Priority Health	BILLING POLICY No. 004
CARE MANAGEMENT SERVICES	
Date of origin: July 2024	**Review dates: 1/2025, 2/2025**

APPLIES TO
All plans

DEFINITION
Priority Health recognizes the value of care management services that are integral to the patient-centered medical home and reimburses for them.

Priority Health reimburses, fee for service, for care management services. Care includes management of patients' medical, functional and psychosocial needs. Reimbursement is available to primary care, specialty physicians and clinical staff providing care management services.

A clinical staff member is a person who works under the supervision of a physician, NP or PA and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service, but who doesn't individually report that professional service.

Only one practitioner can furnish and be paid for care coordination services during a calendar month.

POLICY SPECIFIC INFORMATION
Eligible patients
To be enrolled in care management, patients:

- Are classified as moderate or high risk based on health history
- Have one or more chronic conditions
- Have a completed care plan that meets documentation requirements

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

Billable care management codes
The CPT and HCPCS manuals define billing and coding requirements for both physician and clinical staff member care management services.

When services are performed on the same date as care management services, the care management services should be coded with the appropriate modifier to reflect a significant, separately identifiable service was performed.

Click a code to view billing help and documentation requirements:

- G0511
- G0512
- G9001
- G9002
- G9007
- G9008
- 98966
- 98967
- 98968
- 99484
- 99487
- 99489
- 99490
- 99439
- 99491

- 99437
- 99424
- 99425
- 99426
- 99427
- 99492
- 99493
- 99494
- 99495
- 99496

Telephone visits by clinical staff providing care management services

See the Telephone and e-visits page in our Provider Manual.

Special payment process for some care management codes

Priority Health has a unique process for paying G-code and telephone visit care management services for all lines of business.

1. Practices bill care management G-codes and telephone visit CPT services with their practice charges.

2. Priority Health auto-adjudicates claims, applying a $0 payment.

   On the Remittance Advice, the $0 payment yields the full allowed dollars as provider liability.

   The Remittance Advice processing code is Q11, "no compensation allowed for this service - reporting only."

   The member's claim explanation displays $0 member liability. No copayment or deductible applies.

3. Every 60 days, Priority Health batches a payment for the full allowed amount of each practice's billed G-codes and CPT codes with no member copayment or deductible.

   These payments are processed with a paper check.

   The check payment and Remittance Advice report are mailed to the provider's claims remittance advice address.

   A Remittance Advice report designates claim detail such as member demographics, billed codes, and date of service.

Care management code details

G0511

Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management

Documentation requirements	Tips
• At least 20 minutes of care coordination services documented in the calendar month • Services are provided under the direction of the RHC or FQHC physician, NP, PA or CNM • Services are provided by an RHC or FQHC practitioner or by clinical personnel under general supervision • Beneficiary consent is obtained • Care plan is updated with changes in care or chronic conditions • Evidence of coordination of care between providers and the facilities used	Eligible patients are those that have: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, or • Any behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services.

G0512

Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric care management

Documentation requirements	Tips
• Initiating visit: An E/M, AWV, or IPPE visit furnished by a physician, NP, PA, or CNM was documented no more than one year prior to commencing psychiatric collaborative care services. This would be billed as an RHC or FQHC visit. • At least 70 minutes of psychiatric collaborative care model services are documented in the first calendar month • At least 60 minutes per month in subsequent months • Care team includes: RHC or FQHC practitioner (physician, NP, PA or CNM), behavioral health care manager and a psychiatric consultant • Services are provided under the direction of the RHC or FQHC physician, NP, PA or CNM • Services are provided by an RHC or FQHC practitioner or by behavioral health care manager under general supervision • Beneficiary consent is documented • Evidence of coordination of care between providers and the facilities used	• Patient must have a behavioral health or psychiatric condition that is being treated by the RHC or FQHC practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants psychiatric collaborative care services • Billed once per month per beneficiary meeting time requirements • Must have a FQHC or RHC practitioner, behavioral health provider and psychiatric consultant

G9001

Coordinated care fee, initial assessment

Covered benefit under all plans, no member copay or deductible.

Documentation requirements	Tips
• Date(s) of visit(s) • Appointment duration • Care manager name and credentials • Comprehensive patient assessment • Name of the caregiver and relationship to patient, if caregiver is included in the visit • Diagnoses discussed • Treatment plan, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change • Care plan, including challenges and interventions • Patient understanding and agreement with the care plan • Physician coordination activities and approval of care plan • Name of member's PCP	• Care provided by a clinical staff member • Initial care management assessment only • May be billed once annually for patients with ongoing care management • Must include a face-to-face visit with the patient • Work must encompass a minimum of 30 minutes, some of which may be without the patient present • Physicians may also bill G9008 if care meets billing and documentation requirements • Date of service = date the assessment was completed

G9002

Coordinated care fee, individual face-to-face visit

Covered benefit under all plans, no member copay or deductible.

