Providence Health Plan

Coding Policy Alerts

January/February 2025

This is the January/February 2025 issue of Providence Health Plan's Coding Policy Alerts. The focus of this update is to communicate to providers new or revised coding policies, as well as general billing and coding information.

Providence Health Plan

CODING POLICY UPDATES

Coding Policy 67.0.E (Telemedicine Services for All Plans Except Medicare)	Providence Health Plan (PHP) is adopting the 2025 CPT Evaluation and Management (E/M) codes for telemedicine visits for Commercial plans in 2025. CPT codes 99202-99215 have been removed from this policy and replaced with CPT codes 98000-98007, which are used to report synchronous audio-video visits for both new and established patients. Providers are referred to guidelines published by the AMA in the 2025 CPT book for use of these codes. See also Coding Policy 92.0 (Synchronous Audio-Only Visits) for information about the 2025 CPT codes for synchronous audio-only visits, CPT codes 98008-98015. PHP also accepts the 2025 CPT code for virtual check-in, CPT code 98018. Additional changes to this policy include the addition of CPT codes 94625-94626, 96202-96203, 97550-97552, 98960-98962 and HCPCS codes G0011, G0013, G0539-G0543, G0560, which are included on the list of codes CMS allows to be performed by telemedicine. CPT code 90849 was removed from this policy, as it is not on the list of codes CMS allows to be performed by telemedicine. In general, PHP follows CMS guidelines for identifying services that may be billed as telemedicine, although PHP does allow additional services that are not included on the CMS list. All references to temporary provisions made for the COVID-19 public health emergency (PHE) were removed from the policy. Changes made for the PHE will be permanently adopted for the Commercial telemedicine policy. All changes to the policy are identified in the "Policy Revision History" section at the end of the policy. Coding Policy 67.0.E is available on ProvLink, both above and below the login.
Coding Policy 67.0.A (Telemedicine Services for Medicare Plans	The telemedicine policy for Medicare plans is under review and has not yet been updated for 2025. The current policy will remain in effect with no changes until March 31, 2025, or until further notice.
Coding Policy 92.0 (Synchronous Audio-Only Visits, formerly Telephone Services)	PHP is adopting the 2025 CPT Evaluation and Management (E/M) codes for synchronous audio-only visits for all lines of business. The title of Coding Policy 92.0 has been changed from "Telephone Services" to "Synchronous Audio-Only Visits." CPT codes 99441-99443 were deleted effective 12/31/2024, and these codes were removed from the policy and replaced with CPT codes 98000-98016. PHP also accepts the 2025 CPT code for virtual check-in, CPT code 98018. Providers are referred to guidelines published by the AMA in the 2025 CPT book for use of these codes. References to temporary provisions made for the COVID-19 PHE were removed from the policy. All changes to the policy are identified in the "Policy Revision History" section at the end of the policy. Coding Policy 92.0 is available on ProvLink, both above and below the login.
Coding Policy 13.0 (Bundled or Adjunct Services)	HCPCS code J2001 was retired 9/31/24 and replaced with HCPCS code J2003. HCPCS code J2003 has been added to Coding Policy 13.0 to replace HCPCS code J2001. CPT codes 38225-38227, which are effective 1/1/2025, are status "B" (bundled services) on the Medicare Physician Fee Schedule and were added to this policy. HCPCS code G0559, which was effective 1/1/2025, was added to the policy for Commercial lines of business only. All changes to the policy are identified in the "Policy Revision History" section at the end of the policy. Coding Policy 13.0 is available on ProvLink, both above and below the login.

Providence Health Plan

GENERAL CODING GUIDELINES

Care Management Services

PHP does not currently maintain coding policies specific to Care Management Services (codes 99487-99490). Providers are reminded to report services in accordance with the CPT guidelines set forth by the American Medical Association (AMA), ensuring compliance with all coding parentheticals and requirements outlined in the CPT codebook, as well as CMS coding guidelines and maximum frequency edits.

PHP adheres to National Correct Coding Initiative (NCCI) edits for procedure-to-procedure edits and Medicare's Medically Unlikely Edits (MUE) for maximum number of units that can be reported per date of service. Providers shall submit no more than one claim per a calendar month representing the total combined time spent on care management services during the entire month. The provider is not permitted to submit multiple claims for services rendered within the same month.

There are three general categories of care management services: chronic care management (99490, 99439, 99491, 99437), complex chronic care management (99487, 99489), and principal care management (99424, 99425, 99426, 99427). Each of the three categories is further differentiated by who provided the service and how much total time was spent on the service per a calendar month.

