Safer Suicide Care Billing Tip Sheet

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

Type of Service	Detail	Medicaid	Medicare	Third Party	Eligible Provider	Documentation	Time Requirement	Comments
Behavioral Health Services	Psychiatric diagnostic evaluation with medical services (NEW patient or re-evaluation). Psychiatric diagnostic evaluation with medical services	90792	90792	90792	Prescribers only (MD, NP,PA, APRN)	• Psychiatric diagnostic evaluation with medical services is an integrated biopsychosocial and medical assessment, including history, mental status, other physical examination elements as indicated, and recommendations. • Additional exam elements (pertinent to care). Prescription of medication or coordination of medications as part of medical care. • Order/review of medical diagnostic studies – Lab, imaging, and other diagnostic studies. • Medical thought process must be clearly reflected in assessment and plan.	none specified	• 90792 applies to new patients or to patients undergoing re-evaluation. Use this code only once per day regardless of the number of sessions or time that the provider spends with the patient on the same day. • When the patient goes for a psychiatric diagnostic evaluation, report either 90791 (Psychiatric diagnosis evaluation) or 90792 (Psychiatric diagnostic evaluation with medical services). • In the past, most payers would allow you to only report one unit of psychiatric diagnostic evaluation code per patient. Now, guidelines have been revised, and payers will allow you to claim for more than one unit of 90791 or 90792 if the initial psychiatric diagnostic evaluations extend beyond one session, as long as the sessions are on different dates. • An example of this extended evaluation would be when the psychiatrist is evaluating a child and will see the child with parents in one session and then evaluate the child independently in another session. So, depending on medical necessity, you can claim for more than one unit of 90791 or 90792 when the psychiatrist performs the evaluation in more than one session spread over more than one day. • When billing for Medicare, CMS will allow only one claim of 90791 or 90792 in a year. However, in some cases, depending on the medical necessity, Medicare might allow reimbursement for more than one unit of 90791 or 90792. You can also report these codes when the psychiatrist is seeing the patient after a span of three years. Code 90792 has a CCI conflict with code 90791. A modifier is not allowed to override this relationship.

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Behavioral Health Services	Psychiatric diagnosis evaluation (Can be used for assessment of suicide risk by a non- prescribing provider.)	90791	90791	90791	*Licensed* Mental Health Provider (PsyD, PhD, LCSW, LMSW)	• Psychiatric diagnostic evaluation is an integrated biopsychosocial assessment, including history, mental status, and recommendations.	45 minutes	• This code can be used to assess someone for risk by many payers even if they have had an assessment that year. No longer needs to be the initial session for most payers. • When the patient goes for a psychiatric diagnostic evaluation, report either 90791 (Psychiatric diagnosis evaluation) or 90792 (Psychiatric diagnostic evaluation with medical services). • In the past, most payers would allow you to only report one unit of psychiatric diagnostic evaluation code per patient. Now, guidelines have been revised, and payers will allow you to claim for more than one unit of 90791 or 90792 if the initial psychiatric diagnostic evaluations extend beyond one session, as long as the sessions are on different dates. • An example of this extended evaluation would be when the psychiatrist is evaluating a child and will see the child with parents in one session, and then evaluate the child independently in another session. So, depending on medical necessity, you can claim for more than one unit of 90791 or 90792 when the psychiatrist performs the evaluation in more than one session spread ove+l4r more than one day. • When billing for Medicare, CMS will allow only one claim of 90791 or 90792 in a year. However, in some cases, depending on the medical necessity, Medicare might allow reimbursement for more than one unit of 90791 or 90792. You can also report these codes when the psychiatrist is seeing the patient after a span of three years.I5 Code 90792 has a CCI conflict with code 90791. A modifier is not allowed to override this relationship.
	Psychotherapy, with patient and/or family member	90832	90832	90832	*Licensed* Mental Health Provider (PsyD, PhD, LCSW, LMSW)	Diagnoses for therapy – Reason for treatment: • Time of therapy (in minutes) that is face to face • Method of therapy • Assessment of symptoms • Summary of therapy •Identified goals and objectives for the therapy and the patient status with these • Identified plan for return, homework, and follow up * Signed and dated • Supervision as required by licensure level	Standard – 30 minutes (16–37-minute time frame)	•This code is often used to help engage patients at risk. This code can be used before the assessment code. •Psychotherapy is the treatment of mental illness and behavioral disturbance in which the physician or other qualified health care professional, through definitive therapeutic communication, attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage growth and development. •All therapy services are time based, and time must be documented within the record.

