New Hampshire Medicaid
Provider Communication
July 12, 2024

To: NH Medicaid Enrolled Providers
From: NH Division of Medicaid Services

Purpose
This document provides guidance for Primary Care Providers (PCPs) and other Enrolled Providers in NH Medicaid about new primary care services and billing codes associated with the New Hampshire Medicaid Care Management (NH MCM) program under the reprocured Managed Care Organization (MCO) contracts and including the NH Medicaid Fee-for-Service program effective September 1, 2024. Detailed descriptions of each billable code are provided below. Refer to the applicable provider manuals, Managed Care Organization provider materials, federal guidance, and administrative rules for full detail on Medicaid billing requirements.

Who is eligible to bill? The individual services eligible for payment may depend on the type of service provider as listed below. The participating providers must be under a written contract with the MCO to provide services to Members or enrolled in Fee-for-Service NH Medicaid for NH Medicaid Fee-for-Service enrolled beneficiaries.

Target members: All adults and children

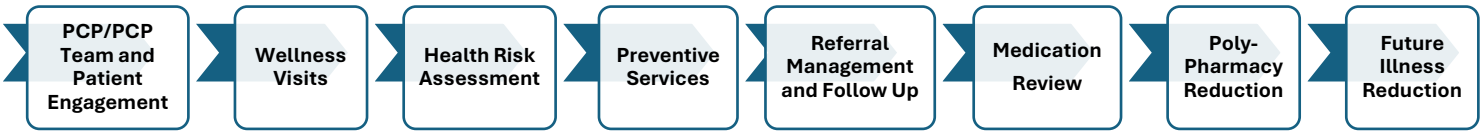

Figure 1. Logic Model for Primary Care and Preventive Services Coverage Resulting in Improved Population Health

Description of billable services/codes:

1. **Wellness Visits**
    a. Wellness visits are appointments during which primary care providers can create or update a personalized prevention plan by addressing health maintenance activities and ensuring health records are current.[4] Wellness visits are associated with patient satisfaction and better health outcomes in physical, mental, and social health.[4] Regular visits help build a strong, trusting relationship between patients and their providers, which is shown to have positive effects on health outcomes. For example, patients who were connected to a specific clinician had higher rates of preventive services received and early detection of diseases.[5-7]
    b. Recommended intervals: age-appropriate intervals for well child checks for children and yearly for adults

Description		CPT code	Billing Provider
Initial new patient preventive medicine evaluation (including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures)	Infant <1 year	99381	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	Early childhood 1-4 years	99382	
	Late childhood 5-11 years	99383	
	Adolescent 12-17 years	99384	
	18-39 years	99385	
	40-64 years	99386	
	≥65 years	99387	
Established patient periodic preventive medicine examination (including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures)	Infant <1 year	99391	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	Early childhood 1-4 years	99392	
	Late childhood 5-11 years	99393	
	Adolescent 12-17 years	99394	
	18-39 years	99395	
	40-64 years	99396	
	≥65 years	99397	

2. Patient-Focused Health Risk Assessment

a. A Health Risk Assessment (HRA) is a comprehensive, systematic method used to evaluate a Member's medical and family history, health behaviors, environment, access to food, employment status, education and literacy levels, and family circumstances to develop personalized health plans that are tailored to their specific needs, preferences, and risk factors.[8] Assessing health-related social needs, which can drive as much as 80 percent of health outcomes (*Figure 2*),[9,10] is particularly important as Medicaid enrollees are more likely to struggle with basic needs. When HRA data is interpreted and used to develop individually tailored health plans, it can be effective in connecting patients with resources for unmet health related needs.

b. Examples of tools used for assessing patients' health related needs:
   i. Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)[11]

c. Recommended intervals: performed once annually

d. This service is reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, lifestyle counseling, preventive screening and care coordination.

