physician Standby Service (CPT Code 99360)

Services rendered and billed with code 99360 must not include services provided during the time period when CPT code 99291 or 99292 is billed.

Other procedures not directly related to critical care management, such as setting fractures or suturing lacerations, are not included when billing for critical care. These non-critical care procedures must be billed with the appropriate CPT4 or HCPCS Level III codes.

Teaching Physician Billing Requirements for Evaluation and Management Services

The Medi-Cal program will pay for direct patient care services in a teaching setting when directly provided by teaching physicians (*California Code of Regulations* [CCR], Title 22, Section 51503). The entry(ies) into the medical record by the teaching and resident physician(s) constitute the documentation for the services and together must support the medical necessity of the services.

Definitions:

- Resident physician:
A person who participates in an approved graduate medical education (GME) program, including programs in osteopathy, dentistry and podiatry. This includes interns, residents and fellows in the GME program but does not include students.
- Teaching physician:
A physician (other than another resident physician) who involves resident physicians in the care of his/her patients
- Approved graduate medical education program:
A residency program approved by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Council on Postdoctoral Training of the American Osteopathic Association, by the Commission on Dental Education of the American Dental Association, or by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

Evaluation and Management (E&M) services (CPT codes <<99202>> thru 99499) performed by teaching physicians must follow specific guidelines in order to allow payment for services provided

When physician services are provided by the resident and teaching physician, both of them must document their services in the patient's medical record. When the service has been performed in part by a resident physician, the claim must include the GC modifier (this service has been performed in part by a resident physician under the direction of a teaching physician) for each service. If the service was provided solely by the teaching physician, the claim should not be billed with the GC modifier.

On medical review, the combined entries into the medical record by the teaching physician and the resident physician constitute the documentation for the service and together must support the medical necessity of the service.

Payment may be made for any of the following three scenarios:

- The teaching physician personally performs all the required elements of an E&M service without a resident physician.

The teaching physician must document as he/she would document in a non-teaching setting and the documentation must support the level of the service billed. This is the only scenario in which the GC modifier is not required.

- The teaching physician personally performs all the required elements of an E&M service and a resident physician has also performed and documented the E&M service. The teaching physician must document that he/she performed the E&M service and that he/she was directly involved in the management of the patient. The teaching physician may or may not reference the resident physician's documentation.

The composite of the teaching physician's and resident physician's documentation together must support the level of the service billed by the teaching physician.

- The resident physician performs all the required elements of an E&M service in the presence of, or jointly with, the teaching physician and documents the service. In this scenario, the teaching physician must document that he/she was present during the performance of the service and that he/she was directly involved in the management of the patient. If the teaching physician does not perform all of the required elements of the E&M service, his/her documentation must reference the resident physician's documentation. The composite of the teaching physician's and resident physician's documentation together must support the level of the service billed by the teaching physician.

Advance Care Planning

Advance care planning codes are used to report face-to-face service between a physician or other qualified health care professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.

CPT code 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms, by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family members, and/or surrogate) is reimbursable twice a year with a TAR override.

CPT code 99498 (advance care planning including the explanation and discussion of advance directives such as standard forms, by the physician or other qualified health care professional; each additional 30 minutes) is reimbursable once a year with a TAR override.

Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care

The USPSTF recommendation is that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.

Billing Codes

The following HCPCS codes may be used to bill for these services as outpatient services only:

- G0442 (annual alcohol misuse screening, 15 minutes)
- G0443 (brief face-to-face behavioral counseling for alcohol misuse, 15 minutes)

Code G0442 is limited to one screening per year, any provider, unless otherwise medically necessary.

Code G0443 may be billed on the same day as code G0442. Code G0443 is limited to 3 sessions per recipient per year, any provider, unless otherwise medically necessary.

Required Screening Tools

Providers must use one of the following validated screening tools:

- The Alcohol Use Disorder Identification Test (AUDIT)
- The Alcohol Use Disorder Identification Test-Consumption (AUDIT-C), or
- A single-question screening, such as asking, “How many times in the past year have you had 4 (for women and all adults older than 65 years) or 5 (for men) or more drinks in a day?”

Brief Emotional/ Behavioral Assessment

Reimbursement for CPT code 96127 is limited to three times a year per recipient.

Chronic Care Management Services

Chronic care management services (CCM) are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. CPT codes 99490 and 99491 each have a frequency limit of once per month. «CPT codes 99490, 99491 and 99439» are reimbursable when they meet the criteria below.

CPT code 99490 (chronic care management services, «first» 20 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month) is reimbursable 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

«CPT code 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 [List separately in addition to code for primary procedure]) must be billed in conjunction with code 99490.»

CPT code 99491 (chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month) is reimbursable 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

Reimbursement for CPT code 99490 assumes 15 minutes of work by the billing practitioner. Only one practitioner can be reimbursed for CPT code 99490 per calendar month.

CPT codes 99490 and 99491 are not reimbursable in the same calendar month by any provider.

HCPCS code G0506 (comprehensive assessment of and care planning for patients requiring chronic care management services) is reimbursable for practitioners who furnish a CCM-initiating visit and personally perform extensive assessment and CCM care planning beyond the usual effort described by the initiating visit code. HCPCS code G0506 has a frequency limit of once per provider, per lifetime.

