Agenda

- Telemedicine (98000-98016)
- Advanced Primary Care Management (G0556-G0558)
- Other G codes
  - G2211 – OK with Office Visits done with Preventive Services
  - G0537-G0538 ASCVD Risk Assessment and Management
  - G0539-G0544 Caregiver Training
  - G0546-G0551 Interprofessional Consult (eConsults) BH professionals

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Telemedicine Evaluation and Management Services CPT 2025

Peter Hollmann, MD

Bottom Line Take Aways

- CPT created new telemedicine codes (98000-98016)
- Most commercial plans appear to have not considered the use of these new codes
- Medicare will not be using these codes
  - Report Audio-video as you have in 2024 (99202-99215 with -95)
  - Telephone codes (99441-99443) have been deleted, so audio-only services are now reported like Audio-Video except with modifier -93
- BCBSRI will not be using these codes
  - No coding change from 2024 (Medicare Advantage plans will now apply copays/co-insurance)
- UHC Medicaid will not be using these codes
- Other payers have not responded to requests and most published policies pre-date creation of new codes
  - Therefore, understanding the codes may be useful. Keep up to date with CPT and Provider Policy bulletins from plans.

Bottom Line Take Aways

- Congress must act for telemedicine to be covered by Medicare after 12/31/2024.
  - We do not expect Medicare Advantage plans to stop, but they may.
  - This will go to the wire with a Congressional bill package about funding the government or not.
  - Primary Care First has a waiver, and it will be covered.
- RI Law requires coverage for Commercial (employer type and individual “Obamacare”)
- RI Medicaid will continue to cover telemedicine
- If covered by Medicare, Audio only requires patient refusal/inability to do audio-video

Telephone Services

Telephone Services ~~(99441-99443)~~

- 99441-99443 Deleted
- Original Medicare will revert to office visit codes with modifier -93
- Local Commercial plans are still held to telehealth mandate; follow 2024 guidance and continue to review plan policy bulletins to monitor adoption of 98008-98016
- Local Medicaid plans' 2024 policies remain (NHPRI still references 99411-99443, but also covers E&M as telephone only)
- For plans following CPT rules, audio-only are reported using the new telemedicine codes (98008-98016)
- Refer to payer guidance on recommended modifiers to accompany telephone-only visits (e.g., modifier -93 or –FQ)

Telemedicine Services Code Structure in CPT

Telemedicine Services Code Structure

Evaluation and Management

- Telemedicine Services
  - Synchronous Audio-Video Evaluation and Management Services
    - New Patient
      - 98000 - 98003
    - Established Patient
      - 98004 - 98007
  - Synchronous Audio-Only Evaluation and Management Services
    - New Patient
      - 98008 - 98011
    - Established Patient
      - 98012 - 98015
  - Brief Synchronous Communication Technology Service (eg, Virtual Check-In)
    - 98016

Telemedicine Services Subsection Structure

Same categories and structure as Office or Other Outpatient codes 99202-99205 and 99211-99215.

Example:

99202 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

98000 **Synchronous audio-video visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

Telemedicine Services Guidelines

Telemedicine Services Guidelines

Image Courtesy of Getty Images

Guidelines include the following:

- Codes describe real-time, interactive encounters between physician or other QHP and patient.
- Based on level of MDM OR total time for E/M performed on date of encounter just like office visits.
- Not used for routine telecommunications related to a previous encounter (e.g., to communicate lab results).
- May be used for follow-up of previous encounter when follow-up is required.

Synchronous Audio-Video Evaluation and Management Services

Synchronous Audio-Video Evaluation and Management Services (98000-98007)

►**Synchronous Audio-Video Evaluation and Management Services**◄

►Codes 98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007 may be reported for new or established patients. Synchronous audio and video telecommunication is required. These services may be reported based on total time on the date of the encounter or MDM.◄

Synchronous Audio-Video Evaluation and Management Services (98000-98007) – CPT allows Prolonged Services Just Like Office Visits

98002 **Synchronous audio-video visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

98003 **Synchronous audio-video visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making.

