



2017 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care

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New in 2017:

- Code 99420 has been replaced with codes 96160 and 96161, which can be used for reporting administration and scoring of a patient/caregiver transition readiness or self-care assessment using a standardized, scorable tool.
- New clinical vignettes have been added with recommended coding suggestions.

Improving transition from pediatric to adult health care is a national priority, a medical home standard, and a meaningful use requirement for electronic health records. Health care transition involves increasing youth's ability to manage their own health and effectively use health services. It also involves ensuring an organized clinical process to prepare youth and families for adult-centered care, transfer to a new adult provider, and integration into adult health care.

In 2011, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians published a clinical report on transition that represents expert opinion and consensus on practice-based implementation of transition for *all* youth, beginning early in adolescence and continuing through young adulthood.¹ These joint recommendations were subsequently translated into a set of clinical tools, called the "Six Core Elements of Health Care Transition." These tested tools were updated in 2014 and are available at no cost from Got Transition, the national resource center on health care transition (www.gottransition.org).

To support the delivery of recommended transition services in pediatric and adult primary and specialty care settings, Got Transition and the American Academy of Pediatrics partnered to develop this transition payment tip sheet. It begins with a listing of transition-related CPT codes and corresponding Medicare fees and relative value units (RVUs), effective as of 2017. It also includes a set of clinical vignettes with recommended CPT and ICD coding and CPT coding descriptions for transition-related services with selected coding tips.²

Transition Coding and Reimbursement

Transition Related Services		100% Medicare Payment, 2017		
CPT Code	Service Description	Office	Facility	RVUs*
Office or Other Outpatient Services, New Patient				
99201†	Self-limited or minor problem, typically 10 minutes	\$44.50	\$27.28	1.24/0.76
99202†	Low to moderate severity problem, typically 20 minutes	\$75.73	\$51.32	2.11/1.43
99203†	Moderate severity problem, typically 30 minutes	\$109.46	\$77.88	3.05/2.17
99204†	Moderate to high severity problem, typically 45 minutes	\$166.17	\$131.72	4.63/3.67
99205†	Moderate to high severity problem, typically 60 minutes	\$209.24	\$171.55	5.83/4.78
Office or Other Outpatient Services, Established Patient				
99211†	Minimal presenting problems, typically 5 minutes	\$20.46	\$9.33	0.57/0.26
99212†	Self-limited or minor problem, typically 10 minutes	\$44.14	\$25.84	1.23/0.72
99213†	Low to moderate severity problem, typically 15 minutes	\$73.93	\$51.68	2.06/1.44
99214†	Moderate severity problem, typically 25 minutes	\$108.75	\$79.68	3.03/2.22
99215†	Moderate to high severity problem, typically 40 minutes	\$146.43	\$112.69	4.08/3.14
Office or Other Outpatient Consultations, New or Established Patients¹				
99241†	Self-limited or minor problem, typically 15 minutes	\$48.09	\$33.02	1.34/0.92
99242†	Low severity problem, typically 30 minutes	\$90.44	\$69.27	2.52/1.93
99243†	Moderate severity problem, typically 40 minutes	\$123.82	\$96.90	3.45/2.70
99244†	Moderate to high severity problem, typically 60 minutes	\$185.19	\$155.76	5.16/4.34
99245†	Moderate to high severity problem, typically 80 minutes	\$225.75	\$192.73	6.29/5.37
Care Plan Oversight Services²				
99339	Individual physician supervision of a patient 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), or key caregiver(s) involved in patient's care; integration of new information into medical treatment plan; or adjustment of medical therapy; within a calendar month; 15-29 minutes	\$78.24	NA	2.18/NA
99340	30 minutes or more	\$109.82	NA	3.06/NA
Prolonged Services³				
99354†	Prolonged evaluation and management (E/M) or psychotherapy beyond the typical service time, in office or other outpatient setting, with direct contact beyond the usual service; first hour	\$131.35	\$123.82	3.66/3.45
99355†	Each additional 30 minutes	\$99.06	\$91.87	2.76/2.56
99358	Prolonged E/M services before and/or after direct patient contact; first hour	\$113.41	\$113.41	3.16/3.16
99359	Each additional 30 minutes	\$54.55	\$54.55	1.52/1.52
Medical Team Conference⁴				
99366	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	\$43.43	\$42.71	1.21/1.19
99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	NA	\$57.07	NA/1.59