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Behavioral Health Services	Psychotherapy, with patient and/or family member	90834	90834	90834	*Licensed* Mental Health Provider (PsyD, PhD, LCSW, LMSW, LMHC, LMFT)	Diagnoses for therapy – Reason for treatment: • Time of therapy (in minutes) that is face to face • Method of therapy • Assessment of symptoms • Summary of therapy • Identified goals and objectives for the therapy and the patient status with these • Identified plan for return, homework, and follow up * Signed and dated • Supervision as required by licensure level	Standard – 45 min (38–52-minute time frame)	This code is most often used for risk assessment and safety planning for someone at risk.
	Psychotherapy for crisis	90839	90839	90839	*Licensed* Mental Health Provider (PsyD, PhD, LCSW, LMSW)	Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.	60 minutes recommended; (30–74 minutes and may vary by state payer)	This is a helpful code to use for patients at risk of suicide if they meet the criteria. This code is often paid at a higher rate and does not require prior authorization.
	Add-on code for psychotherapy for crisis	90840	90840	90840	Mental Health Provider (PsyD, PhD, LCSW, LMSW)		Use as add-on code with 90839 for each additional 30 minutes beyond the first 74 minutes	Be sure to use this code for patients at risk and in crisis with whom you spend more time.

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Behavioral Health Services	Add-on code for complexity	90795	90795	90795	*Prescriber*			Many patients at risk for suicide are complex and/or present with complex situations – Consider adding interactive complexity code 90785 for those patients: • Add-on code to the code for a primary psychiatric service • May be reported, as appropriate, with 90791,90792,90832,90833,90894,90896,90853,90837,99201- 99255,99304-99337, and 99341-99350 One of the following must exist during the session in order to report 90785: • Maladaptive communication (e.g., high anxiety, high reactivity, repeated questions or disagreement) • Emotional or behavioral conditions inhibiting implementation of treatment plan • Mandated reporting/event exists (e.g., abuse or neglect) • Play equipment, devices, interpreter, or translator required due to inadequate language expression or different language spoken between patient and professional.
Chronic Care Management (CCM)	Chronic Care Management (Assessment & Planning)		G0506		Physician or nonphysician practitioner (Physician Assistant [PA], Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Certified Nurse-Midwife [CNM]) and their clinical staff	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service) Document chronic care management services, with the following required elements: • Multiple (2 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		Non-registered nurse, non-licensed clinical staff can perform activities, as directed by a physician or other qualified health care professional.

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Chronic Care Management (CCM)	Chronic care management services, additional 20 minutes		G0506	99490	Physician or other qualified health care professional	Document chronic care management services, with the following required elements: • Multiple (2 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	20 minutes per month	(Do not report 99487, 99489, 99490 during the same month with 90951-90970, 93792, 93793, 98960-98962, 98966-98969, 99071, 99078, 99080, 99091, 99339, 99340, 99358, 99359, 99366-99368, 99374-99380, 99441-99444, 99495, 99496, 99605-99607)
	Chronic care management service, additional 30 minutes		G0506	99491	Physician or other qualified health care professional	Document chronic care management services, with the following required elements: • Multiple (2 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	30 minutes per month	
	Complex chronic care management services, with outpatient visit		G0506	99487	Physician or other qualified health care professional	Document: • Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline • Establishment or substantial revision of a comprehensive care plan • Moderate or high complexity medical decision-making • 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	60 minutes of clinical staff time, per calendar month	(Do not report 99487, 99489, 99490 during the same month with 90951-90970, 93792, 93793, 98960-98962, 98966-98969, 99071, 99078, 99080, 99091, 99339, 99340, 99358, 99359, 99366-99368, 99374-99380, 99441-99444, 99495, 99496, 99605-99607)