Description	CPT code	Billing Provider
Administration and interpretation of patient-focused health risk assessment	96160	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)

Other focused assessments:

Description	CPT code	Billing Provider
Administration and interpretation of developmental screening (e.g. milestone, speech and language)	96110	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
Assessment of emotional and behavioral problems (e.g. ADHD scale, depression inventory)	96127	

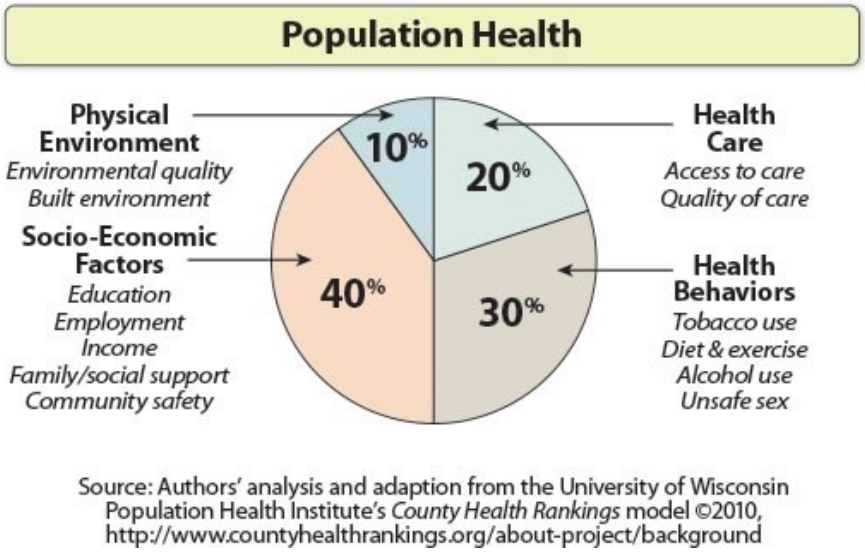

Figure 2. Contributors of Health Outcomes.

3. Lifestyle Counseling

a. Unhealthy lifestyles contribute to significant burden of illness in the U.S. Some estimates show that approximately 80 percent of chronic illness and premature mortality can be prevented by not smoking, being physically active, and eating a healthy diet.[12] Lifestyle counseling by primary care providers allows an opportunity to educate patients about the impact of their lifestyle choices and empower them to take control of their health. It is associated with improvement in biometric and cardiovascular health outcomes in people who are at risk.[13,14] Participating Providers can offer continuous guidance, motivation, and accountability, helping patients set realistic goals and develop long-term healthy habits while fostering an authentic patient-provider relationship.

b. Included individual or group lifestyle counseling services: preventive medicine counseling, smoking cessation, alcohol and/or substance screening and counseling, obesity counseling

c. This service is reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, lifestyle counseling, preventive screening and care coordination.

Description		CPT Code	Billing Provider
Individual preventive medicine counseling and/or risk factor reduction intervention(s)	Appx 15 min	99401	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	Appx 30 min	99402	
	Appx 45 min	99403	
	Appx 60 min	99404	
Group preventive medicine counseling and/or risk factor reduction intervention(s) by a physician or other qualified health care professional	Approx 30 min	99411	
	Approx 60 min	99412	
Individual smoking and tobacco use cessation counseling	4-10 min	99406	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	>10 min	99407	

Individual brief face-to-face behavioral counseling for alcohol misuse	15 min	G0443	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
Individual face-to-face behavioral counseling for obesity	15 min	G0447	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
Group (2-10) face-to-face behavioral counseling for obesity by a physician or other qualified health care professional	30 min	G0473	

4. Preventive Services

a. Preventive services play an integral role in promoting the health and wellbeing of our members. Preventive screenings allow early identification and detection of diseases when treatment is most effective, thereby preventing complications that can lead to morbidity and mortality.[15] Some estimate that greater use of proven preventive services in the U.S. could save two million life-years annually and result in total savings of $3.7 billion.[16] Despite their importance, Healthy People data show a clear decline in uptake of preventive screenings, likely exacerbated by the COVID-19 pandemic. In 2015, only 8.5 percent of adults aged 35 years and older living in the U.S. received all recommended high-priority preventive services, and that number fell to 5.3 percent in 2020,[17] emphasizing a critical gap in care in this area.

b. Providers are encouraged to offer preventive screenings at age-appropriate and risk-factor intervals in alignment with all A- and B-level United States Preventive Services Task Force (USPSTF) guidelines.

c. This services may be reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, lifestyle counseling, preventive screening and care coordination.