Chronic care management (CCM) codes may only be reported by the single physician or other qualified health care professional (QHCP) who assumes the care management role with a particular patient for the calendar month. Only one unit of codes 99490, 99491, 99487, 99424, or 99426 may be reported per calendar month, while a maximum of two units of 99439 or 99427 may be reported.

Time used in reporting these services may not represent time spent in another reported service. Only the time of the clinical staff of the reporting professional is counted, and the reporting professional's time is additionally included only if he or she is not otherwise reporting his or her care management time with another service. Only the time of one clinical staff member or reporting professional may be counted when two or more are meeting about the patient at the same time.

Care Management Services

Service Type	Provided By	Time spent in the Calendar Month	CPT Code(s) Reported
Chronic Care Management (CCM)	Clinical staff	Less than 20 minutes	*Not reported separately*
		20-39 minutes	99490
		40-59 minutes	99490 and +99439
		60 or more minutes	99490 and +99439 x 2
	Physician or other QHCP	Less than 30 minutes	*Not reported separately. Time may be used to meet 99490 threshold, if appropriate.*
		30-59 minutes	99491

		60 minutes or more	99491 and +99437 x each additional 30 minutes (≥60 minutes x 1, ≥90 min x 2, etc.)
Complex CCM	Clinical staff	Less than 60 minutes	*Not reported separately*
		60-89 minutes	99487
		90 minutes or more	99487 and +99489 x each additional 30 minutes (≥90 minutes x 1, ≥120 min x 2, etc.)
	Physician or other QHCP	1 or more minutes	*Not reported separately. Time may be used to meet 99487 threshold, if appropriate.*
Principal Care Management (PCM)	Clinical staff	Less than 30 minutes	*Not reported separately*
		30-59 minutes	99426
		60-89 minutes	99426 and 99427
		90 minutes or more	99426 and 99427 x 2
	Physician or other QHCP	Less than 30 minutes	*Not reported separately. Time may be used to meet 99426 threshold, if appropriate.*
		30-59 minutes	99424
		60 minutes or more	99424 and +99425 x each additional 30 minutes (≥60 minutes x 1, ≥90 min x 2, etc.)

A list of services not reported in the same calendar month is provided in the parenthetical instructions following the care management codes in the CPT codebook. The same physician or other QHCP may report evaluation and management (E/M) services separately during the same calendar month. However, if the clinical staff performs care management services on a day when the physician or other QHCP reports an E/M service, care management services are not reported. If care management services are performed within the postoperative period of a reported surgery performed by the same provider, the care management services are not separately reportable.

Transitional Care Management Services

CPT codes 99495-99496 are used to report transitional care management (TCM) services provided to patients whose conditions require moderate or high-complexity medical decision making (MDM) during transitions from a facility setting to their community setting.

TCM requires a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames. Providers are reminded that all services required to support the TCM codes must be documented in the patient's record.

Only one individual may report TCM services and only once per patient within 30 days of discharge. TCM commences upon the date of discharge and continues for the next 29 days. The date of service reported is the date the practitioner completes the initial required face-to-face visit.

	Both the level of MDM and the length of time before the first face-to-face visit occurs after discharge determine the appropriate CPT code reported for these services; time alone or MDM alone do not support code selection. Code 99495 is reported for TCM with MDM of at least moderate complexity and the first face-to-face post-discharge visit within 8-14 days. Code 99496 is reported for TCM with MDM of high complexity and the first face-to-face post-discharge visit within 7 days.

New and Deleted CPT Codes for 2025	Health Insurance Portability and Accountability Act (HIPAA) requires that providers use the most current code sets when billing services. Providence Health Plan (PHP) uses the most current published code sets for coverage issues and pricing. These include HCPCS Level I (CPT) codes published by the American Medical Association (AMA), HCPCS Level II codes, ICD-10-CM (diagnosis) codes, and ICD-10-PCS (inpatient procedure) codes. Systematic implementation of approved HCPCS Level I (CPT) and Level II codes is effective on January 1st of each year. For additional details, providers are referred to PHP Coding Policy 19.0 (Service Code Policy), which is available on ProvLink. In September, 2024, the American Medical Association (AMA) released four hundred twenty (420) CPT code changes in the 2025 Appendix B – Summary of Additions, Deletions, and Revisions. The Appendix B is published annually and is available each year in the AMA CPT codebook, which includes new, deleted, and revised CPT code changes. Some of these changes were effective prior to 2025 but had not previously been published in the CPT book. Providers are advised to review details about these changes at the AMA website and in the 2024 edition of the CPT book.

New	270
Deleted	112
Revised	38
Total	**420**