When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

►(For services 75 minutes or longer, use prolonged services code 99417)◄

Synchronous Audio-Video Evaluation and Management Services (98000-98007)

98006 **Synchronous audio-video visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

98007 **Synchronous audio-video visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

►(For services 55 minutes or longer, use prolonged services code 99417)◄

Payment Amounts (AV and Audio-only)

- CMS does publish the RVU file on these codes even though they do not use them.
- The work RVUs are almost the same, but the Practice Expense RVUs are less, so if the RVUs were used, payment would be less. Audio only is a little less than Audio-Video
- RI regulation requires payment the same as in-person for Primary Care and BH, but not specialty care
- Medicare states their laws require payment to be the same as in-person and that is why they are not using 98000-98016

Synchronous Audio-Only Evaluation and Management Services

Synchronous Audio-Only Evaluation and Management Services (98008-98015)

►Synchronous Audio-Only Evaluation and Management Services◄

►Codes 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015 may be reported for new or established patients. They require more than 10 minutes of medical discussion. For services of 5 to 10 minutes of medical discussion, report 98016, if appropriate. If 10 minutes of medical discussion is exceeded, total time on the date of the encounter or MDM may be used for code level selection.◄

The only thing that is different about these codes compared to AV and Office Visits is that there is a time minimum to use them.

Synchronous Audio-Only Evaluation and Management Services (98008-98015)

►New Patient◄

98008 **Synchronous audio-only visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

98009 **Synchronous audio-only visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

Synchronous Audio-Only Evaluation and Management Services (98008-98015) also use Prolonged Services

98010 **Synchronous audio-only visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

98011 **Synchronous audio-only visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

►(For services 75 minutes or longer, use prolonged services code 99417)◄

Synchronous Audio-Only Evaluation and Management Services (98008-98015) Errata (CPT Mistake)

YOU CAN IGNORE THESE INSTRUCTIONS ABOUT REPORTING OTHER SERVICES

►Established Patient◄

#●**98012** **Synchronous audio-only visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion.

When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.

►(Do not report 98012 for home and outpatient INR monitoring when reporting 93792, 93793)◄ correct

►(Do not report 98012 when using 99374, 99375, 99377, 99378, 99379, 99380 for the same call[s])◄ correct

►(Do not report 98012 during the same month with 99487, 99489)◄ incorrect

►(Do not report 98012 when performed during the service time of 99495, 99496)◄ incorrect

Why are those instructions wrong?

- Do not replace the Telephone (99441-99443) codes with audio-only codes in various coding rules – a CPT editor did this search/replace in error.
- Do treat them the same as office visit codes regarding exclusionary language.
- Never count the same time twice for all time-based codes or potentially time-based (i.e., either MDM or total on the date of the encounter)
- For example:
  - One can report audio only visits after the first E/M that qualified the service to be Transitional Care Management
  - One can report audio-only visits in the same month as reporting Complex Chronic Care Management
  - One cannot use any time of the physician/QHP on the date of an audio-only E/M towards the time of any Care Management code.

FAQs

- What is “medical discussion”?
  - Talking to the patient, just as you would in the office, excluding time spent on non-medical issues.
- If the discussion is 8 minutes but counting charting, prep, follow-up etc. and the total time on the date of the encounter is 12 minutes, can I use the audio-only codes?
  - No, because you did not meet the 10-minute threshold for medical discussion
- If the discussion is 11 minutes, do I then use total time on the date of the encounter?
  - Once you hit the 10-minute threshold you can use total time OR medical decision-making level just like an office visit or audio-video visit.

Brief Synchronous Communication Technology Service (e.g., Virtual Check-In)

(The CMS G code is deleted and replaced with an identical CPT code)

Deletion of HCPCS Code G2012 (“Virtual Check-In”)

- CMS deleted HCPCS code G2012:

Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

- CPT created 98016 using the identical language

Brief Synchronous Communication Technology Service (e.g., Virtual Check-In) (98016)

Image Courtesy of Getty Images

- Patient-initiated
- Virtual check-in
- Established patients only
- Does not originate from related E/M service from previous 7 days
- Does not lead to E/M service within next 24 hours or soonest available appointment
- Time from virtual check-in may be added to time of E/M service for total time when virtual check-in leads to E/M service on same calendar date (and therefore 98016 may not be billed).

