Coding for Care Management and Other Non-Direct Services

Primary care services often take place when the patient or family is not present in the office. In addition, caring for children with complex chronic medical issues is extremely time-consuming with much of the time spent not always by the physician but clinical staff in the practice doing non-direct care coordination services. The resource will go over many of the non-direct services provided to pediatric patients, including the most fragile population. Keeping in mind that these children are very complex and it is important to capture all details in their diagnostic picture (eg, by reporting all applicable ICD-10-CM codes).

Topics:
- Transitional Care Management
- Care Management Services
- Care Plan Oversight
- Online Digital E/M Services
- Prolonged Non-Direct E/M Services
- Telephone Care
- Interprofessional Consultation
- Medical Team Conference

Transition Care Management and Care Management

Reported under the directing physician or other qualified health care professional, however, the time requirement can be met by clinical staff working under the direction of the reporting physician or other qualified health care professional.

Transition Care Management

These services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient’s community setting (home, domiciliary, rest home, or assisted living). TCM commences on the date of discharge and continues for the next 29 days and requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. Any additional E/M services provided after the initial may be reported separately.

Refer to the CPT manual for complete details on reporting care management and TCM services.

- Do not report for patients “discharged” from the emergency department.

99495  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
- Medical decision-making (MDM) of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496  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
TCM Table

<table>
<thead>
<tr>
<th>Level of MDM</th>
<th>First face-to-face within 7 days of discharge</th>
<th>First face-to-face within 14 days of discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>99495</td>
<td>99495</td>
</tr>
<tr>
<td>High</td>
<td>99496</td>
<td>99495</td>
</tr>
</tbody>
</table>

**Care Management Services**

Codes are selected based on the amount of time spent by clinical staff providing care coordination activities. CPT clearly defines what is defined as care coordination activities. In order to report chronic care or complex chronic care management codes, you must

1. provide 24/7 access to physicians or other qualified health care professionals or clinical staff;
2. use a standardized methodology to identify patients who require chronic complex care coordination services
3. have an internal care coordination process/function whereby a patient identified as meeting the requirements for these services starts receiving them in a timely manner
4. use a form and format in the medical record that is standardized within the practice
5. be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

For patients with only one chronic condition, refer to Care Plan Oversight. Note these codes require time is spent by the provider, not clinical staff.

99490  **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.

Do not report 99490 for chronic care management services that do not take a minimum of 20 minutes in a calendar month.

99491  **Chronic care management** services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the same elements as 99490 (see above)

**Complex chronic care management** is reported by the physician or qualified health care professional who provides or oversees the management and coordination of all of the medical, psychosocial, and daily living needs of a patient with a chronic medical condition. Typical pediatric patients

1. receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy)

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided.
2. have two or more chronic continuous or episodic health conditions expected to last at least 12 months (or until death of the patient) and places the patient at significant risk of death, acute exacerbation or decompensation, or functional decline

3. commonly require the coordination of a number of specialties and services.

**99487**  
**Complex chronic care management** services;
- 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.

Do not report 99487 for chronic care management services that do not take a minimum of 60 minutes in a calendar month.

**+99489**  
each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (Report with 99487)

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time (minimum)</th>
<th>Performing provider</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>99490</td>
<td>20 m/month</td>
<td>Clinical staff w/ physician direction</td>
<td>Care management</td>
</tr>
<tr>
<td>99491</td>
<td>20 m/month</td>
<td>Physician or other QHP</td>
<td>Care management</td>
</tr>
<tr>
<td>99487</td>
<td>60m/month</td>
<td>Clinical staff w/ physician direction (may include physician or QHP time)</td>
<td>Complex care management</td>
</tr>
<tr>
<td>+99489</td>
<td>Each add’tl 30 m/month</td>
<td>Clinical staff w/ physician direction (may include physician or QHP time)</td>
<td>Complex care management</td>
</tr>
</tbody>
</table>

m, minute. Note for only 1 chronic condition, please refer to care plan oversight or other services.
**Care Plan Oversight**
The following per month codes are for physician time only. The patient only needs on chronic medical condition.

- **99339** Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient’s care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

- **99340** 30 minutes or more

- **99374** Care plan oversight services requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports and related lab studies, communications, integration of new information into treatment plan, and/or adjustment of medical therapy, patient under care of home health agency, 15-29 min.

- **99375** 30 min. or more

- **99377** Care plan oversight services, patient under care of hospice, 15-29 min.

- **99378** 30 min. or more

- **99379** Care plan oversight, patient in a nursing facility, 15-29 min.

- **99380** 30 min. or more

**Online Digital Evaluation and Management Service**
These are patient-initiated services with physicians or other qualified health care professionals (QHPs) who are allowed to report E/M services. Online digital E/M services require physician or other QHP’s evaluation, assessment, and management of the patient and are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. These are more appropriate when dealing with a more minor issue or during a month when you are not coding or providing more robust care thus this time would be reported under another service like care management.