Transition Related Services		100% Medicare Payment, 2017		
CPT Code	Service Description	Office	Facility	RVUs*
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional	NA	\$37.33	NA/1.04
Preventive Medicine Services⁵				
99384	Initial comprehensive preventive medicine, new adolescent patient; ages 12-17	\$136.74	\$103.72	3.81/2.89
99385	Ages 18-39	\$132.43	\$99.42	3.69/2.77
99394	Periodic comprehensive preventive medicine, established adolescent patient; ages 12-17	\$117.00	\$87.93	3.26/2.45
99395	Ages 18-39	\$119.	\$90.44	3.33/2.52
Health Risk Assessment⁶				
96160	Administration of patient-focused health risk assessment instrument (e.g., transition readiness assessment) with scoring and documentation, per standardized instrument	\$4.67	NA	0.13/NA
96161	Administration of caregiver-focused health risk assessment instrument (e.g., transition readiness assessment) for the benefit of the patient, with scoring and documentation, per standardized instrument	\$4.67	NA	0.13/NA
Care Management Services⁷				
99487	Complex chronic care management services with required elements: multiple chronic conditions expected to last at least 12 months; 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	\$93.67	\$52.76	2.61/1.47
99489	Each additional 30 minutes	\$47.02	\$26.56	1.31/0.74
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: multiple chronic conditions expected to last at least 12 months; chronic conditions place the patient at significant risk of death, acute exacerbation/decomposition, or functional decline; comprehensive care plan established; implemented, revised, or monitored	\$42.71	\$32.66	1.19/0.91
Transitional Care Management Services⁸				
99495†	Includes communication (direct contact, telephone, electronic) with patient/caregiver within 2 business days of discharge; medical decision making of at least moderate complexity during service period; and face-to-face visit within 14 calendar days of discharge	\$165.45	\$111.98	4.61/3.12
99496†	Includes 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; and face-to-face visit, within 7 calendar days of discharge	\$234.00	\$162.22	6.52/4.52

Transition Related Services		100% Medicare Payment, 2017		
CPT Code	Service Description	Office	Facility	RVUs*
Telephone Services⁹				
99441	Telephone E/M service provided by a physician or other qualified health professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided 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	\$14.00	\$12.92	0.39/0.36
99442	11-20 minutes	\$27.28	\$25.84	0.76/0.72
99443	21-30 minutes	\$40.20	\$38.76	1.12/1.08
On-Line Medical Evaluation¹⁰				
99444	On-line evaluation and management service provided by physician or other qualified health care professional who may report E/M services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network	NA	NA	NA
Interprofessional Telephone/Internet Consultations¹¹				
99446	Interprofessional telephone/Internet assessment and management services provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health professional; 5-10 minutes of medical consultative discussion and review	NA	NA	NA
99447	11-20 minutes	NA	NA	NA
99448	21-30 minutes	NA	NA	NA
99449	31 minutes or more	NA	NA	NA
Education and Training for Patient Self-Management¹²				
98960†	Education and training of patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with a patient (could include caregiver/family) each 30 minutes; individual patient	\$28.35	NA	0.79
98961†	2-4 patients	\$13.64	NA	0.38
98962†	5-8 patients	\$10.05	NA	0.28
Miscellaneous Services¹³				
99078	Educational services rendered to patients by physician or other qualified health professional in a group setting (e.g., obesity or diabetic instructions)	NA	NA	NA
Modifiers¹⁴				
25	Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the other service	NA	NA	NA

* In some cases, payers will not use the Medicare total RVUs for a service in the calculation of physician payment. Instead, they may apply their own relative value adjustments.

NA: Certain CPT codes do not have assigned RVUs.

† These CPT codes may be used for reporting synchronous telemedicine services when appended by modifier 95, and involving electronic communication using interactive telecommunication equipment that includes, at minimum, audio and video.

Transition Clinical Vignettes

Vignette #1

New 12-year-old male patient is just released from the hospital after having had a traumatic brain injury with loss of consciousness caused by a serious car accident. Pediatrician communicates with parent within 1 day of hospital discharge regarding recommended follow-up treatment. Physician reviews discharge information and needs for pending tests and physical therapy. The physician's clinical staff communicates with a physical therapist to coordinate the treatment plan and contacts youth's school to provide medical authorization for extended absence. Pediatrician has a face-to-face visit with the patient a week following hospital discharge, assesses treatment needs and adherence, and provides education to this complex patient and his parent.

