New Hampshire Medicaid
Provider Communication
Updated:
November 14th, 2025

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 include all Medicaid-enrolled providers who perform the requirements for the services. 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

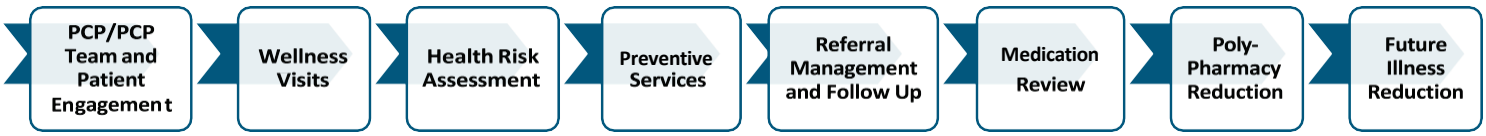


Figure 1. Logic Model for Primary Care and Preventive Services Coverage Resulting in Improved Population Health

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 These services are reimbursable in addition to separate and identifiable services such as health risk assessments, chronic disease prevention counseling, preventive services, care coordination and comprehensive medication reviews.

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	GP, UC, FP, IM, OB/GYN, PED, or 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	GP, UC, FP, IM, OB/GYN, PED, or 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 patients' 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 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]

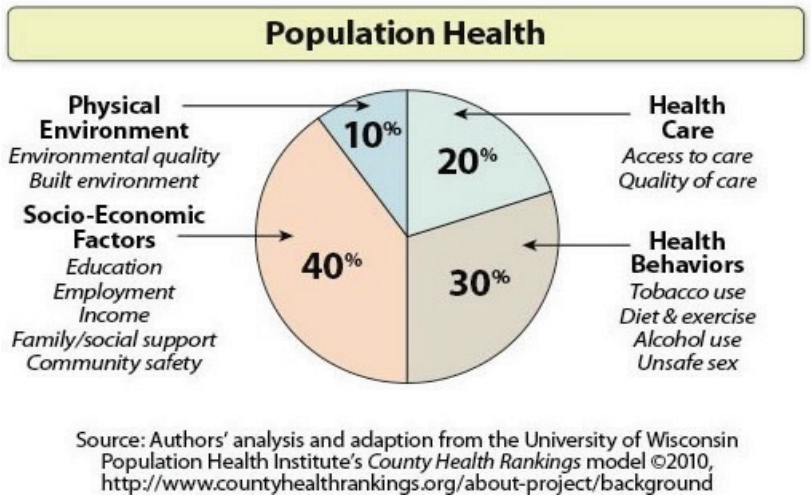
c. Recommended intervals: performed once annually

d. These services are reimbursable as separate and identifiable services and are not required to be performed during wellness visit, chronic disease prevention counseling, preventive services, care coordination and comprehensive medication reviews. These services can be provided and reimbursed if performed at the same times or times other than during an office visit, wellness visit or during any other reimbursable service.

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

Other focused assessments:

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



Source: Authors' analysis and adaption from the University of Wisconsin Population Health Institute's *County Health Rankings* model ©2010, http://www.countyhealthrankings.org/about-project/background

Figure 2. Contributors of Health Outcomes.

3. Chronic Disease Prevention Counseling

a. Unhealthy behaviors 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] Chronic Disease Prevention counseling by primary care providers allows an opportunity to educate patients about the impact of their health behaviors 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. These services are reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, preventive services, care coordination and comprehensive medication reviews. These services can be provided and reimbursed if performed at the same times or times other than during an office visit, wellness visit or during any other reimbursable service.

Description		CPT Code	Billing Provider
Individual preventive medicine counseling and/or risk factor reduction intervention(s)	Appx 15 min	99401	GP, UC, FP, IM, OB/GYN, PED, or 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	4-10 min	99406	GP, UC, FP, IM, OB/GYN, PED, or

use cessation counseling	>10 min	99407	PA/NP This service may also be provided by a NH Medicaid enrolled Pharmacist and billed to NH Medicaid by the clinic or pharmacy that the pharmacist is affiliated.

Individual brief face-to-face behavioral counseling for alcohol misuse	15 min	G0443	GP, UC, FP, IM, OB/GYN, PED, or PA/NP
Individual face-to-face behavioral counseling for obesity	15 min	G0447	GP, UC, FP, IM, OB/GYN, PED, or 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. These services may be reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, chronic disease prevention counseling, care coordination and comprehensive medication reviews. These services can be provided and reimbursed if performed at the same times or times other than during an office visit, wellness visit or during any other reimbursable service.

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	GP, UC, FP, IM, OB/GYN, PED, or 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 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 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. These services are reimbursable in addition to separate and identifiable services such as a wellness visit, health risk assessment, chronic disease prevention counseling, preventive services, and comprehensive medication reviews. These services can be provided and reimbursed if performed at the same times or times other than during an office visit, wellness visit or during any other reimbursable service.

Long Form CPT Code Description		CPT Code
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
	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
	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 multiple (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 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	First 20 min of **clinical staff time directed by health care professional**, per calendar month	99490
	Additional 20 min of **clinical staff time directed by health care professional**, per calendar month (List separately in addition to code for primary procedure)	99439

	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
	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
Face-to-face transitional care management (TCM) 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

Face-to-face transitional care management (TCM) 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

*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. The service 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 Management (TCM) service.