- Patient must be established (problem can be new)
- Services must be initiated through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms

+ Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided

- Reported once for the physician’s or other QHP’s (including all in the same group practice) cumulative time during a seven-day period
- The seven-day period begins with the physician’s or other QHP’s initial, personal review of the patient-generated inquiry.
- Online digital E/M services require permanent documentation storage (electronic or hard copy) of the encounter.
- Do not report these codes separately if the patient is seen within 7 days of the service.

99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

99422 11-20 minutes

99423 21 or more minutes

**Prolonged Non-Direct E/M Service**
Report these codes when either directed to or when no other service is more appropriate. This code requires a minimum of 30 minutes of time spent by the reporting provider (eg, physician) in a single calendar day. Time spent on that same day does not have to be continuous. This code may be reported in addition to another service or alone.

99358 **Prolonged E/M services** before or after direct patient care; first hour

+99359 each additional 30 min. *(Use in conjunction with 99358)*

**Telephone Care Services**
Telephone care, regardless of provider, must be initiated by the parent, patient or the guardian. The telephone call cannot be related to an E/M service within the previous 7 days nor can they lead to an appointment within the next 24 hours or soonest available. This is not telehealth or telemedicine.

99441 **Telephone evaluation and management** to patient, parent or guardian not originating from a related E/M service within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

+ Codes are *add-on* codes, meaning they are reported separately in addition to the appropriate code for the service provided
The following codes are reported by nonphysician providers who may independently bill such as physical therapists and psychologists, but are not reported for clinical staff (eg, RN) unless noted in writing by your payer.

98966 **Telephone assessment and management** service provided by a **qualified nonphysician healthcare professional** to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967 11-20 minutes of medical discussion

98968 21-20 minutes of medical discussion

**Interprofessional Telephone/Internet/Electronic Health Record Consultations**

An interprofessional telephone/internet/EHR consultation (ITC) is an assessment and management service in which a patient’s treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician or other qualified health care professional in the diagnosis and/or management of the patient’s problem without patient face-to-face contact with the consultant.

- The patient may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem.
- Patient cannot have been seen by the consultant within the last 14 days.
- If the ITC leads to a transfer of care, these codes cannot be used if the consultant sees the patient (eg, visit or surgery) within the next 14 days or soonest available appointment of the consult.
- Codes include a review of pertinent medical records, laboratory and/or imaging studies, medication profile, pathology specimens, etc, however, for codes 99446-99449 the majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion.
- Codes 99446-99449, 99451 should not be reported more than once within a seven-day interval, therefore if time is spent over multiple days, count the total time and report one code.

99446 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a **consultative physician**, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review

99447 11-20 minutes of medical consultative discussion and review

99448 21-30 minutes of medical consultative discussion and review

99449 31 minutes or more of medical consultative discussion and review

99451 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a **consultative physician**, including a written report to the patient’s treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

+ Codes are *add-on* codes, meaning they are reported separately in addition to the appropriate code for the service provided
**99452** Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

- Use prolonged services (99354-99359) if the time spent exceeds 30 mins on a single calendar day
- Only report once in 14 days time

**ITC Summary Table**

<table>
<thead>
<tr>
<th>ITC Code</th>
<th>Time</th>
<th>Written Report</th>
<th>Verbal report</th>
<th>Who Reports?</th>
</tr>
</thead>
<tbody>
<tr>
<td>99446</td>
<td>5-10m</td>
<td>√</td>
<td>√</td>
<td>Consultative physician</td>
</tr>
<tr>
<td>99447</td>
<td>11-20m</td>
<td>√</td>
<td>√</td>
<td>Consultative physician</td>
</tr>
<tr>
<td>99448</td>
<td>21-30m</td>
<td>√</td>
<td>√</td>
<td>Consultative physician</td>
</tr>
<tr>
<td>99449</td>
<td>&gt;30m</td>
<td>√</td>
<td>√</td>
<td>Consultative physician</td>
</tr>
<tr>
<td>99451</td>
<td>5m &gt;</td>
<td>√</td>
<td></td>
<td>Consultative physician</td>
</tr>
<tr>
<td>99452</td>
<td>16m&gt;</td>
<td>√</td>
<td></td>
<td>Treating/Requesting provider</td>
</tr>
</tbody>
</table>

**Medical Team Conference**

This code is reported when a minimum of 3 qualified health care professionals meet without the patient or family present in any setting. If the patient or family is present, the physician will report the appropriate E/M service. These codes cannot be reported in addition to the per day critical or intensive care service codes. Code 99367 is for physicians, while 99368 is for qualified healthcare professionals when the patient or family is not present. Code 99366 is only for the qualified healthcare professional when the patient or family is present. A physician or advanced practitioner would report an E/M service (eg, 99214) as appropriate.

**99366** Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional

**99367** Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician

**99368** Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more participation by nonphysician qualified health care professional

+ Codes are *add-on* codes, meaning they are reported separately in addition to the appropriate code for the service provided Current Procedural Terminology® 2019 American Medical Association. All Rights Reserved.