Coding: CPT 99496 (Transitional care management service)
 ICD-10-CM: S06.2X3D (Diffuse traumatic brain injury with loss of consciousness of 1 hr to 5 hrs 59 min, Subsequent encounter)

Vignette #2

Preventive medicine visit with new 14-year-old female patient with no chronic conditions. Physician updates medical history, completes physical exam, and provides anticipatory guidance as part of the comprehensive preventive medicine examination. The teen and their parent separately complete a scorable transition readiness assessment form, which asks a set of questions about the teen's self-care skills. In addition to risk factor reduction counseling, the physician also reviews and discusses a few of the youth specific self-care skill needs identified by the youth and parent.

Coding: CPT 99384 (Preventive medicine visit, new patient, ages 12-17)
 Modifier 25 (Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the other service)
 CPT 96160 (patient-focused health risk assessment instrument)
 CPT 96161 (Caregiver focused health risk assessment instrument)
 ICD-10-CM: Z00.129 (Encounter for routine child health examination without abnormal findings)
 Z71.89 (Persons encountering health services for other counselling and medical advice, not elsewhere classified)

Vignette #3

Office visit with established 16-year-old male patient with moderate persistent asthma presenting with difficulties breathing and sleeping. He was recently in the ER for asthma complications due to inconsistent use of corticosteroids. While waiting for the physician, youth completes a scorable transition readiness assessment form. The physician provides counseling regarding medication adherence and knowing his symptoms, including ones that he quickly needs to see the doctor for instead of going to the ER. During the visit, the physician also updates the youth's medical summary with the youth so that he better understands his treatment and encourages the youth to add his medical information on his iPhone given patient often forgets to take his meds. The physician reviews the transition readiness assessment form and revises his plan of care to address needed self-care skills and changes in medication. The total physician visit is 25 minutes. After the physician meets with the patient, the nurse, who is a certified asthma educator, provides the patient with 20 minutes of education and training on asthma self-care using a standardized curriculum.

Coding: CPT 99214 (Office visit, established patient, moderate severity problem, 25 minutes)
 CPT 96160 (patient-focused health risk assessment instrument)
 CPT 98960 (Education and training of patient self-management)

ICD-10-CM: J45.40 (Moderate persistent asthma, uncomplicated)

Vignette #4

Preventive medicine visit with established 18-year-old female for her final pediatric visit before she goes off to college. She wants to see a new physician who treats adults, and she asks the physician for suggestions. She has been treated for major depressive disorder (mild) since she was 14. During the visit, the patient describes high levels of stress associated with all the changes that are happening in her life and persistent sadness. The physician takes an extra 15 minutes to re-assesses her depression and determines that a different medication is required. The physician reviews the last transition readiness assessment conducted when the youth was 17, updates the medical summary, and recommends an adult physician who can accept her as a new patient. He also recommends that she schedule a visit with her child/adolescent psychiatrist to discuss her depression and transfer plans to an adult psychiatrist. Following the visit, the physician takes an extra 30 minutes of non-face-to-face time to prepare a transfer letter for her to take to college and to her new adult provider that includes an updated medical summary, plan of care, and transition readiness assessment.

Coding: CPT 99395 (Preventive medicine visit, established visit, ages 18-39)
 CPT 99213-25 (Office visit, established patient, low to moderate severity, 15 minutes, with significant, separately identifiable E/M service above and beyond the service performed by the same MD)
 CPT 99358 (Prolonged E/M services before and/or after direct patient contact; first hour)

ICD-10-CM: Z00.121 (Encounter for routine child health examination with abnormal findings)
 F41.8 (Other specified anxiety disorders)