Type of Service	Detail	Medicaid	Medicare	Third Party	Eligible Provider	Documentation	Time Requirement	Comments
Chronic Care Management (CCM)	Complex chronic care management services, initial 60 minutes per month		G0506	99487	Directed by a physician or other qualified health care professional	Document the following required elements: • Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline • Establishment or substantial revision of a comprehensive care plan • Moderate or high complexity medical decision-making	60 minutes of clinical staff time, per calendar month.	(Do not report 99487, 99489, 99490 during the same month with 90951-90970, 93792, 93793, 98960-98962, 98966-98969, 99071, 99078, 99080, 99091, 99339, 99340, 99358, 99359, 99366-99368, 99374-99380, 99441-99444, 99495, 99496, 99605-99607)
	Complex chronic care management services, additional 30 minutes		G0506	99489	Directed by a physician or other qualified health care professional	Document the following required elements • Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline • Establishment or substantial revision of a comprehensive care plan • Moderate or high complexity medical decision-making	Additional 30 minutes of clinical staff time, per calendar month	(Report 99489 in conjunction with 99487) (Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month)

Type of Service	Detail	Medicaid	Medicare	Third Party	Eligible Provider	Documentation	Time Requirement	Comments
Collaborative Care Management (CoCM)	Initial psychiatric collaborative care management CoCM, First Month		G0502	99492	Physicians, LCSW, PA, clinical psychologists, CNS, medical assistant under PCP	Document the following required elements: 1. Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional 2. Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan 3. Review by the psychiatric consultant with modifications of the plan if recommended 4. 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 5. Provision of brief interventions using evidence-based techniques, such as behavioral activation, motivational interviewing, and other focused treatment strategies	70 minutes per calendar month	In consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional

Type of Service	Detail	Medicaid	Medicare	Third Party	Eligible Provider	Documentation	Time Requirement	Comments
Collaborative Care Management (CoCM)	Subsequent psychiatric collaborative care management, Subsequent Months		G0503	99493	Physicians, LCSW, PA, clinical psychologists, CNS, medical assistant under PCP	Document the following required elements: 1. Tracking patient follow-up and progress using the registry, with appropriate documentation 2. Participation in weekly caseload consultation with the psychiatric consultant 3. 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 4. Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant 5. Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies 6. Monitoring of patient outcomes using validated rating scales 7. Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment	60 minutes per calendar month	In consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional
	Initial or subsequent psychiatric collaborative care management, **over initial billing time requirement**		G0504 List separately in addition to code for primary procedure; (use G0504 in conjunction with G0502, G0503)	99494	Physicians, LCSW, PA, clinical psychologists, CNS, medical assistant under PCP	Same as G0502 and G0503.	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

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Collaborative Care Management (CoCM)	General BHI	In some states where CoCM codes have been added	G0507	99484	Directed by a physician or other qualified health care professional	Document: 1. Initial assessment or follow-up monitoring, including the use of applicable validated rating scales 2. Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes 3. Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation 4. Continuity of care with a designated member of the care team	20 minutes or more	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time per calendar month. I20CMS therefore created HCPCS G0511 (General Care Management Services) for use by RHCs and FQHCs whenever the requirements for CPT 99490 (20 minutes or more of CCM services), CPT 99487 (at least 60 minutes of complex CCM services) or HCPCS G0507 (20 minutes or more of behavioral health issues services) are provided. RHC and FQHC claims submitted using CPT 99490 for dates of service occurring after December 31, 2017, will be denied.
	General Care Management Services	99490 In some states where CoCM Codes have been added	G0511	99490	Physicians, LCSW, PA, clinical psychologists, CNS, medical assistant under PCP	All elements of CCM services billed previously under CPT codes 99490 or 99487 or initial assessment or follow-up monitoring, including use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; continuity of care with a designated member of the care team.	Minimum of 20 minutes per calendar month	G0511 can be billed for general behavioral health integration services (BHI) and Chronic Care Management (CCM) services that were previously billed using CPT codes 99490 or 99487. Service elements must include: • All elements of CCM services billed previously under CPT codes 99490 or 99487 or initial assessment or follow-up monitoring, including use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; continuity of care with a designated member of the care team. • G0511 may only be billed once per month per beneficiary and may not be billed if other care management services, such as transitional care management or home health care supervision, are billed for the same time period. CMS therefore created HCPCS G0511 (General Care Management Services) for use by RHCs and FQHCs whenever the requirements for CPT 99490 (20 minutes or more of CCM services), CPT 99487 (at least 60 minutes of complex CCM services) or HCPCS G0507 (20 minutes or more of behavioral health issues services) are provided. RHC and FQHC claims submitted using CPT 99490 for dates of service occurring after December 31, 2017, will be denied.