Description		Recommended CPT Code	Billing Provider
Individual alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT, DAST) and brief intervention (SBI)	15 to 30 min	99408	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
	>30 min	99409	
Individual annual alcohol misuse screening	5 to 15 min	G0442	
Individual annual depression screening	5 to 15 min	G0444	

5. Care Coordination

a. Current healthcare systems do not necessarily have all the structure to facilitate coordinated care among primary care providers, specialty providers, patients, and other health providers (e.g. pharmacy, community resources, social services, mental health facilities).[18,19] Fragmented care, as a result, often leads to duplicate studies, ineffective communications, and distrust in the system that can result to inefficient care.[20] Care coordination ensures that all providers and organizations provide the right care at the right time, leading to continuous, cohesive, and consistent care, while incorporating the patient's goals and preferences (*Figure 3*).[18] When care is coordinated well, all players involved in the patient's health care know who is responsible for different aspects of the patient's care.[18]

b. On a national level, Care Coordination is measured by Care Coordination Quality Measure for Primary Care (CCQM-PC) surveys that are administered to the patients[18]
c. Newly reimbursable services in New Hampshire Medicaid involving elements of care coordination include Complex Chronic Care Management (CCM) and Transitional Care Services (TCM).
d. This service is reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, lifestyle counseling, preventive screening and care coordination.

Description		Recommended CPT Code	Billing Provider
Clinical Outpatient Care Coordination performed by Staff with Physician or Other Qualified Health Care Professional Supervision	First hour (List separately in addition to code for outpatient Evaluation and Management service)	99415	Clinical staff incident to physician (supervision) within any clinical discipline.
	Each additional 30 min (List separately in addition to code for prolonged service)	99416	
Care management services for a single high-risk disease, with the following elements: One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care	First 30 minutes provided personally by qualified health care professional, per calendar month	99424	Providers (MD, DO), PA/NP; Incident-to Care Coordination performed by staff under the supervision of a Physician.
	Each additional 30 min provided personally by qualified health care professional, per calendar month (List separately in addition to code for primary procedure)	99425	
	First 30 min of clinical staff time directed by health care professional, per calendar month	99426	
	Each additional 30 min of clinical staff time directed by health care professional, per calendar month (List separately in addition to code for primary procedure)	99427	
Care management services for multile (two or more) chronic conditions with the following required elements: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of	First 20 min of clinical staff time directed by health care professional, per calendar month	99490	Physicians (MD, DO), PA/NP; Incident-to Care Coordination performed by staff under the supervision of a Physician.
	Additional 20 min of clinical staff time directed by health care professional, per calendar month (List separately in	99439	

the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored	addition to code for primary procedure)		
	First 30 min provided personally by health care professional, per calendar month	99491	
	Additional 30 min provided personally by health care professional, per calendar month (List separately in addition to code for primary procedure)	99437	
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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making	First 60 min of clinical staff time directed by health care professional, per calendar month	99487	Physicians (MD, DO), PA/NP; Incident-to Care Coordination performed by staff under the supervision of a Physician.
	Each additional 60 min of clinical staff time directed by health care professional, per calendar month (List separately in addition to code for primary procedure)	99489	
Care management services for behavioral health conditions, with the following 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.	20 min or more clinical staff time directed by health care professional	99484	Physicians (MD, DO), PA/NP; Incident-to Care Coordination performed by staff under the supervision of a Physician.

Face-to-face 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*	At least moderate level of medical decision making during the service period, within 14 calendar days of discharge*	99495	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
Face-to-face 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*	High level of medical decision making during the service period, within 7 calendar days of discharge*	99496	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)

*The within 2 business days of discharge refers to the requirement to communicate with the patient within the 2 business days of the discharge, often this is to check on the patient, review a medication list, check if there are questions and set up the appointment and is often completed and documented in the chart by a RN. The appointment then needs to occur within the 7 or 14 calendar days. Both of these components need to take place for the billing of the Transition of Care Appointment type.