Vignette #5

Office visit with an established 20-year-old female patient with spastic quadriplegia due to cerebral palsy. She has a seizure disorder and depends on a motorized wheelchair for mobility, an iPad for communication, and a gastrostomy tube for nutrition. During this regular chronic care visit, the physician spends 40 minutes with the patient and assesses her level of readiness for an adult model of care using a transition readiness assessment form, reviews the enteral formula she is using, and reconciles her seizure medication. The physician talks with the young adult and parent about the timing for transfer and adult provider preferences. The physician suggests a new adult doctor to transfer to. The young adult, though not the parent, is eager to transfer to adult care over the next few months. The physician discusses with the young adult and parent the actions that need to take place prior to the transfer, including coordinating transfer plans with her other providers, preparing an updated medical summary and emergency care plan, and consulting with the new adult doctor. The physician spends greater than 50% of the visit counseling. Following this last pediatric visit, the pediatrician and clinical staff devote an additional 60 minutes to non-face-to-face care management services to prepare the transfer letter, contact the young adult's other specialists to coordinate the transfer information, consult with the new adult doctor, and call the young adult to review final plans for transfer, with the date for the initial adult appointment.

Coding: CPT 99215 (Office visit, established patient, high severity problem, 60 minutes)
 CPT 96160 (Patient-focused health risk assessment instrument)
 CPT 99487 (Complex chronic care management service, 60 minutes)

ICD-10-CM: G40.90 (Epilepsy, unspecified, not intractable)
 Z93.1 (Gastrostomy status)

Vignette #6

A 23-year-old with pediatric onset systemic lupus erythematosus with rash, arthritis, and renal disease on hydroxychloroquine, prednisone, and Mycophenolate Mofetil is transferred to an adult rheumatologist for adult focused rheumatological care. Prior to the initial visit, the medical assistant makes pre-visit call to determine need for special accommodations and offers appointment reminder. During the visit, the new adult physician receives and reviews the transfer letter, transition care plan, medical summary, emergency care plan, and transition readiness assessment from the pediatric rheumatologist. The nurse has her fill out a scorable self-care assessment while waiting to see the adult rheumatologist. The adult physician spends more than 50% of the 45-minute visit discussing information about their practice and their consent and privacy approach and establishes a communication plan with the young adult. The physician also updates and shares the medical summary, including the medication reconciliation and plan of care, with the new young adult patient. The physician reviews the self-care assessment and determines if the young adult is ready for an adult approach to care and if she can coordinate her primary and specialty care. She also assesses if she needs family support or other care management support. The physician begins the process of identifying and contacting a new adult internist for primary care and additional subspecialists, including an adult nephrologist and ophthalmologist for the young adult. The insurer requires new prior authorizations for medications.

Coding: CPT 99204 (Moderate to high severity problem, typically 45 minutes)
 CPT 96160 (Patient-focused health risk assessment instrument)

ICD-10-CM: M32.14 (Glomerular disease in systemic lupus erythematosus)

Vignette #7

New adult provider office visit with a 22-year-old young adult transitioning from their pediatric provider who was seen 6 months earlier for a preventive visit. The new young adult male comes with no previous medical records from the pediatrician. The physician completes a medical history and a physical exam noting his BMI is 27. The patient fills out a scorable self-care assessment form, the physician and young adult jointly fill out a medical summary, and the physician assists the young adult to put their emergency contact information and key medical information into their phone. The physician spends > 50% of the 30-minute visit counseling the patient reviewing and discussing needed self-care assessment skills, interfacing with the adult practice, and discussing nutrition and exercise weight reduction strategies.

Coding: CPT99203 (New patient outpatient service)
 CPT 96160 (Patient focused health risk assessment instrument)

ICD 10-CM: E66.3 (Overweight and obesity)
 Z71.89 (Persons encountering health services for other counselling and medical advice, not elsewhere classified)

CPT Description of Selected Transition-Related Codes^{2, 3}

¹**Office or Other Outpatient Consultations** (99241-99245) A consultation is a type of E/M service provided at the request of another physician or other appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem. A physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. A consultation initiated by a patient and/or family and not requested by a physician or other appropriate source is not reported using the consultation codes but may be reporting using the office visit codes as appropriate. The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source. If a consultation is mandated (e.g., by a third party payer), 32 should be reported. Any specifically identifiable procedure (i.e., identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately. If subsequent to the completion of a consultation the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the appropriate E/M service code should be reported.

Coding Tip: Although Medicare no longer recognizes consultation codes, most other payers still allow their use. It is important to distinguish the difference between consultations and transfer of care. Transfer of care is the process whereby a physician or other qualified health care professional who is providing management for some/all of a patient's problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. Consultation codes should not be reported by the physician or other qualified health care professional who has agreed to accept transfer of care before an initial evaluation, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation.