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Collaborative Care Management (CoCM)	Psychiatric Collaborative Care Model services		G0512			Documentation includes: •Outreach and engagement of patients; initial assessment, including administration of validated scales and resulting in a treatment plan; •Entering patients into a registry for tracking patient follow-up and progress; •Participation in weekly caseload review with psychiatric consultant and modifications to treatment, if recommended; •Provision of brief interventions using evidence-based treatments such as behavioral activation, problem-solving treatment, and other focused treatment activities; •Tracking patient follow-up and progress using validated rating scales; •Ongoing collaboration and coordination with treating FQHC and RHC providers; •Relapse prevention planning and preparation for discharge from active treatment.	Minimum of 60 minutes per calendar month	• G0512 may only be billed once per month per beneficiary and may not be billed at the same time as G0511.
Medical Consultation	Medical Consultation	99241-99245	99241-99245	99241-99245	Prescribers only (MD, NP,PA, APRN)	Documentation of consultation and review	None	•Consultation codes should not be billed repeatedly or when the consultation is prompted by the patient/family. •A third-party-mandated consultation •Provision by a physician or qualified non-physician practitioner whose advice, opinion, recommendation, suggestion, direction or counsel is requested for evaluation and treatment recommendations of a patient, since that individual's expertise in a specific medical area is beyond the scope of knowledge of the requesting physician or qualified non-physician practitioner •Provision of a written report of findings/recommendations from the consultant to the referring physician or qualified non-physician practitioner
Medical Team Conference	Medical Team Conference	99366-99369	99366-99369	Varies	All members of the health care team with at least 3 participants	Documentation of all members present; time spent and documentation of plan	30 minutes	While many of these codes have time attached to them and are seldom used , case discussions for patients at risk for suicide often meet or exceed the time frames allowing for some additional revenue to support care for patients at risk.

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Multifamily Groups	Multiple family group psychotherapy	90849	90849	Varies	*Licensed* Mental Health Provider (PsyD, PhD, LCSW, LMSW)	Documentation of participation and progress toward treatment goals.		• The therapist provides multiple family group psychotherapy by meeting with several patients' families together. This is usually done in cases involving similar issues. The session may focus on the issues of the patient's care needs and problems. • Attention is also given to the impact the patient's condition has on the family. This code is reported once for each family group present. • Will often be included in contracts if requested.
Behavioral Health Groups	Group psychotherapy	90853	90853	Varied	*Licensed* mental health provider, PsyD, PHD, LCSW, LMSW	Documentation of participation and progress toward treatment goals.		• Requires at least 2 members of a group but no more than 12 in most states. •The psychiatric treatment provider conducts psychotherapy for a group of several patients in one session. Group dynamics are explored. Emotional and rational cognitive interactions between individual persons in the group are facilitated and observed. Personal dynamics of any individual patient may be discussed within the group setting. Processes that help patients move toward emotional healing and modification of thought and behavior are used, such as facilitating improved interpersonal exchanges, group support, and reminiscing. The group may be composed of patients with separate and distinct maladaptive disorders or persons sharing some facet of a disorder. This code should be used for group psychotherapy involving patients other than the patients' families. • Patients at risk benefit from group treatment. Offering both individual and group treatment can give patients more choices as well as increase revenue. • The interactive complexity code can be added to this service for the specific patient for whom this issue applies. • The +90785 is the add on code for this, and the documentation in the specific patient record would need to reflect this component of care.
Family Therapy	Family psychotherapy (without patient present)	90846	90846	Most places	Licensed behavioral health providers only	Must document all members present, clinical necessities, plan, and time spent	50 minutes	• The therapist provides family psychotherapy in a setting where the care provider meets with the patient's family without the patient present. The family is part of the patient evaluation and treatment process. Family dynamics as they relate to the patient's mental status and behavior are a main focus of the sessions. • Attention is also given to the impact the patient's condition has on the family, with therapy aimed at improving the interaction between the patient and family members. • Meetings with the family of a patient at risk following their assessment is often overlooked as a separate service. Using these codes can increase revenue as it could be an additional billable visit.

