

Summary BCBSM and Priority Health Billable Procedure codes – Care Management applicable CPT codes and HCPCS Codes v17.0

This multi-payer table offers a high-level summary for BCBSM Provider Delivered Care Management and Priority Health

| Code | Description | Delivery Method | Licensed Care Team | Unlicensed Care Team* | Physician | Quantity Limits | Modifier | Notes |
|---------------------------------|------------------------------------|--|--|-----------------------|-----------|---|--|--|
| G9001 BCBSM | Coordinated care fee — initial | Individual, face to face, video or telephonic* | X | | | One per patient per day | | Initiation of Care Management (Comprehensive Assessment) Appropriate for licensed staff engaging in care management. * It must be documented in the medical record why the services were conducted via telephone. (i.e., no smart phone, doesn't know how to use video or indicate discomfort presenting into office). |
| G9001 Priority Health | Coordinated care fee — initial | Individual, face to face Can be provided virtually; bill with 02 Place of Service (POS) | QHP -RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master's Level in Nutrition | | | May be billed once annually for patients with ongoing care management | Use 95 modifier to identify the visit as virtual visit, or the GT modifier for Medicaid. Providers who bill using the Place of Service 02, instead of the 95 or GT modifier, will be reimbursed at the standard facility-based rate. | Must have completed required care management training Documentation: 1. Date(s) of visit(s) Appointment duration 2. Care manager name and credentials Comprehensive patient assessment 3. Name of the caregiver and relationship to patient, if caregiver is included with the visit 4. Diagnoses discussed 5. Treatment plan, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change 6. Care plan, including challenges and interventions Patient understanding and agreement with care plan 7. Physician coordination activities and approval of care plan 8. Name of member's PCP |
| G9002 BCBSM | Coordinated Care fee — maintenance | Individual, face to face , video, or telephonic* | X | | | For visits >45 minutes may quantity bill in 30 min. increments | 2P Payable when PDCM program is discussed with patient and patient declines engagement. Billable once per condition per year | Individual face to face visit. Appropriate for licensed staff engaging in care management. * It must be documented in the medical record why the services were conducted via telephone. (i.e., no smart phone, doesn't know how to use video or indicate discomfort presenting into office). |

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| G9002 Priority Health | Coordinated Care fee — Individual face to face visit | In person visit with patient, may include caregiver involvement Can be provided virtually; bill with O2 Place of Service (POS) | QHP: RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master’s Level in Nutrition | QHP: CDE, CAE | | Code may be billed one time per day | Use 95 modifier to identify the visit as virtual visit, or the GT modifier for Medicaid. Providers who bill using the Place of Service O2, instead of the 95 or GT modifier, will be reimbursed at the standard facility-based rate. | Documentation: 1. Date(s) of visit(s) Appointment duration 2. Care manager name and credentials 3. Name of the caregiver and relationship to patient, if caregiver is included with the visit 4. Diagnoses discussed 5. Treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change 6. Care plan update 7. Patient understanding and agreement with care plan 8. Physician coordination activities and approval of care plan Name of member's PCP |
| G9007 BCBSM | Team conference | Face to face, video, telephone or secure web conf. between physician, physician assistant, or advance practice nurse and care team | | | X | 1 per patient per practitioner per day | | Team conference does not include patient; email communication doesn't apply. Can be documented by a care-team member |
| G9007 Priority Health | Coordinated care fee, scheduled team conference | Scheduled care team meetings: physician, care manager and other QHPs | Physician, QHP -RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master’s Level in Nutrition | | X | One time per day | | Documentation: 1. Date(s) of conference(s) Conference duration 2. Care team names and credentials Diagnoses discussed 3. Treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change 4. Care plan updates Physician coordination activities and approval of care plan Can be documented by a care-team member |