²**Care Plan Oversight Services** (99339, 99340) Care plan oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility or domiciliary, or non-face-to-face services. The complexity and approximate time of the care plan oversight services provided within a 30-day period determine code selection. Only one individual may report services for a given period of time, to reflect the sole or predominant supervisory role with a particular patient. These codes should not be reported for supervision of patients in nursing facilities or under the care of home health agencies unless they require recurrent supervision of therapy. The work involved in providing very low intensity or infrequent supervision services is included in the pre- and post-encounter work for home, office/outpatient and nursing facility or domiciliary visit codes. These codes are reported separately from codes 99374-99380, which refer to care plan oversight services for patients under the care of a home health agency, hospice, or nursing facility.

Coding Tip: Unlike chronic care management and transitional care management services, time included in care plan oversight is only that of the physician or other qualified health care professional and not that of clinical staff.

³**Prolonged Services** *Prolonged service with direct patient contact (99354, 99355)* These codes are used when a physician or other qualified health care professional provides prolonged services involving direct patient contact that is provided beyond the usual service. Direct patient contact is face-to-face and includes additional non-face-to-face services on the patient's floor or unit in the hospital or nursing facility during the same session. This service is reported in addition to the primary procedure (i.e., the designated E/M service at any level or psychotherapy, code 90837, 60 minutes with patient and/or family member) and any other services provided at the same session. Codes 99354 and 99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the physician or other qualified health care professional on that date is not continuous. 99354 is used to report the first hour of prolonged service on a given date, depending on the place of service. It should be used only once per date, even if the time spent by the physician or other qualified health care professional is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the E/M or psychotherapy codes. The use of time-based add-on codes requires that the primary E/M service has a typical or specified time published in the CPT codebook. 99355 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. It may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Coding Tip: For E/M service that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, use 99415, 99416. Do not report 99354 or 99355 with 99415 or 99416.

Prolonged service without direct patient contact (99358, 99359) are used when a prolonged service is provided that is not face-to-face time in the office or outpatient setting and is beyond the usual physician or other qualified health care professional service time. This service is reported in relation to other physician or other qualified health care professional services, including E/M services at any level. This prolonged service may be reported on a different date than the primary service to which it is related. For example, extensive record review may relate to a previous E/M service performed earlier and commences upon receipt of past records. However, it must relate to a service or patient where (face-to-face) patient has occurred or will occur and relate to ongoing patient management. A typical time for the primary service need not be established within the CPT code set. Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by the physician or other qualified health care professional on a given date providing prolonged service, even if the time spent is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported. Code 99359 is used to report each additional 30 minutes beyond the first hour regardless of the place of service. It may also be used to report the final 15 to 30 minutes of prolonged services on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. Do not report 99358, 99359 for time spent in care plan oversight services, anticoagulant management, medical team conferences, online medical evaluations, or other non-face to face services that have more specific codes and no upper time limit in the CPT code set. Codes 99358 and 99359 may be reported when related to other non-face-to face service codes have a published maximum time (e.g., telephone services).

Coding Tip: Codes 99358 and 99359 must be related to an E/M service, procedure, or other non-face-to-face service with a published maximum time.

⁴**Medical Team Conferences** (99366-99368) These codes include face-to-face participation by a minimum of 3 qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the patient), with or without the presence of the patient, family member(s), community agencies, surrogate decision maker(s) (e.g., legal guardian), and/or caregiver(s). The participants are actively involved in the development, revision, coordination, and implementation of health care service needed by the patient. Reporting participants shall have performed face-to-face evaluations or treatments of the patient, independent of any team conference, within the previous 60 days. Physicians or other qualified health care professionals who may report E/M services should report their time spent in a team conference with the patient and/or family present using E/M codes (and time as the key controlling factor for code selection when counseling and/or coordination of care dominates the services). These introductory guidelines do not apply to services reported using E/M codes. However, the individual must be directly involved with the patient, providing face-to-face services outside of the conference visit with other physicians and qualified health care professionals or agencies. Reporting participants shall document their participation in the team conference as well as their contributed information and subsequent treatment recommendations. No more than one individual from the same specialty may report 99366-99368 at the same encounter. Individuals may not report these codes when their participation is part of a facility or organizational service contractually provided by the organization or facility. The team conference starts at the beginning of the review of an individual patient and ends at the conclusion of the review. Time related to record keeping and report generation is not reported. The reporting participant shall be present for all time reported. The time reported is not limited to the time that the participant is communicating to the other team members or patient and/or family. Time reported for medical team conferences may not be used in the determination of time for other services such as care plan oversight, home, domiciliary, or rest home care plan oversight, prolonged services, psychotherapy, or another E/M service. For team conferences where the patient is present for any part of the duration of the conference, nonphysician qualified health care professionals (e.g., speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians) report the team conference face-to-face code 99366.