Documentation requirements	Tips
• Date(s) of visit(s) • Appointment duration • Care manager name and credentials • Name of the caregiver and relationship to patient, if caregiver is included in the visit • Diagnoses discussed • Treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change • Care plan update • Patient understanding and agreement with the care plan • Physician coordination activities and approval of care plan • Name of member's PCP	• Care provided by a clinical staff member • Must include a face-to-face visit with the patient • May include caregiver involvement • Focused discussion of the patient's care plan • Treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change • Ongoing care plan development • Code may be billed one time per day

G9007

Coordinated care fee, scheduled team conference

Covered benefit under all plans, no member copay or deductible.

Documentation requirements	Tips
• Date(s) of conference(s) • Conference duration • Care team names and credentials • Diagnoses discussed • Treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change • Care plan updates • Physician coordination activities and approval of care plan	• Scheduled care team meetings: physician, care manager and other clinical staff member • Care provided by a physician • Patient is not present • Care plan developed, decisions documented • Self-management goals • Billed under physician's name • Code may be billed one time per day

G9008

Coordinated care fee, scheduled conference, physician oversight service

Covered benefit under all plans, no member copay or deductible

Documentation requirements	Tips
• Date(s) of visit • Appointment duration • Care team member names and credentials • Name of the caregiver and relationship to patient, if caregiver is included with the visit • Diagnoses discussed • Treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change • Preparation of shared care plan written by care manager • PCP approval of care plan • Patient understanding and agreement with care plan • Physician coordination activities and approval of care plan	• Care must be provided by a physician. • Service must include patient face-to-face: Either face-to-face with PCP, patient and care manager, OR face-to-face with patient and care manager, with care manager/PCP direct involvement on a separate occasion. • Patient must formally agree to the care plan. • Service must include completion of patient assessment. • Bill code after the patient enrolls in a care management program. • A PCP evaluation and management visit must be billed in close proximity to this visit date. • G9001 or G9002 must also be billed in close proximity to this visit date. • This code may only be billed one time, per practice, during the time that patient is a member of the practice.

98966

Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent or guardian, 5-10 minutes of medical discussion

Documentation requirements	Tips
• Date(s) of contacts • Contact duration • Care team names and credentials • Diagnoses discussed • Development and/or maintenance of a shared care plan • Care team coordination activities • Names of providers contacted in the course of coordinating care • Discussion notes for each contact	• Care provided by a clinical staff member • Non-face-to-face encounter initiated by an established patient or by the patient's guardian • Excludes decision to see the patient within 24 hours of the call

98967

Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent or guardian, 11-20 minutes of medical discussion

Documentation requirements	Tips
• Date(s) of contacts • Contact duration • Care team names and credentials • Diagnoses discussed • Development and/or maintenance of a shared care plan • Care team coordination activities • Names of providers contacted in the course of coordinating care • Discussion notes for each contact	• Care provided by a clinical staff member • Non-face-to-face encounter initiated by an established patient or by the patient's guardian • Excludes decision to see the patient within 24 hours of the call • Excludes calls during the postoperative period of a procedure

98968

Telephone assessment and management service provided by a qualified non-physician health care professional to an established patient, parent or guardian, 21-30 minutes of medical discussion

Documentation requirements	Tips
• Date(s) of contacts • Contact duration • Care team names and credentials • Diagnoses discussed • Development and/or maintenance of a shared care plan • Care team coordination activities • Names of providers contacted in the course of coordinating care • Discussion notes for each contact	• Care provided by a clinical staff member • Non-face-to-face encounter initiated by an established patient or by the patient's guardian • Excludes decision to see the patient within 24 hours of the call • Excludes calls during the postoperative period of a procedure

99484

Care management services for behavioral health - At least 20 minutes of clinical staff time per calendar month

Covered benefit under all plans, member copay and deductible apply

Documentation requirements

- Specific elements of a treatment plan must be provided and documented.
- Documentation should include the initial assessment or follow-up monitoring involving the use of validated rating scales.
- Documentation of behavioral health care planning (including revisions or status change).
- Documentation of organizing/coordinating all aspects (therapy, medications, counseling, and/or psychiatric consultations).
- Ongoing treatment with care management team member.
- Clinical staff should be available to provide the patient with face-to-face services.
- Time of services must be documented and meet minimum time requirements per month.