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| G9008 BCBSM | Physician coordinated care oversight services | Face to Face, video or by telephone; physician discussion with Paramedic, patient, or other health care professionals not part of the care team | | | X | None | | This is a physician-delivered service, commonly used when the physician engages patient into PDCM, physician is actively coordinating care with the team or interacting with another health care provider seeking guidance or background information to coordinate and inform the care process. |
| G9008 Priority Health | Coordinated care fee, scheduled conference, physician oversight service | 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 | | | X | This code may only be billed one time, per practice, during the time that patient is a member of the practice | Use 95 modifier to identify the visit as virtual visit, or the GT modifier for Medicaid. Providers who bill using the Place of Service 02, instead of the 95 or GT modifier, will be reimbursed at the standard facility-based rate. | Documentation: <ol style="list-style-type: none"> 1. Date(s) of visit Appointment duration 2. Care team member names and credentials 3. Name of the caregiver and relationship to patient, if caregiver is included with the visit 4. Diagnoses discussed 5. Treatment plan, self-management education, medication therapy, risk factors, unmet care, physical status, emotional status, community resources, readiness to change 6. 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 |
| S0257 BCBSM | Counseling regarding Advance Directives | Individual face to face, video or telephone | X | | X | One per patient per day | | An evaluation and management service may be billed on the same day and interaction may be with the patient or "surrogate." |
| Note: S0257 Priority Health | S0257 PH pays for this code. S0257 is not part of the PH CM incentive program. | | | | | | | |

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|---------------------------------|---|---|--|-----------------------|-----------|--|--|---|
| 98961 BCBSM | Group education 2-4 patients for 30 min. | Face to face or telephonic *with patient and caregivers | X | | | Quantity bill per 30-minute increments | | * It must be documented in the medical record why the services were conducted via telephone. (i.e., no smart phone, doesn't know how to use video or indicate discomfort presenting into office). |
| 98961 Priority Health | Group education and training, 2-4 patients, each 30 min. | Face to face with patient and caregivers | QHP: RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master's Level in Nutrition | QHP: CDE, CAE | | Quantity bill per 30-minute increments | Use 95 modifier to identify the visit as virtual visit, or the GT modifier for Medicaid. Providers who bill using the Place of Service 02, instead of the 95 or GT modifier, will be reimbursed at the standard facility-based rate. | Documentation: <ol style="list-style-type: none"> 1. Name, Licensure of Group Visit Facilitator(s) Primary Care Physician 2. Date of Class 3. Total Number of Patients in Attendance: 2-4 patients or 5-8 patients 4. Group Visit Duration: 30 min 60 min 90 min if >90 min, indicate total minutes 5. Diagnoses Relevant to the Group Visit 6. Location of Class 7. Nature and Content of Group Visit 8. Objective(s) of the Training 9. Status Update: Medical Condition, Care Needs, Progress to Goal, Interventions, and Target Dates 10. Have some level of individualized interaction (BCBSM) All active diagnosis <p>** Group education is reimbursable however not a part of the incentive program **</p> |
| Note: | PH pays for this code. 98961 is not part of the PHCM incentive program. | | | | | | | |

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|---------------------------------|--|--|--|-----------------------|-----------|--|--|--|
| 98962 BCBSM | Group education 5-8 patients for 30 Minutes | Face to face or telephonic * with patient and caregivers | X | | | Quantity bill per 30-minute increments | | * It must be documented in the medical record why the services were conducted via telephone. (i.e., no smart phone, doesn't know how to use video or indicate discomfort presenting into office). |
| 98962 Priority Health | Group education and training, 5-8 patients, each 30 min. | Face to face with patient and caregivers | QHP: RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master's Level in Nutrition | QHP: CDE, CAE | | Quantity bill per 30-minute increments | Use 95 modifier to identify the visit as virtual visit, or the GT modifier for Medicaid. Providers who bill using the Place of Service 02, instead of the 95 or GT modifier, will be reimbursed at the standard facility-based rate. | Documentation: 1. Name, Licensure of Group Visit Facilitator(s) Primary Care Physician 2. Date of Class 3. Total Number of Patients in Attendance: 2-4 patients or 5-8 patients 4. Group Visit Duration: 30 min 60 min 90 min if >90min, indicate total minutes 5. Diagnoses Relevant to the Group Visit 6. Location of Class 7. Nature and Content of Group Visit 8. Objective(s) of the Training 9. Status Update: Medical Condition, Care Needs, Progress to Goal, Interventions, and Target Dates 10. Have some level of individualized interaction (BCBSM) All active diagnosis |
| 98966 BCBSM | Phone services 5-10 minutes | Call with patient or caregiver | X | X | | No quantity billing | 2P Payable when PDCM program is discussed with patient and patient declines engagement Billable once per condition per year | Not appropriate for appointment reminders or delivering lab results. Generally used to discuss care issues, such as progress toward goals, update of patient's condition, follow up to emergency department visit or hospitalization when not part of transition of care service. |