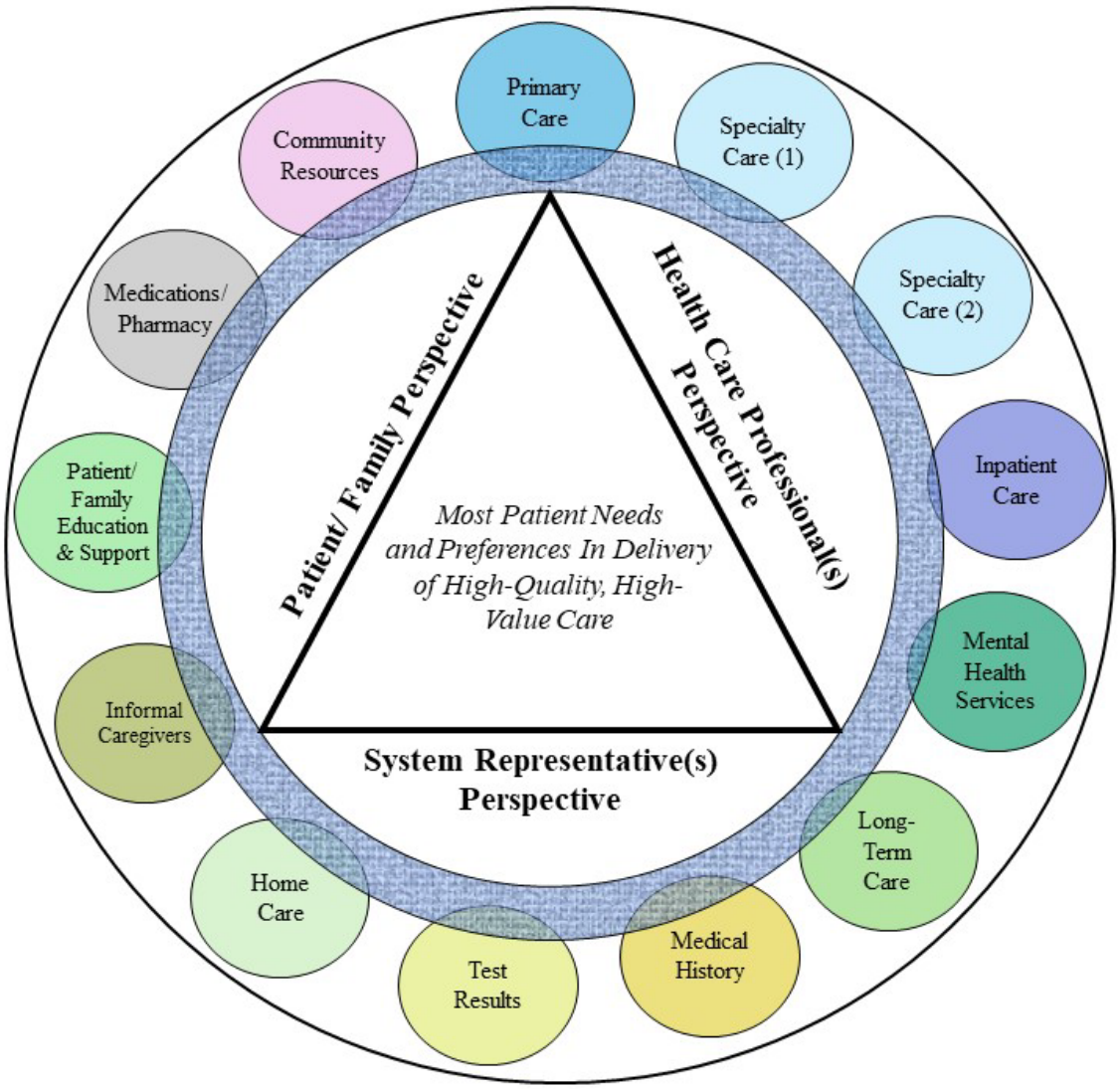

Figure 3. Care Coordination Ring (Figure adapted from AHRQ[20]). The central goal of care coordination is in the middle. The colored circles represent some of the possible participants, settings, and information important to the care pathway and workflow. The blue ring connecting the colored circles is Care Coordination—namely, anything that bridges gaps along the care.