«Psychiatric Collaborative Care Management Services

Psychiatric collaborative care management services are reimbursable when billed by the treating physician or other qualified health professional for treatment of a patient's mental health or substance use disorder. The billing codes and required elements are listed below.

CPT code 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) is reimbursable 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.»

«CPT code 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) is reimbursable with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation
- Participation in weekly caseload consultation with the psychiatric consultant;
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers;
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;
- Monitoring of patient outcomes using validated rating scales; and
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment

CPT code 99494 (initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional) (List separately in addition to code for primary procedure):

The frequency limit for CPT code 99492 and 99493 is one per calendar month. The frequency limit for CPT code 99494 is two per calendar month.

Note: CPT codes 99492 and 99493 may not be reimbursed in the same calendar month.»

Depression Screening

Medi-Cal reimburses screening adults and children ages 12 and older for depression as an outpatient service only. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment options including referral to mental health specialists, and appropriate follow-up.

Billing Codes

HCPCS Code	Description
G8431	Screening for depression is documented as being positive and a following-up plan
G8510	Screening for depression is documented as negative, a follow-up plan is not required

Pregnant or Postpartum Recipients

Providers of prenatal care and postpartum care may submit claims twice per year per pregnant or postpartum recipient: once when the recipient is pregnant and once when she is postpartum.

The combined total claims for screening pregnant or postpartum recipients using HCPCS codes G8431 and/or G8510 may not exceed two per year, per recipient, by any provider of prenatal or postpartum care. For claim submission instructions, providers should refer to the *Pregnancy: Early Care and Diagnostic Services* and *Pregnancy: Postpartum and Newborn Referral Services* sections in the appropriate Part 2 manual.

Postpartum Screening at Infant Visits

Providers of well-child and episodic care for infants may submit claims for maternal depression screening up to four times during the infant's first year of life. Bright Futures recommends screening for maternal depression at the infant's one-month, two-month, four-month and six-month visits, with referral to the appropriate provider for further care if indicated. When a postpartum depression screening is provided at the infant's medical visit, the screening must be billed with the infant's Medi-Cal ID. The only exception to this policy is that the mother's Medi-Cal ID may be used during the first two months of life if the infant's Medi-Cal eligibility has not yet been established.

Records for maternal depression screenings must be maintained in a separate medical record to document the mother's screening results and any recommendations/referrals that were given. The American Academy of Pediatrics and the Centers for Medicare & Medicaid Services (CMS) recommend that treatment of postpartum depression include a parenting component. For more information on resources for providers and patients may visit www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Communications/Maternal-Mental-Health.aspx.

Recipients Who Are Not Pregnant or Postpartum

Screening for depression is reimbursable for recipients 12 years of age or older who are not pregnant or postpartum once per year, per recipient, per provider.

Not Separately Reimbursable

HCPCS codes G8431 and G8510 may not be billed for the same date of service, for the same recipient, by the same provider.

Screening Tools

Medi-Cal requires the use a validated depression screening tool. Some examples include:

- Patient Health Questionnaire (PHQ-9)
- Edinburgh Postnatal Depression Scale (EPDS)
- Beck Depression Inventory (BDI)
- Geriatric Depression Scale (GDS)

Opioid Use Disorder Treatment Services

Outpatient treatment services for opioid use disorder (OUD), which include management, care coordination, psychotherapy and counseling are reimbursable using HCPCS codes G2086, G2087 and G2088. At least one psychotherapy service must be furnished in order to bill for HCPCS codes G2086 thru G2088. Although the descriptions for these codes refer to “office-based treatment,” these services may be delivered via telehealth when they meet Medi-Cal requirements. More information is available in the *Medicine: Telehealth* section of the appropriate Part 2 Medi-Cal provider manual.

The codes are not reimbursable for treatment in an opioid treatment program.

Billing Codes

The HCPCS billing codes are as follows:

Opioid Disorder Billing Codes

HCPCS Code	Description
G2086	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)

Frequency Limits

HCPCS codes G2086 and G2087 each have a frequency limit of once per calendar month, per recipient, any provider and G2088 has a frequency limit of two per calendar month, per recipient, any provider. Only one provider can be reimbursed for HCPCS code G2086, G2087 or G2088 per calendar month.

Smoking and Tobacco Cessation Counseling

«Face-to-face counseling for smoking and tobacco cessation is reimbursable when provided by a physician, physician assistant, nurse practitioner, certified nurse midwife, licensed midwife, licensed clinical social worker, licensed marriage and family therapist, licensed professional clinical counselor, or psychologist.». Documentation must be maintained in the patient file that includes total time spent and what was discussed, including cessation techniques, resources and follow-up for each visit. «Patients must be offered information about the California Smoker’s Helpline (1-800-NO-BUTTS).

Tobacco cessation counseling is reimbursable in all settings including, but not limited to inpatient, outpatient and emergency department, and there is no yearly frequency limit.

Smoking and Tobacco Cessation Counseling Billing Codes Table

HCPCS Code	Description
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

The frequency limit for codes 99406 and 99407 is one counseling session per day.»

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	Facility type "14" must be billed in conjunction with admit type "1."
0	Specify the appropriate Place of Service and use modifier U2.
1	Modifier 26 (professional component) is not reimbursable for these procedures.