Brief Synchronous Communication Technology Service (e.g., Virtual Check-In) (98016)

►**Brief Synchronous Communication Technology Service (eg, Virtual Check-In)**◄

►Code 98016 is reported for established patients only. The service is patient-initiated and intended to evaluate whether a more extensive visit type is required (eg, an office or other outpatient E/M service [99212, 99213, 99214, 99215]). Video technology is not required. Code 98016 describes a service of shorter duration than the audio-only services and has other restrictions that are related to the intended use as a "virtual check-in" or triage to determine if another E/M service is necessary. When the patient-initiated check-in leads to an E/M service on the same calendar date, and when time is used to select the level of that E/M service, the time from 98016 may be added to the time of the E/M service for total time on the date of the encounter.◄

Brief Synchronous Communication Technology Service (eg, Virtual Check-In) (98016)

98016 **Brief communication technology-based service** (eg, virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion

►(Do not report 98016 in conjunction with 98000-98015)◄

►(Do not report services of less than 5 minutes of medical discussion)◄

Minimum time FAQs

- Office visits
  - No minimum time. If using time for level selection use total time (including non-medical discussion time) on the date of the encounter and each time is a threshold level. Document total time in the note.
- Audio-video telemedicine
  - No minimum time. If using time for level selection use total time (including non-medical discussion time) on the date of the encounter and each time is a threshold level. Document total time in the note.
- Audio-only
  - More than 10 minutes medical discussion. Once 10-minute threshold is met, can use total time (including non-medical discussion time) on the date of the encounter.
- Virtual Check-in
  - Minimum 5 minutes medical discussion

Advanced Primary Care Management – Medicare

Disclosures

- *The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents*. (The standard CMS presenter disclosure).
- Presenter is not a CMS representative
- Presenter has participated in CPC+, Primary Care First and Medicare Shared Savings Program ACO.

Advanced Primary Care Management

ATTRIBUTE	COMMENT
Resource recognition	Explicit attempt to recognize the resources required to provide advanced primary care, based upon demonstrations. Predictable payment.
Stimulate wider practice transformation	Provides clear financial incentives and support to build and maintain an advanced primary care practice (and participate in VBP models) including population management
Support Value Based Payment	Practices meet several required attributes by participating in Advanced Alternative Payment Models (eg ACO REACH, Primary Care First, MSSP). APCM practices help ACOs to succeed.

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Advanced Primary Care Management

ATTRIBUTE	COMMENT
Equity	Explicit attempt to recognize the additional resources required to provide advanced primary care to those with challenging SDOH who are also more likely to have chronic illness.
Administrative simplification	Replaces several under reported time-based codes No complex attribution method No complex risk adjustment factor method
Accountability	Administratively minimalist

APCM Levels

TABLE 24: Patient-Centered Risk Stratification for Billing APCM Codes

Level 1 [G0556]	Level 2 [G0557]	Level 3 [G0558]
Patients with one or fewer chronic conditions.	Patients with two or more chronic conditions.	Patients with two or more chronic conditions and who are Qualified Medicare Beneficiaries.

Presentation Format

- The descriptor (the code language) – official
  - Will present the initial part that varies by code level
  - Will then present the language that is identical in ALL 3 of the codes.
- A Table from CMS that has slightly more detail -official
- My interpretation of the comments and responses that CMS put in the final rule – it is from the rule but not ve.rbatim and thus not official.
- Because it is repetitive, each section will not be read by the presenter, but is a reference

G0556 Descriptor Base

- **G0556** Advanced primary care management services for a patient with *one chronic condition* [expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline], *or fewer,* provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate:

Descriptor G0557- Level 2 base

G0557 Advanced primary care management services for a patient *with multiple (two or more) chronic conditions* expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate:

Descriptor G0558- Level 3 base

G0558 Advanced primary care management services *for a patient that is a Qualified Medicare Beneficiary with multiple (two or more) chronic conditions* expected to last at least 12 months, or until the death of the patient, which place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all primary care and serves as the continuing focal point for all needed health care services, per calendar month, with the following elements, as appropriate:

Descriptor (code language cont'd): Consent and Initiation

- Consent;

  ++ Inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply.

  ++ Document in patient's medical record that consent was obtained.

- Initiation during a qualifying visit for new patients or patients not seen within 3 years;

Descriptor (code language cont'd): Access, Continuity, Alternative Visits

- Provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week;
- Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours;

Descriptor (code language cont'd): Comprehensive Care Management

- Overall comprehensive care management;
  - ++ Systematic needs assessment (medical and psychosocial).
  - ++ System-based approaches to ensure receipt of preventive services.
  - ++ Medication reconciliation, management and oversight of self-management.