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| 98966 Priority Health | 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 | Call with established patient, parent or guardian | QHP: RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master’s Level in Nutrition | QHP: CDE, CAE | | | | Documentation: 1. Date(s) of contacts 2. Contact duration 3. Care team names and credentials 4. Diagnoses discussed 5. Development and/or maintenance of a shared care plan 6. Care team coordination activities 7. Names of providers contacted in the course of coordinating care 8. Discussion notes for each contact |
| 98967 BCBSM | Phone services 11- 20 minutes | Call with patient or caregiver | X | X | | No quantity billing | 2P Payable when PDCM program is discussed with patient and patient declines engagement Billable once per condition per year | Appropriate for licensed staff performing care management functions by phone. Not appropriate for appointment reminders or delivering lab results. |
| 98967 Priority Health | Telephone assessment (see above), 11-20 minutes of medical discussion | Call with established patient, parent or guardian | QHP: RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master’s Level in Nutrition | QHP: CDE, CAE | | | | Documentation: 1. Date(s) of contacts 2. Contact duration 3. Care team names and credentials 4. Diagnoses discussed 5. Development and/or maintenance of a shared care plan 6. Care team coordination activities 7. Names of providers contacted in the course of coordinating care 8. Discussion notes for each contact |

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| 98968 BCBSM | Phone services 21-30 min | Call with patient Or caregiver | X | X | | No quantity billing | 2P Payable when PDCM program is discussed with patient and patient declines engagement. Billable once per condition per year | Appropriate for licensed staff performing care management functions by phone. Not appropriate for appointment reminders or delivering lab results. |
| 98968 Priority Health | Telephone assessment (see above), 21-30 minutes of medical discussion | Call with established patient, parent or guardian | QHP: RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master’s Level in Nutrition | QHP: CDE, CAE | | | | Documentation: 1. Date(s) of contacts 2. Contact duration 3. Care team names and credentials 4. Diagnoses discussed 5. Development and/or maintenance of a shared care plan 6. Care team coordination activities 7. Names of providers contacted in the course of coordinating care Discussion notes for each contact |
| 99078 Priority Health | Physician educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions) | Group setting | Physician | | X | | Use 95 modifier to identify the visit as virtual visit, or the GT modifier for Medicaid. Providers who bill using the Place of Service 02, instead of the 95 or GT modifier, will be reimbursed at the standard facility-based rate. | |

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| 99484 Priority Health | Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional | Face to face | Physician, QHP : RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master's Level in Nutrition | | X directed by a physician or other qualified health care professional | Once per calendar month | | Required elements: initial assessment or follow-up monitoring, including the 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; and continuity of care with a designated member of the care team. General behavioral health integration care management services are provided face-to-face by clinical staff, under the direct supervision of a qualified clinician, to a patient with a diagnosed health care condition, including substance abuse issues requiring care management services for a minimum of 20 minutes per month. |
| 99487 BCBSM | Care management services 31-75 minutes per month | Non-face-to-face clinical coordination | X | X | | Once per patient per calendar month | | Care Coordination |

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| 99487 Priority Health | Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, 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 | Care must be coordinated by a physician and the care team. Patient does not need to be present | Physician, QHP : RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master's Level in Nutrition | | | Once per patient per calendar month | | Documentation: 1. Date(s) of contacts Contact duration 2. Care team names and credentials Diagnoses discussed 3. Development and/or maintenance of a shared care plan Care team coordination activities 4. Names of providers contacted in the course of coordinating care Discussion notes for each contact |
| 99489 BCBSM | Care management services every additional 30 minutes per month | Non-face-to-face clinical coordination | X | X | | Time-based quantity billing | | After 75 minutes, this code can be quantity billed in 30 minute increments. |
| 99489 Priority Health | Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure) | Care must be coordinated by a physician and the care team. Patient does not need to be present | Physician, QHP : RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master's Level in Nutrition | | X | Billed in cases where the cumulative time exceeds 90 minutes. Multiple units may be billed | | Documentation: 1. Date(s) of contacts Contact duration 2. Care team names and credentials Diagnoses discussed 3. Development and/or maintenance of a shared care plan Care team coordination activities 4. Names of providers contacted in the course of coordinating care Discussion notes for each contact |