⁵**Preventive Medicine Services** (99384-99385, 99394-99395) The extent and focus of the preventive medicine services largely depends on the age of the patient. If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine E/M service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate office/outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the office/outpatient code to indicate that a significant, separately identifiable E/M service was provided on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported. Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventative medicine examination. Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests (e.g., vision, hearing, developmental) identified with a specific CPT code are reported separately. Codes 99384, 99385 and 99394, 99395 include age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures.

⁶**Health Risk Assessment** (96160, 96161) Codes 96160 and 96161 will allow reporting patient risk-assessment instrument administered to either the patient or the caregiver/parent in order to assess the risk of conditions, such as mental disorders, when performed in conjunction with an E/M visit. The separately reported E/M service includes interpreting the rating scale, discussing the results with the patient and/ or caregiver, documenting the patient/caregiver discussion in the patient’s medical record, and providing any referrals to the parent’s or caregiver’s primary care provider or mental health provider.⁴

Coding Tip: CPT 96160 can be used to report transition readiness assessments conducted with youth and self-care assessments conducted with young adults, and CPT 96161 can be used for the caregiver. These services are intended to evaluate youth and young adults’ understanding of their own health and how to effectively use health care. It can be administered with new and established patients with and without chronic conditions. Clinical staff typically administer, score, and document the results of the standardized transition readiness or self-care assessment form completed by the youth or young adult during the patient’s medical encounter. Physician services, reported separately via the evaluation and management (E/M) encounter code, include the interpretation of the transition readiness assessment/self-care assessment, discussion of results, and preparation of a summary report in the patient’s medical record. Codes 96160, 96161 should be separately reported when performed in conjunction with a preventive medicine service or an office outpatient service (i.e., evaluation and management (E/M) codes. Modifier 25 should be appended to the E/M code when both codes are reported on the same day. Of note, both a transition risk assessment instrument and a health risk assessment instrument such as the Rapid Assessment for Adolescent Preventive Service (RAAPS) cannot be billed for during the same visit. A standardized, scorable instrument must be used and recorded in the clinical documentation for the encounter. Two scorable general instruments are the transition readiness assessment (for youth preparing for self-care) and self-care assessment (for young adults) instruments that can be downloaded from the Six Core Elements of Health Care Transition Packages available at www.gottransition.org. Other standardized scorable tools include the Transition Readiness Assessment Questionnaire (TRAQ), On TRAC, UNC TRxANSITION SCALE, STARx Questionnaire, and the Patient Activation Measure.

⁷**Care Management Services** (99487, 99489, 99490) Care management services are management and support services provided by clinical staff under the direction of a physician or other qualified health professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services may include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient’s condition, care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living. A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment goals, symptom management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the practices will be directed/coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan. Codes 99487, 99489, and 99490 are reported only once per calendar month and may only be reported by the single physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month. The face-to-face and non-face-to-face time spent by the clinical staff in

communicating with the patient and/or family, caregivers, professionals, and agencies; revising, documenting, and implementing the care plan; or teaching self-management is used in determining the care management clinical staff time for the month. Only the time of the clinical staff of the reporting professionals is counted. Only count the time of one clinical staff member when 2 or more clinical staff members are meeting about the patient. Do not count any clinical staff time on a day when the physician or qualified healthcare professional reports and E/M service. Care management activities performed by clinical staff typically include:

- communication and engagement with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- collection of health outcomes data and registry documentation;
- patient and/or family/caregiver education to support self-management, independent living, and activities of daily living;
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family;
- management of care transitions not reported as part of transitional care management;
- ongoing review of patient's status, including review of laboratory and other studies not reported as part of an E/M service, noted above;
- development, communication, and maintenance of a comprehensive care plan.