6. Comprehensive Medication Review

An estimated 1.5 million preventable medication-related adverse events are reported to occur each year, with some resulting in serious injury or death.[21] Adverse drug events are associated with $177 billion in medication-related morbidity and mortality from lengthy and high-cost hospitalizations.[22] Polypharmacy, medication mismanagement, nonadherence, low health literacy, and increase in age are independent risk factors for adverse drug events.[23] A CMR is an interactive person-to-person or telehealth medication review and consultation conducted in real-time between the patient and/or other authorized individual, such as prescriber or caregiver, and the pharmacist or other qualified provider and is designed to

improve patients' knowledge of their prescriptions, over-the-counter (OTC) medications, herbal therapies and dietary supplements, identify and address problems or concerns that patients may have, and empower patients to self-manage their medications and their health conditions

Once the CMR is complete, the plan or MTM provider must give the targeted beneficiary a written summary that adheres to CMS' standardized format and includes a MAP and PMR, two of the necessary components of an MTM as defined by the APhA. CMS posts standardized documentation with implementation instructions at the following URL (https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM).

a. This service is reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, lifestyle counseling, preventive screening and care coordination.

Description		CPT Code	Billing Provider
Comprehensive Medication Review (CMR) addressing potential issues related to polypharmacy, medication mismanagement or misuse, medication nonadherence or barriers to obtaining appropriate medications, drug interactions, herbal therapies, dietary supplements, and medication self-management; with documentation of assessment and intervention if necessary and provided.	Documentation of extended visit to perform CMR in addition to E&M Outpatient Visit or in addition to Wellness Visit	Modifier 33 added to E&M or Preventive Health Wellness Visit 99202 99203 99204 99205 99211 99212 99213 99214 99215 99381 99382 99383 99384 99385 99386 99387 99391 99392 99393 99394 99395 99396 99397	Primary Care Provider (GP, FP, IM, OB/GYN, PED, PA/NP)
Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided	New patient; Initial 15 min	99605	Community Pharmacist
	Established patient; Initial 15 min	99606	
	Additional 15 min (List separately in addition to code for primary service)	99607	

References:

1. Shi L. The Impact of Primary Care: A Focused Review. Scientifica (Cairo). 2012;432892. Doi: 10.6064/2012/432892.
2. Goldberg J, Lewis C, Lyons J Summers C, Watkins LD. Increasing Investment in Primary Care—Lessons from States. The Commonwealth Fund. Published Apr 3, 2024. Accessed May 28, 2024. https://www.commonwealthfund.org/blog/2024/increasing-investment-primary-care-lessons-states.
3. NH DHHS. DHHS Awards Medicaid Managed Care Contracts. Accessed May 31, 2024. https://www.dhhs.nh.gov/programs-services/medicaid/dhhs-awards-medicaid-managed-care-contracts
4. Boulware LE, Marinopoulos S, Phillips KA, Hwang CW, et al. Systematic review: the value of the periodic health evaluation. *Ann Intern Med*. 2007;146(4):289. Doi: 10.7326/0003-4819-146-200702200-00008.
5. Fenton JJ, Cai Y, Weiss NS, Elmore JG, et al. Delivery of cancer screening: how important is the preventive health examination? *Arch Intern Med*. 2007;167(6)580. Doi: 10.1001/archinte.167.6.580.
6. Atlas SJ, Grant RW, Ferris TG, Chang Y, Barry MJ. Patient-physician connectedness and quality of primary care. *Ann Intern Med*. 2009;150(5):325. Doi: 10.7326/0003-4819-150-5-200903030-00008.
7. Ferrante JM, Lee JH, McCarthy EP, Fisher KJ, et al. Primary care utilization and colorectal cancer incidence and mortality among Medicare beneficiaries: a population-based, case-control study. *Ann Intern Med*. 2015;159(7):437-446. Doi: 10.7326/0003-4819-159-7-201310010-0003.
8. Schilling B. Health Risk Assessments: What You Don't Know Can Cost You. The Commonwealth Fund. Accessed June 5, 2024. https://www.commonwealthfund.org/publications/newsletter-article/health-risk-assessments-what-you-dont-know-can-cost-you.
9. Solar O, Irwin A. Executive Summary, In*: A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice).* World Health Organization. 2010:1-8. Accessed June 3, 2024. https://iris.who.int/bitstream/handle/10665/44489/9789241500852_eng.pdf
10. Manatt, Phelps & Philips, LLP. Medicaid's Role in Addressing Social Determinants of Health. Robert Wood Johnson Foundation. Published Feb 1, 2019. Accessed June 3, 2024. https://www.rwjf.org/en/insights/our-research/2019/02/medicaid-s-role-in-addressing-social-determinants-of-health.html
11. PRAPARE. PRAPARE Implementation and Action Toolkit. Published March, 2019. Accessed June 3, 2024. https://prapare.org/prapare-toolkit/
12. Katz DL, Frates EP, Bonnet JP, Gupta SK, et al. Lifestyle as Medicine: The Case for a True Health Initiative. *Am J Health Promot*. 2018;32(6):1452-1458. Doi: 10.1177/0890117117705949.
13. Lin JS, O'Connor EA, Evans CV, Senger CA, et al. Behavioral Counseling to Promote a Healthy Lifestyle for Cardiovascular Disease Prevention in Persons with Cardiovascular Risk Factors: An Updated Systematic Evidence Review for the U.S. Preventive Services Task Force [Internet]. Rockveille (MD): Agency for Healthcare Research and Quality (US); 2014 Aug. Report No: 13-05179-EF-1. PMID: 25232633.
14. Morrison F, Shubina M, Turchin A. Lifestyle counseling in routine care and long-term glucose, blood pressure, and cholesterol control in patients with diabetes. *Diabetes Care*. 2012;35(2):334-41. Doi: 10.2337/dc11-1635.
15. Healthy People 2030. Preventive Care. Office of Disease Prevention and Health Promotion. Published 2020. Accessed June 5, 2024. https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care.
16. Maciosek MV, Coffield AB, Flottemesch TJ, Edwards NM, Solberg LI. Greater use of preventive services in U.S. health care could save lives at little or no cost. *Health Aff (Millwood)*. 2010;29(9):1656-60. Doi: 10.1377/hlthaff.2008.0701.
17. Healthy People 2030. Increase the proportion of adults who get recommended evidence-based preventive health care—AHS-08. Published 2022. Accessed June 3, 2024. https://health.gov/healthypeople/objectives-and-data/browse-

objectives/health-care-access-and-quality/increase-proportion-adults-who-get-recommended-evidence-based-preventive-health-care-ahs-08.

18. AHRQ. Chapter 2. What is Care Coordination? Updated June 2014. Accessed May 31, 2024. https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter2.html#fig1
19. Khatri R, Endalamaw A, Erku D, Wolka E, Nigatu F, et al. Continuity and care coordination of primary health care: a scoping review. BMC Health Serv Res. 2023;23:750. Doi: 10.1186/s12913-023-09718-8.
20. AHRQ. Care Coordination. Updated Aug 2018. Accessed May 30, 2024. https://www.ahrq.gov/ncepcr/care/coordination.html
21. Kass B. Reducing and preventing adverse drug events to decrease hospital costs. Agency for Healthcare Research and Quality. Published March 2021. Accessed June 3, 2024. http://archive.ahrq.gov/research/findings/factsheets/errors-safety/aderia/ade.html.
22. Johnson JA, Bootman JL. Drug-related morbidity and mortality. A cost-of-illness model. *Arch Intern Med*. 1995;155(18):1949-56.
23. Chinthammit C, Armstrong EP, Boesen K, Martin R, et al. Cost-Effectiveness of Comprehensive Medication Reviews Versus Noncomprehensive Medication Review Interventions and Subsequent Successful Medication Changes in a Medicare Part D Population. *J Manag Care Spec Pharm*. 2015;21(55):381-9. Doi: 10.18553/jmcp.2015.21.5.381.