99487

Complex chronic care coordination, first hour physician directed, no face-to-face visit, per calendar month

Covered benefit under all plans, member copay and deductible apply

Documentation requirements	**Tips**
• Patient consent written or verbal • Initiating visit (billing provider must see patient prior to beginning CCM) • Date(s) of contacts • Contact duration • Care team names and credentials • Diagnoses discussed • Development and/or maintenance of a shared care plan • Care team coordination activities • Names of providers contacted in the course of coordinating care • Discussion notes for each contact • Includes coordination of services with health care community: Physicians, facilities, ancillary providers, community agencies, etc. • Note the cumulative services provided in one calendar month. • Cumulative time per patient must exceed 60 minutes. • Bill one unit per month for cumulative time of 60 minutes. • Billed date of service: Use the date on which services were last provided during the month.	Care must be coordinated by a physician and the care team. • Patient does not need to be present for team conferences. • Patient contact may be by phone or face-to-face. • Only reported by a single physician or other clinical staff member for the calendar month • Can't also bill prolonged care service in the same month

99489

Add-on code to 99487, each additional 30 minutes

Covered benefit under all plans, member copay and deductible apply

Documentation requirements	Tips
• Patient consent, written or verbal • Initiating visit (billing provider must see patient prior to beginning CCM) • Date(s) of visit and/or contacts • Appointment or contact duration • Name of caregiver and relationship to patient, if caregiver is included with the visit • Care team names and credentials • Diagnoses discussed • Care team coordination activities • Names of providers contacted in the course of coordinating care • Discussion notes for each contact	• Code should only be billed in cases where the cumulative time exceeds 90 minutes. • Care is coordinated by a physician and the care team • Patient does not need to be present for team conferences. • Add-on code to 99487 • Multiple units may be billed • Billed date of service: Use the date on which services were last provided during the month. • Only reported by a single physician or other clinical staff member for the calendar month

99490

Chronic care management services, first 20 minutes of clinical staff time directed by physician or clinical staff member

Not a covered benefit for group or individual commercial plans. Covered benefit under Medicare and Medicaid. Copay may apply.

Documentation requirements	**Tips**

• Patient content, written or verbal
• Initiating visit (billing provider must see patient prior to beginning CCM)
• Date(s) of visit(s) and/or contacts
• Appointment or contact duration
• Care team names and credentials
• Diagnoses discussed
• Care team coordination activities
• Names of providers contacted in the course of coordinating care
• Comprehensive care plan
• Discussion notes for each contact
• Development and/or maintenance of a shared care plan
• As appropriate: Treatment plan, self-management education, medication therapy, visit factors, unmet care, physical status, emotional status, community resources, readiness to change
	• Management must take at least 20 minutes of staff time over the course of one month.
	• Work must be directed by a physician or qualified health professional.
	• Patients must have two or more chronic conditions that place them at a significant risk of death, acute exacerbation/decompensation, or functional decline.
	• Care plan must be implemented, revised or monitored during the course of care.
	• Only reported by a single physician or other clinical staff member for the calendar month
	• Don't report in the same calendar month as (not all-inclusive list, see CPT for further instructions):
	  ○ ESRD related services (CPT 90951-90970)
	  ○ Home health care supervision (G0181)
	  ○ Hospice care supervision (G0182)

99439

Documentation requirements	Tips
• Patient consent written or verbal • Initiating visit (billing provider must see patient prior to beginning CCM) • Date(s) of visit(s) and/or contacts • Appointment or contact duration • Care team names and credentials • Diagnoses discussed • Care team coordination activities • Names of providers contacted in the course of coordinating care • Comprehensive care plan • Discussion notes for each contact • Development and/or maintenance of a shared care plan • As appropriate: Treatment plan, self-management education, medication therapy, visit factors, unmet care, physical status, emotional status, community resources, readiness to change	• Add-on code to 99490. Can't be reported alone. • Reported no more than 2x per calendar month • May only be reported by the single physician or clinical staff member who assumes the care management for the patient for the calendar month • May not be reported in the postoperative period by the same individual. • See the CPT manual for a list of service not to be reported in the same calendar month

99491

Chronic care management services; first 30 minutes provided directly by a physician or other clinical staff member

Not a covered benefit for group or individual commercial plans. Covered benefit under Medicare and Medicaid. Copay may apply.