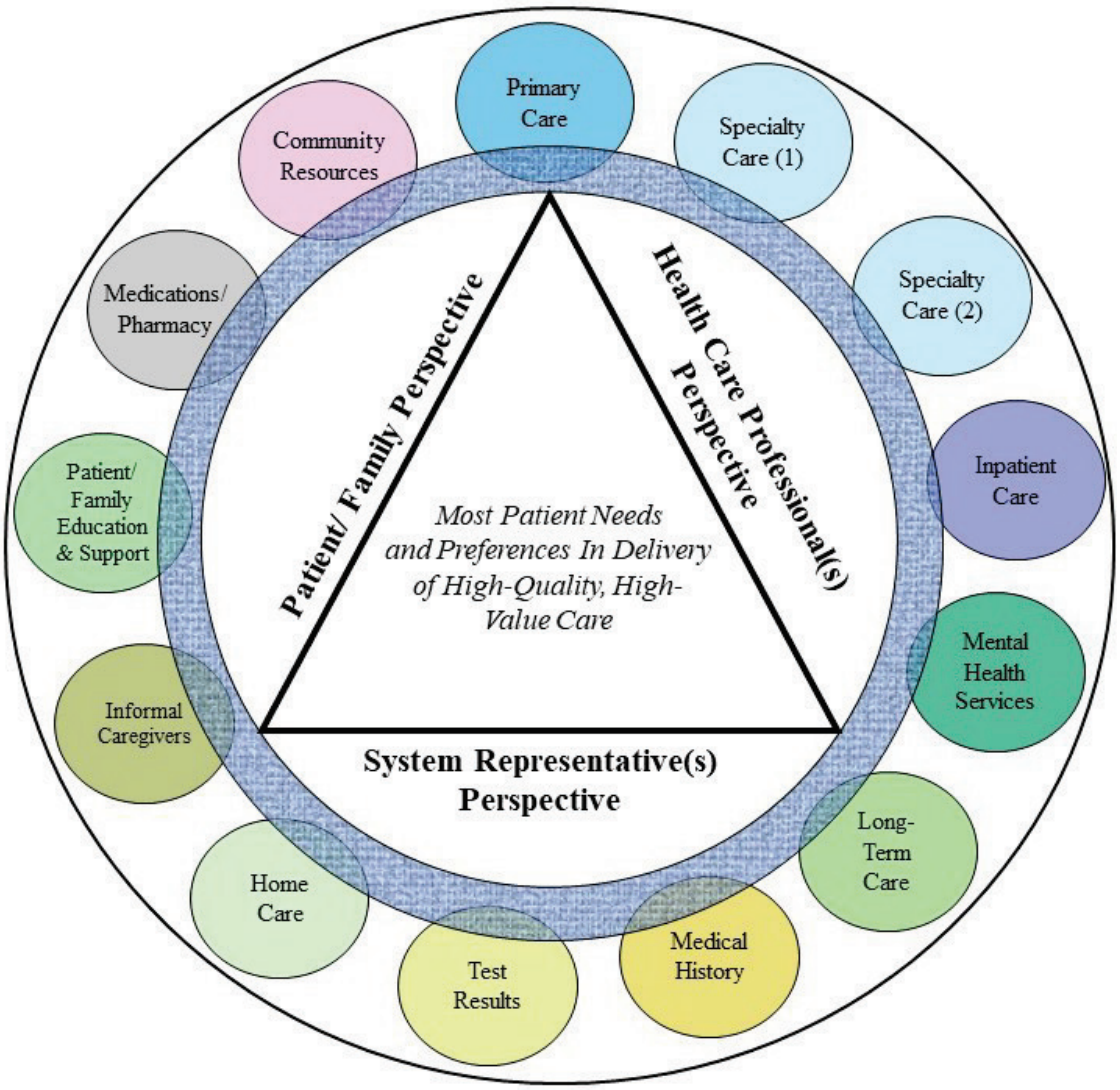


Figure 3. Care Coordination Ring (Figure adapted from AHRQ[20]). The central goal of care coordination is in the middle. The colored circles represent some of the possible participants, settings, and information important to the care pathway and workflow. The blue ring connecting the colored circles 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 Comprehensive Medication Review (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. The CMR may involve the discontinuation of medications and reduction of polypharmacy adverse outcomes.

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. These services can be provided and reimbursed if performed at the same times or times other than during an office visit, wellness visit or during any other reimbursable service.

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	GP, UC, FP, IM, OB/GYN, PED, or PA/NP
Medication therapy management service(s) provided by a	New patient; Initial 15 min	99605	This service must be provided by a NH Medicaid enrolled Pharmacist

pharmacist, individual, face-to-face with patient, with assessment	Established patient; Initial 15 min	99606	and billed to NH Medicaid by the clinic or pharmacy that the

and intervention if provided	Additional 15 min (List separately in addition to code for primary service)	99607	pharmacist is affiliated.

7. Blood Lead Testing

The Center for Disease Control and Prevention's (CDC's) Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) has made recommendations on screening and testing for lead levels in children.[24] The CDC has also made recommendations on screening for lead levels in pregnant persons.[25]

a. The billing for blood lead testing may include both the code for the collection of capillary blood specimen as well as for the assay of lead point-of-care test.

Description	CPT Code	Billing Provider
Collection of capillary blood specimen	36416	GP, UC, FP, IM, OB/GYN, PED, or PA/NP
Assay of lead (CLIA-waived test, ie performing LeadCare II test)	83655(QW)	GP, UC, FP, IM, OB/GYN, PED, or PA/NP

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