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Family Therapy	Family psychotherapy (with patient present)	90847	90847	Most places	Licensed behavioral health providers only	Must document all members present, clinical necessities, plan, and time spent	50 minutes	• The therapist provides family psychotherapy in a setting where the care provider meets with the patient's family with the patient present. The family is part of the patient evaluation and treatment process. Family dynamics as they relate to the patient's mental status and behavior are a main focus of the sessions. • Attention is also given to the impact the patient's condition has on the family, with therapy aimed at improving the interaction between the patient and family members. • Meetings with the family of a patient at risk following their assessment is often overlooked as a separate service. Using these codes can increase revenue as it could be an additional billable visit
Screening: Screening is important for identifying patients at risk for suicide. Screening can also generate additional revenue.	Behavioral or emotional screening	96127 Not above PPS rate	G0444 (see comments)	Varied	MD, NP, PA, PsyD, PHD, LCSW, LMSW	Document the screening instrument, score, results and interpretation, and recommendation.	• Tool included in record • No time	MEDICARE patients only: • If SYMPTOMS ARE REPORTED prior to routine screening, use CPT 96127. • If NO SYMPTOMS are reported prior to routine screening, use code G0444 instead of CPT 96127. •Examples: PHQ2/9
	Developmental Screening (96110)	96110 Not above PPS rate	G0451	Varied	MD, NP, PA, PsyD, PHD, LCSW, LMSW	Document the screening instrument, score, results and interpretation, and recommendation.	• Tool included in record • No time	• Examples: ASQ, ASQ-SE, PSC, Vanderbilt MCHAT. • Medicare does not separately pay for CPT codes 92605 or 92618. Medicare considers these service as always bundled into payment for other services not specified. • Medicare no longer covers 96110 because its policy is to not cover screens. • However, CMS did allow a way for Medicare to pay for developmental screening by also proposing to add a temporary code, a supplemental HCPCS Level II G-code, G0451 Developmental testing with interpretation and report, per standardized instrument, which is valued on the previously published values of CPT code 96110. Medicare is required to pay G codes. Medicaid and private payers will often, but not always, follow suit. There is no guarantee of continued reimbursement, but G0451 may be an alternative to 96110. Because of the potential for confusion with these codes, documentation should be very clear.
	Depression screen, annual		G0444		MD, APRN, PhD and other licensed providers, as licensed and regulated by individual states and Medicare	Document the annual screening instrument, score, results and interpretation, and recommendation.	15 minutes	Screening for depression in adult is **once per year. Use standardized instrument.**
SBIRT: Screening, Brief Intervention, and Referral to Treatment	Substance abuse screenings (not a threshold visit)+B32	H0049/50 Not above PPS rate	G0442	Varied		Document the screening instrument, score, results and interpretation, and recommendation.	• Tool included in record • No time	Examples: DAST, CAGE, ORT