Descriptor (code language cont'd): Electronic, comprehensive, patient-centered care plan

- Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan with typical care plan elements when clinically relevant;

  ++ Care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver;

Descriptor (code language cont'd): Care Coordination

- Coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable;

  ++ Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care.

  ++ Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated.

Descriptor (code language cont'd): Interagency Communication

- Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record;

Descriptor (code language cont'd): Enhanced Patient Communication

- Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate;

  ++ Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits).

Descriptor (code language cont'd): Population Management and Accountability

- Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate;
- Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients;
- Be assessed through performance measurement of primary care quality, total cost of care, and meaningful use of Certified EHR Technology.

How to know QMB status

“Because all Medicare providers and suppliers are prohibited from billing QMBs for Medicare cost sharing, we have established mechanisms in place to help practitioners identify QMB patients. The Medicare 270/271 HIPAA Eligibility Transaction System (HETS) became effective in November 2017. Through HETS, health care providers can determine QMB status for each patient prior to billing. We also include QMB information in the Medicare Remittance Advice (RA) for fee-for-service claims after claims processing. Practitioners should consider asking their third-party eligibility-verification vendors how their products reflect the QMB information in HETS. We also recognize that, in some larger practices or practices that are part of larger health systems, there may be administrative staff or billing departments that have access to this information. For practitioners who furnish services to QMBs, including those who plan to bill for Level 3 APCM services, it would be important to establish internal workflows to ensure proper identification of patients with QMB status. Additional information can be found at https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1128.pdf. Practitioners can also learn a patient’s QMB status directly through State Medicaid agencies.”

Check Your Patient's Eligibility

Check patient eligibility through these online tools and services:

- Medicare Administrative Contractor (MAC) online provider portal
- MAC Interactive Voice Response (IVR) system
- Billing agencies, clearinghouses, or software vendors
- Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS)

You refers to the provider billing Medicare-covered supplies or services.

You may see different Medicare eligibility responses based on the tool you use.

To check eligibility, enter your patient's:

- MBI
- First and last name
- Date of birth (MM/DD/YYYY)

When the information matches a Medicare record, we'll return an eligibility response containing information like:

Checking Medicare Eligibility — MLN Fact Sheet

- Periods & Spells
  - ESRD
  - Home health
  - Hospice
  - Hospital
  - Qualified Medicare Beneficiary
  - Skilled nursing facility and benefit days remaining

Payment Rates

TABLE 27: Final APCM Bundled Codes and Valuation

Code	Short Descriptor	Reference Codes	CMS Work RVU	Approximate National Non-Facility Rate
G0556	APCM for patients with up to one chronic condition	99490	0.25	$15
G0557	APCM for patients with multiple (two or more) chronic conditions	99490, 99439, 99487, 99489	0.77	$50
G0558	APCM for QMBs enrollees with multiple chronic conditions	Calculated as a relative increase from G0557	1.67	$110

If practice has mix of entire Medicare FFS population weighted average is $59 (0.36@$15)+(0.28@$50)+(0.36@$110)

This was ballparked by presenter from stats in rule about 2+ conditions and QMB#, total bene# and should be considered very approximate. Without QMB effect would be $37. Not a CMS projection.

Duplicative (Bundled into APCM) services

You can report these or APCM, not both, in the same month, same single practitioner

TABLE 26: Care Management and CTBS which are Substantially Duplicative of APCM Services

Service	Description
Care Management Services (12 CPT Codes)	
Chronic Care Management (CCM) (CPT Codes 99487, 99489, 99490, 99491, 99439, 99437)	Management of all care for patients with two or more serious chronic conditions, timed, per month
Principal Care Management (PCM) (CPT Codes 99424, 99425, 99426, 99427)	Management of all care for patients with one serious chronic condition, timed, per month
Transitional Care Management (TCM) (CPT Codes 99495, 99496)	Management of transition from acute care or certain outpatient stays to a community setting, with face-to-face visit (bundled into payment for the code), once per patient within 30 days post-discharge

Duplicative (Bundled into APCM) services (when same month same single practitioner) Table 26

