**Notes for Users-** These code descriptions were developed by a team of health care chaplains led by Transforming Chaplaincy and HealthCare Chaplaincy Network and building on descriptions in use by the Veterans Health Administration. They are meant to guide implementation of these codes throughout US health care. Users should note that the wording of the codes themselves was set by CMS and must be used as written. Comments on the descriptions are welcome and should be sent to George Handzo (ghandzo@healthcarechaplaincy.org) or Andrew Andresco (Andrew\_W\_Andresco@rush.edu).

**HCPCS Codes with Descriptions**

*Codes should be applied to all settings of care including virtual/telehealth visits or groups.*

# Chaplain Assessment

**Q9001 Assessment by chaplain services**

* Assessment includes spiritual, religious, existential (S/R/E) history, identifying S/R/E concerns and resources, the level and nature of spiritual distress, and the impact of S/R/E issues/resources on the patient’s coping, their health status and their receipt of health services. Recommendations for addressing S/R/E issues in patient care should be included.
* Use comprehensive and evidence-based spiritual assessment models/tools.
* This HCPCS code would be applied for spiritual assessments.
* Documentation and chart review are included in this code and may not be coded separately.
* For encounters that do not meet this code’s criteria, use the individual counseling codes instead even if it is an initial encounter (listed below).

Required elements for documentation:

* Relevant spiritual, religious, existential history and practices and their importance.
* Current S/R/E concerns/needs, resources, and practices and their impact on coping with illness and health status.
* The level and nature of spiritual distress.
* Recommendations for addressing S/R/E issues in patient care.
* Relevant family, social, community, and developmental factors impacting the patient’s coping and health (e.g., family and social dynamics, community resources/needs, and developmental history), where applicable.
* Assessment of pertinent emotional state(s)/expressions or state of mind including suicidal/homicidal ideation where applicable.
* Care plan or treatment plan, including the frequency and nature/types of chaplaincy services/interventions needed for ongoing care/treatment as appropriate.
* If counseling is planned, the documentation should indicate that the patient consents to and is able to participate in and benefit from counseling.
* Anticipated treatment duration (interval), where applicable.

# Chaplain Individual Counseling

**Q9002 Counseling, Individual, by chaplain services**

* Counseling including bereavement.
* This HCPCS code would be applied for any established patient.
* Counseling of others related to the patient can be included if the encounter would normally be included in documentation and the interactions are separate from the visit with the patient.
* Counseling of staff is not included with this code.
* Documentation and chart review are included in this code and may not be coded separately.

Required elements for documentation:

* Reason for encounter.
* Currently acute and relevant S/R/E concerns/needs and resources and their impact on coping with illness and health status (as presented in the encounter).
* The current level and nature of spiritual distress (as presented in the encounter).
* Appropriate high-risk factors (such as suicidal/homicidal ideation) where applicable.
* Chaplaincy interventions and their outcomes/impact should be explicitly stated.
	+ Using published taxonomies or established/consensus-based terminology for describing chaplaincy interventions is highly recommended.
	+ Listing interventions should be limited to a few most important/impactful interventions that were most helpful/useful to the care recipient.
* Recommendations for addressing S/R/E issues in patient care.
* Changes in treatment plan when appropriate, indicating the frequency and nature/types of chaplaincy services/interventions needed for ongoing care/treatment.
* Time spent.

**Q9003 Counseling, Group, by chaplain services**

* This HCPCS code would be applied for any established patient in a chaplain-led group discussion.
* Documentation and chart review are included in this code and may not be coded separately.
* Documentation must be present in each patient’s health record.

Required elements for documentation:

* Reason for encounter and the goal(s) of group counseling.
* Currently acute and relevant S/R/E concerns/needs and resources and their impact on coping with illness and health status (as presented in the encounter).
* The current level and nature of spiritual distress (as presented in the encounter).
* Appropriate high-risk factors (such as suicidal/homicidal ideation) where applicable.
* Chaplaincy interventions and their outcomes/impact should be explicitly stated.
	+ Using published taxonomies or established/consensus-based terminology for describing chaplaincy interventions is highly recommended.
	+ Listing interventions should be limited to a few most important/impactful interventions that were most helpful/useful to the care recipient.
* Recommendations for addressing S/R/E issues in patient care.
* Changes in treatment plan when appropriate, indicating the frequency and nature/types of chaplaincy services/interventions needed for ongoing care/treatment.
* Time spent.