Documentation requirements	**Tips**

• Patient consent, verbal or written
• Initiating visit (billing provider must see patient prior to beginning CCM)
• Date(s) of visit(s) and/or contacts
• Appointment or contact duration
• Care team names and credentials
• Diagnoses discussed
• Care team coordination activities
• Names of providers contacted in the course of coordinating care
• Comprehensive care plan
• Discussion notes for each contact
• Development and/or maintenance of a shared care plan
• As appropriate: Treatment plan, self-management education, medication therapy, visit factors, unmet care, physical status, emotional status, community resources, readiness to change
	• Management must take at least 30 minutes of staff time over the course of one month.
	• Work must be performed by a physician or qualified health professional.
	• Patients must have two or more chronic conditions that place them at a significant risk of death, acute exacerbation/decompensation, or functional decline.
	• Care plan must be implemented, revised or monitored during the course of care.
	• Any time spent in a face-to-face E/M visit cannot be included in the care management service
	• Not reported for less than 30 minutes
	• Only reported by a single physician or other clinical staff member for the calendar month
	• Only time personally spent by the physician or clinical staff member may be counted
	• Do not report in the same calendar month as (not all-inclusive list, see CPT for further instructions):
	  ○ ESRD related services (CPT 90951-90970)
	  ○ Home health care supervision (G0181)
	  ○ Hospice care supervision (G0182)

99437

Add-on code to 99491. Chronic care management services; each additional 30 minutes by a physician or other clinical staff member, per calendar month.

Not a covered benefit for group or individual commercial plans. Covered benefit under Medicare and Medicaid. Copay may apply.

Documentation requirements	Tips
• Patient consent written or verbal • Initiating visit (billing provider must see patient prior to beginning CCM) • Date(s) of visit(s) and/or contacts • Appointment or contact duration • Care team names and credentials • Diagnoses discussed • Care team coordination activities • Names of providers contacted in the course of coordinating care • Comprehensive care plan • Discussion notes for each contact • Development and/or maintenance of a shared care plan • As appropriate: Treatment plan, self-management education, medication therapy, visit factors, unmet care, physical status, emotional status, community resources, readiness to change	• Add-on code to 99491. Can't be reported alone. • Any time spent in a face-to-face E/M visit cannot be included in the care management service • Not reported for less than 30 minutes • Only reported by a single physician or other clinical staff member for the calendar month • Only time personally spent by the physician or clinical staff member may be counted • Should not be reported more than 2x per calendar month (Medicaid champs)

99424

Principal care management, for a single high-risk disease; first 30 minutes provided personally by a physician or other clinical staff member, per calendar month

Documentation requirements	**Tips**

• Patient consent
• One complex chronic condition expected to last 3 months
• Risks must be documented: risk of hospitalization, exacerbation / decompensation, functional decline or death
• Development of a disease specific care plan to include
• Monitoring and/or revision
• Any adjustments in medication(s)
• Any management of condition unusually complex due to comorbidities
• Ongoing communication and care coordination between practitioners furnishing care
	• Should only be reported 1x per calendar month
	• Only time personally spent by the physician or clinical staff member may be counted
	• Don't report in the same calendar month as (not all-inclusive list):
	  ○ ESRD related services (CPT 90951-90970)
	  ○ Home health care supervision (G0181)
	  ○ Hospice care supervision (G0182)

99425

Principal care management, for a single high-risk disease; each additional 30 mins provided by a physician or other clinical staff member, per calendar month

Documentation requirements	**Tips**

• Patient consent written or verbal
• Initiating visit (billing provider must see patient prior to beginning CCM)
• One complex chronic condition expected to last 3 months
  ○ Risks must be documented: risk of hospitalization, exacerbation/decompensation, functional decline or death
• Development of a disease specific care plan to include
  ○ Monitoring and/or revision
• Any adjustments in medication(s)
• Any management of condition unusually complex due to comorbidities
• Ongoing communication and care coordination between practitioners furnishing care
	• Add-on code for 99424
	• Only time personally spent by the physician or clinical staff member may be counted
	• Should not be reported more than 2x per calendar month

99426

Principal care management, for a single high-risk disease; first 30 minutes of clinical staff time directed by a physician or other clinical staff member, per calendar month