Communication Technology-Based Services (15 CPT Codes)	
Interprofessional Internet Consultation (IPC) (CPT Codes 99446, 99447, 99448, 99449, 99451, 99452)	Consultations between or among certain kinds of medical practitioners.
Remote Evaluation of Patient Videos/Images (HCPCS code G2250)	Remote evaluation of recorded video and/or images submitted by patient
Virtual Check-In (HCPCS codes G2251, G2252)	Virtual check-in service to decide whether an office visit or other service is needed
Online Digital E/M (e-Visit) (CPT codes 98970, 98971, 98972, 99421, 99422, 99423)	Communication between patient and their provider through an online patient portal

TABLE 25: APCM Service Elements* and Practice-Level Capabilities

Consent • Inform the patient of the availability of APCM services; that only one practitioner can furnish and be paid for these services during a calendar month; of the right to stop services at any time (effective at the end of the calendar month); and that cost sharing may apply* (may be covered by supplemental health coverage) • Document in patient's medical record that consent was obtained
Initiating Visit for New Patients (separately paid) • Initiation during a qualifying visit for new patients • An initiating visit is not needed: (1) if the beneficiary is not a new patient (has been seen by the practitioner or another practitioner in the same practice within the past three years) or (2) if the beneficiary received another care management service (APCM, CCM, or PCM) within the previous year with the practitioner or another practitioner in the same practice.
24/7 Access to Care and Care Continuity • Provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week. In the event of afterhours communication with a beneficiary, whoever is responsive to the patient's concerns must document and communicate their interaction with the beneficiary to the primary care team/practitioner. • Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments • Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as home visits and/or expanded hours, as appropriate
Comprehensive Care Management • Overall comprehensive care management may include, as applicable • Systematic needs assessment (medical and psychosocial) • System-based approaches to ensure receipt of preventive services • Medication reconciliation, management and oversight of self-management

Table 25:

Patient-Centered Comprehensive Care Plan • Development, implementation, revision, and maintenance of an electronic patient-centered comprehensive care plan which is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care, can be routinely accessed and updated by care team/practitioner, and copy of care plan to patient/caregiver
Management of Care Transitions (for example, discharges, ED visit follow-up, referrals, as applicable) • Coordination of care transitions between and among health care providers and settings, including transitions involving referrals to other clinicians, follow-up after an emergency department visit, or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities, as applicable • Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care. • Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after ED visits and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated
Practitioner, Home-, and Community-Based Care Coordination • Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), as applicable, and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors in the patient's medical record

Enhanced Communication Opportunities

- Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face-to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication technology-based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate
- Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits)

Patient Population-Level Management

- Analyze patient population data to identify gaps in care and offer additional interventions, as appropriate
- Risk stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients
- A practitioners who is participating in a Shared Savings Program ACO, REACH ACO, Making Care Primary, or Primary Care First satisfies this requirement

Performance Measurement

Be assessed on primary care quality, total cost of care, and meaningful use of CEHRT, which can be met in several ways:

- For practitioners who are MIPS eligible clinicians, by registering for and reporting the Value in Primary Care MVP**
- A practitioner who is part of a TIN participating in a Shared Savings Program ACO satisfies this requirement through the ACO's reporting of the APM Performance Pathway***
- A practitioner who is participating in a REACH ACO, a Making Care Primary, or a Primary Care First practice satisfies this requirement by virtual of meeting requirements under the CMS Innovation Center ACO REACH, Making Primary Care Primary, or Primary Care First models.

Flexible, Reasonable, Medically Appropriate: Requires Responsible Actions

- The APCM Practice Level Capabilities align with those currently in use for Chronic Care Management
- The APCM Elements are modeled after the demonstrations (e.g. PCF)
- There may be a desire for details. A summary statement may be made that CMS is not prescriptive but expects practitioners to know the best method to meet the principles and goals in their practice for the specific patient
- The elements are not required monthly. “Capacity” and “clinically appropriate” govern.
- Team-based care with general supervision.
- Clinically appropriate documentation

Table 25 with presenter annotations based upon text of Rule

- Consent
  - Billing practitioner must obtain
  - Oral or written
  - No required frequency
  - New consent of billing practitioner changes
  - Cannot use a CCM/PCM consent
- Initiating Visit
  - Only for new patients (using CPT definition of new patient)
  - Can be telemed
  - Annual Wellness Visit included

Table 25 with presenter annotations based upon text of Rule

- 24/7 Access and Care Continuity
  - Must have access to EMR, but can be via escalation protocol
  - CMS understands real-time access to medical record may not always be feasible
  - Not all the alternatives to traditional office visits are required
- Care Management
  - Systematic assessment with management based upon individual patient e.g. long-term vs. short-term management