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SBIRT: Screening, Brief Intervention, and Referral to Treatment	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 15 to 30 minutes	99408	G0396	99408	MD, APRN, PhD and other licensed providers, as licensed and regulated by individual states and Medicare	• Denote start/stop times or total face-to-face time with patient • Administration of structured instrument, score/results, and recommendations For patients who scored positive on alcohol or substance use misuse screen, also document: • Efforts to assist patient in setting goals • Plan • Educational materials provided • Efforts to reinforce adherence to plan and encouragement to return for visits for continued support • Rescreen plan, (at least annually)	15 to 30 minutes	• Review existing practices prior to using codes. It may be more beneficial to use EM or BH code. • Use standardized instrument. • Denote start/stop time or total face- to-face time with the patient (because some SBIRT Healthcare Common Procedure Coding System [HCPCS] codes are time- based codes).I32
	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes	99409	G0397	99409	MD, APRN, PhD and other licensed providers, as licensed and regulated by individual states and Medicare	• Denote start/stop times or total face-to-face time with patient; include explanation for extended time • Administration of structured instrument, score/results, and recommendations For patients who scored positive on alcohol or substance use misuse screen, also document: • Efforts to assist patient in setting goals • Plan • Educational materials provided • Efforts to reinforce adherence to plan and encouragement to return for visits for continued support • Rescreen plan, (at least annually)	31 minutes or more	• Review existing practices prior to using codes. It may be more beneficial to use EM or BH code. • Denote start/stop time or total face- to-face time with the patient (because some SBIRT Healthcare Common Procedure Coding System [HCPCS] codes are time- based codes).
	Annual alcohol misuse screening		G0442		MD, APRN, PhD and other licensed providers,F34 F34as licensed and regulated by individual states and Medicare	Document the annual screening instrument, score, results and interpretation, and recommendation	15 minutes	• Screen for alcohol misuse in adults, including pregnant women, once per year. • Use standardized instrument, for example, AUDIT.

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SBIRT: Screening, Brief Intervention, and Referral to Treatment	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes		G0443		MD, APRN, PhD and other licensed providers, as licensed and regulated by individual states and Medicare	For patients **who scored positive** on annual alcohol misuse screen (in addition to above) document: • Efforts to assist patient in setting goals • Plan • Educational materials provided • Efforts to reinforce adherence to plan and encouragement to return for visits for continued support • Rescreen plan, (at least annually)	15 minutes	Maximum 4 per year for individuals who screen positive for alcohol misuse
Medication Prescription (Mental Health)	Prescription of medication	99213-99214 (E and M codes)	99213-99214 (E and M codes)	99213-99214 (E and M codes)	Prescribers only (MD, NP,PA, APRN)	Patient/support staff can document the following that must be confirmed by the provider. • Chief complaint (CC) • Past medical history (PMH) • Medications (PMH) • Allergies (and reactions) • Social history (SH) • Family history (FH) • Review of systems (ROS) Providers must document history of present illness (HPI), exam, and medical decision-making/plan		
General Medication Reconciliation	Medication reconciliation done by PCP	99213-99214 (E and M codes)	99213-99214 (E and M codes)	99213-99214 (E and M codes)	Prescribers only (MD, NP,PA, APRN)	Patient/support staff can document the following, which must be confirmed by the provider: • Chief complaint (CC) • Past medical history (PMH) • Medications (PMH) • Allergies (and reactions) • Social history (SH) • Family history (FH) • Review of systems (ROS) **Providers must document** history of present illness (HPI), exam, and medical decision-making/plan		

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General Medication Reconciliation	Medication reconciliation done by RN	99211 (E and M code)	99211 (E and M code)	99211 (E and M code)	RN Not Threshold Visit	Patient/support staff can document the following, which must be confirmed by the provider: • Chief complaint (CC) • Past medical history (PMH) • Medications (PMH) • Allergies (and reactions) • Social history (SH) • Family history (FH) • Review of systems (ROS) Providers must document history of present illness (HPI), exam, and medical decision-making/plan	Typically, 5 minutes are spent performing or supervising these service	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
Care Management and Nursing Visits	Nursing visits	99211 (E and M code)	99211 (E and M code)	99211 (E and M code)	RN	Care management and/or nursing visit activities	Typically, 5 minutes are spent performing or supervising these services.	Nursing visits: Nurses are part of a care team and have the ability to review safety plans as part of other visits, such as pressure checks or flu shots, which could mean the ability to use this code. Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.