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| 99490 Priority Health | Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored. | Face to face/non face to face Available to Medicare Advantage and Medicaid members only | Physician, QHP : RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master's Level in Nutrition | | | Once per calendar month | | Time spent face-to-face or non-face-to-face with clinical staff communicating with the patient, family, caregivers, other health care professionals, and agencies revising, documenting, and putting into action the care plan or teaching the patient self-management skills or techniques may be used to determine the care management staff time for that one-month time period. Time with clinical staff is reported only when there are two or more staff members meeting regarding the specific patient. Additionally, time with clinical staff should not be counted if the clinician has reported an E/M service for that same date. For members with Medicare or Medicaid coverage |
| 99492 Priority Health | Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies. | Non-face-to-face | Physician, QHP : RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master's Level in Nutrition | | | | | The required elements include outreach and engagement; initial patient assessment that involves the administration of a validated rating scale; development of an individual patient care plan; psychiatric consultant review and modifications, as needed; input of patient data into a registry and tracking of patient progress and follow-up; and provision of brief interventions using evidence-based techniques |

| Code | Description | Delivery | Licensed Care | Unlicensed | Physician | Quantity | Modifier | Notes |
|------|-------------|----------|---------------|------------|-----------|----------|----------|-------|
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| | | Method | Team | Care Team* | | Limits | | |
|---------------------------------|--|------------------|--|------------|--|-----------|--|--|
| 99493 Priority Health | Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment. | Non-face-to-face | Physician, QHP : RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master's Level in Nutrition | | | | | The required elements include tracking patient follow-up and progress via registry; weekly caseload participation with a psychiatric consultant; working together and coordinating with the qualified clinician on a regular basis; additional ongoing review of the patient's progress and recommendations for treatment changes, including medications with the psychiatric consultant; provision of brief interventions with the use of evidence-based techniques; monitoring patient outcomes using validated rating scales; and relapse prevention planning |
| 99494 Priority Health | Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure) | Non-face-to-face | Physician, QHP : RN, RD, MSW, CDE, CAE, Pharmacist, PA, NP Effective 1/1/2021: RN, NP, PA, LMSW, Certified Diabetes Educator (CDE), Asthma Educator-Certified (AE-C), Clinical Pharmacist, Respiratory Therapist, Registered Dietician, Registered Dietitian Nutritionist, Master's Level in Nutrition | | | 2 per day | | 99494 for each additional 30 minutes of initial or subsequent care in a calendar month. |

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| 99495 Priority Health | Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge | One face-to-face encounter in addition to other services performed within the specific timeframe by licensed clinical staff; can be provided virtually; bill with 02 POS | Physician | | | May only be reported one time within 30 days of discharge and by only one provider | Eff. May 2020-Dec 31, 2021: Use 95 modifier to identify the visit as virtual visit, or the GT modifier for Medicaid. Providers who bill using the Place of Service 02, instead of the 95 or GT modifier, will be reimbursed at the standard facility-based rate. | Transitional care management services are reported for patients requiring moderate to high complex medical decision making who are transitioning from an inpatient facility to a home or community type setting, such as a domiciliary or assisted living facility |
| 99496 Priority Health | Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge | one face-to-face encounter in addition to other services performed within the specific timeframe by licensed clinical staff; can be provided virtually; bill with 02 POS | Physician | | | May only be reported one time within 30 days of discharge and by only one provider | Eff. May 2020-Dec 31, 2021: Use 95 modifier to identify the visit as virtual visit, or the GT modifier for Medicaid. Providers who bill using the Place of Service 02, instead of the 95 or GT modifier, will be reimbursed at the standard facility-based rate. | Transitional care management services are reported for patients requiring moderate to high complex medical decision making who are transitioning from an inpatient facility to a home or community type setting, such as a domiciliary or assisted living facility |

Reference: This document is produced by the Michigan Institute for Care Management and Transformation. Content verified by BCBSM and Priority Health.

Note: BCBSM and Priority Health have specified education requirements for care team members which must be completed in order to bill these CPT codes and HCPCS codes.

Questions: micmt-requests@med.umich.edu