Table 25 with presenter annotations based upon text of Rule

- Patient-Centered Comprehensive Care Plan
  - Accessible to all team members
  - Patient friendly (limit jargon and medical terms)
  - Structured and standardize, IT compatible
  - See CPT Care Planning in Care Management Services for typical, but should be medically appropriate
  - Update “when applicable”
  - No specific requirement as to who creates
  - For the patient with no significant needs, the Annual Wellness Visit may suffice

Table 25 with presenter annotations based upon text of Rule

- Care Transitions
  - ≤7 days is ideal and a standard, but
  - Balance access and seeing the continuity practitioner
  - “Active effort”, “Whenever possible”
  - Make an effort to work with the facilities most used by your patients
- Practitioner-, Home-, Community-Based Care Coordination
  - Consider e-consults and collaborative agreements
  - As appropriate share the patient’s psychosocial strengths and needs, and functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors

Table 25 with presenter annotations based upon text of Rule

- Enhanced Communication Opportunities
  - Virtual check-ins, online digital etc. are examples
- Patient Population-Level Management
  - Does not need to be personally performed by billing practitioner
  - **By submitting the APCM claim the practitioner is attesting that the requirements in the code descriptor have been met**
- Performance Measurement
  - Qualifying APM Participants meet
  - New and low volume practitioners meet if they meet the other service and practice requirements
  - Register for MVP between April and November 2025

Payer Policy

- BCBSRI (all products): Not separately reimbursed (bundled).
- UHC (pending)
- NHPRI (pending)
- Medicare Primary Care First: These services may be reported even though you receive a monthly payment already

APCM FAQs

- What if the patient is at home or in an ALF?
  - These would appear to be allowed as it is still an advanced primary care practice, and these patients were included in the demos (CPC+, PCF)
- Can I still use G2211 with the office visit?
  - Yes
- Does the patient need to be seen in the month?
  - No
- Are these time-based?
  - No

APCM FAQs

- Do I have to wait for the end of the month to bill?
  - Nothing says you do
- What if the patient expires in the month or is in the hospital?
  - No rule about death and/or being in the hospital requires care coordination. If someone permanently was going to a nursing home, they are discharged from your practice in effect and billing should cease.
- When will Medicare publish FAQs and MedLearn Matters?
  - Unknown

Other CMS G codes and G code rules

G2211 Complexity Add-on

- Descriptor G2211: Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)
- In 2025, this add-on may be used when billing 99202-99215 alone OR when the office visit requires -25, and is billed in conjunction with a preventive service, but not other procedures
  - Immunizations
  - Annual Wellness Visits
  - Other CMS preventive services
- It still may not be added to home visits
- Still may not be used with other procedures (eg skin biopsy)

ASCVD Risk Assessment and Management

	implants)
G0537	Administration of a standardized, evidence-based Atherosclerotic Cardiovascular Disease (ASCVD) Risk Assessment, 5-15 minutes, not more often than every 12 months
G0538	Atherosclerotic Cardiovascular Disease (ASCVD) risk management services with the following required elements: patient is without a current diagnosis of ASCVD, but is determined to be at intermediate, medium, or high risk for CVD as previously determined by the ASCVD risk assessment; ASCVD-Specific care plan established, implemented, revised, or monitored that addresses risk factors and risk enhancers and must incorporate shared decision-making between the practitioner and the patient; clinical staff time directed by physician or other qualified health care professional; per calendar month

Caregiver Training (BH and misc.)

	per calendar month
G0539	Caregiver training in behavior management/modification for caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; initial 30 minutes
G0540	Caregiver training in behavior management/modification for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face; each additional 15 minutes
G0541	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes

Caregiver Training (BH and misc.)

G0542	Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
G0543	Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers

Interprofessional BH Consultations

G0549	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a verbal and written report to the patient's treating/requesting practitioner; 31 or more minutes of medical consultative discussion and review
G0550	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, including a written report to the patient's treating/requesting practitioner, 5 minutes or more of medical consultative time
G0551	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting practitioner in a specialty whose covered services are limited by statute to services for the diagnosis and treatment of mental illness, 30 minutes

G0546-G0548 are for shorter times

The "eConsult"

Referral

Physicians' powerful ally in patient care