Documentation requirements	**Tips**

• Patient consent written or verbal
• Initiating visit (billing provider must see patient prior to beginning CCM)
• One complex chronic condition expected to last 3 months
  ○ Risks must be documented: risk of hospitalization, exacerbation/decompensation, functional decline or death
• Development of a disease specific care plan to include
  ○ Monitoring and/or revision
• Any adjustments in medication(s)
• Any management of condition unusually complex due to comorbidities
• Ongoing communication and care coordination between practitioners furnishing care
	• Should only be reported 1x per calendar month
	• Don't report in the same calendar month as (not all-inclusive list):
	  ○ ESRD related services (CPT 90951-90970)
	  ○ Home health care supervision (G0181)
	  ○ Hospice care supervision (G0182)

99427

Principal care management, for a single high-risk disease; each additional 30 minutes of clinical staff time directed by a physician or other clinical staff member, per calendar month

Documentation requirements	**Tips**

• Patient consent written or verbal
• Initiating visit (billing provider must see patient prior to beginning CCM)
• One complex chronic condition expected to last 3 months
  ○ Risks must be documented: risk of hospitalization, exacerbation/decompensation, functional decline or death
• Development of a disease specific care plan to include
  ○ Monitoring and/or revision
• Any adjustments in medication(s)
• Any management of condition unusually complex due to comorbidities
• Ongoing communication and care coordination between practitioners furnishing care
	• Add-on code for 99426
	• Should not be reported more than 2x per month

99492

Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other clinical staff member

Covered benefit under all plans, member copay and deductible apply

Documentation requirements	Tips
• Enter patient in a registry and track patient follow-up and progress • Initial assessment of the patient • Provision of brief interventions using evidence-based techniques • Appointment duration	• Reported only by the treating physician or clinical staff member, as the psychiatric consultant's services are included in these codes. The treating physician pays the psychiatric consultant through a contractual arrangement. • Time spent in PCCM activities while the patient is in observation or inpatient hospital status should not be included while reporting these services. • PCCM activities to coordinate care with the emergency department may be included in the time of service reported. • A new episode of care starts after a break in episode of six calendar months or more.

99493

Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other clinical staff member

Covered benefit under all plans, member copay and deductible apply.

Documentation requirements	Tips
• Track patient follow-up and progress using the registry • Appointment duration • Relapse prevention planning with patients as they achieve remission of symptom • Additional review of progress and recommendations for changes in treatment	• Reported only by the treating physician or clinical staff member • Weekly conversations must occur

99494

Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of BHCM activities, in consultation with a psychiatric consultant, and directed by the treating physician or other clinical staff member

Documentation requirements	Tips
• Appointment duration	• List separately in addition to code for primary procedure. • Use 99494 in conjunction with 99492, 99493

99495

Transitional care management: moderate complexity, patient contact within 2 business days of discharge and a face-to-face within 14 calendar days of discharge

Covered benefit under all plans, member copay and deductible apply

Documentation requirements	Tips
• Date of office visit • Date of phone visit • Diagnoses discussed • Refer to CPT Manual for additional documentation requirements.	• Care is provided by a physician. • Code is intended to be used in place of an office-based evaluation and management service. • Patient contact must occur by phone within 2 business days of discharge. This call should include medication reconciliation. • An office visit within 14 calendar days of discharge is also required. • The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The date of service you report should be the 30th day post-discharge. • You may submit the claim on the 30th day post-discharge. • Search cms.gov for helpful reference materials regarding transitional care management services.

99496

Transitional care management: high complexity, patient contact within 2 business days of discharge and a face-to-face within 7 calendar days of discharge

Covered benefit under all plans, member copay and deductible apply.

Documentation requirements	Tips
• Date of office visit • Date of phone visit • Diagnoses discussed • Refer to CPT Manual for additional documentation requirements.	• Care is provided by a physician. • Code is intended to be used in place of an office-based evaluation and management service. • Patient contact must occur by phone within 2 business days of discharge. This call should include medication reconciliation. • An office visit within 7 calendar days of discharge is also required. • The 30-day period for the TCM service begins on the day of discharge and continues for the next 29 days. The date of service you report should be the 30th day post-discharge. • You may submit the claim on the 30th day post-discharge. • Search cms.gov for helpful reference materials regarding transitional care management services.

REFERENCES

- Chronic Care Management Services (CMS)
- Chronic Care Management – Guides and Resources (WPS – Government Health Administrators)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Jan. 2, 2025	• Added information for the following codes: 99424, 99425, 99426, 99427, 99437, 99439 • Updated documentation requirements and tips for the following codes: 99487, 99489, 99490, 99491 • Added a References section
Jan. 30, 2025	• Updated QHP to clinical staff member throughout • Added definition of clinical staff member
Feb. 4, 2025	Added "Disclaimer" section