The care management office/practice must have the following capabilities:

- provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week;
- provide continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- provide timely access and management for follow-up after an emergency department visit or facility discharge;
- utilize an electronic health record system so that care providers have timely access to clinical information;
- use a standardized methodology to identify patients who require care management services;
- have an internal care management process/function whereby a patient identified as meeting the requirements for the services starts receiving them in a timely manner;
- use a form and format in the medical record that is standardized within the practice;
- be able to engage and educate patients and caregivers as well as coordinate care among all service professionals, as appropriate for each patient.

E/M services may be reported separately by the same physician or other qualified health care professional during the same calendar month. Care management services include care plan oversight services, prolonged services without direct patient contact, anticoagulant management, medical team conferences, education and training, telephone services, online medical evaluation, preparation of special reports, analysis of data, transitional care management services, medication therapy management services, and, if performed, these services may not be reported separately during the month for which 99487, 99489, and 99490 if reporting ESRD services during the same month. Care management may be reported in any calendar month during which the clinical staff time requirements

are met. If care management resumes after a discharge during a new month, start a new period or report transition care management services. If discharge occurs in the same month, continue the reporting period or report transitional care management services. Do not report 99487, 99489, 99490 for any post-discharge care management services for any days within 30 days of discharge, if reporting 99495, 99496.

Chronic Care Management Services (99490) are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have 2 or more chronic conditions or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decomposition, or functional decline. Code 99490 is reported when, during the calendar month, at least 20 minutes of clinical staff time is spent in care management activities.

Complex Chronic Care Management Services (99487, 99489, 99490) are provided during a calendar month that includes criteria for chronic care management services as well as establishment or substantial revision of a comprehensive care plan; medical, functional, and/or psychosocial problems requiring medical decision-making of moderate or high complexity; and clinical staff care management services for at least 60 minutes, under the direction of a physician or other qualified health care professional. Physicians or other qualified health care professionals may not report complex chronic care management services if the care plan is unchanged or requires minimal change (e.g., only a medication is changed or an adjusted in a treatment modality is ordered). Medical decision-making as defined in the E/M guidelines is determined by the problems addressed by the reporting individual during the month. Patients who require complex chronic care management services may be identified by practice-specific or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for caregiver, and/or repeat admissions or emergency department visits. Typical adult patients who receive complex chronic care management services are treated with 3 or more prescription medications and may be receiving other types of therapeutic interventions. Typical pediatric patients receive 3 or more therapeutic interventions. All patients have 2 or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Typical patients have complex diseases and morbidities and as a result, demonstrate one of the following: need for a coordination of a number of specialties and services; inability to perform activities of daily living and/or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver; psychiatric and other medical co morbidities (e.g., dementia and COPD or substance abuse and diabetes); and/or social support requirements or difficulty with access to care.

Coding Tip: Chronic care management code 99490 was developed to align with the Centers for Medicare & Medicaid Services (CMS) benefit specifications for Medicare coverage of CCM. The CMS has outlined specific coverage criteria that may be adopted by Medicaid and private health plans, including 2 points of consideration for physicians who wish to provide CCM services.

1. Practices providing CCM services must have certain capabilities, including use of an HER. Health plans may adopt the CMS requirement for use of an HER that meets certification requirements for Medicare and Medicaid HER incentive programs in place on December 13 of the prior year.
2. Chronic care management activities are provided by clinical staff under the supervision of the physician or QHP reporting CCM services. Check with payers for the level of supervision required. The CMS has allowed an exception to the requirement for direct supervision (i.e.,

physician presence in the office suite when staff perform activities) for CCM services provided to Medicare patients. This 99490 exception allows staff to perform CCM activities under the physician's or QHP's general supervision (i.e., supervising provider is available as needed by phone) as long as all other incident-to requirements are met.

To report code 99490, physicians must meet the required practice capabilities, document the patient's care plan, and supervise clinical staff activities of CCM. At least 20 minutes of clinical staff time spent in CCM activities must be documented. Time spent in activities personally performed by a physician may be counted toward CM when provided on a date when no face-to-face service was provided.

⁸**Transitional Care Management** (99495, 99496) are used to report transitional care management services (TCM). These services are for new or established pediatric or adult patients 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 upon the date of discharge and continues for the next 29 days. TCM is comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction. Non-face-to-face services, under the direction of the physician or other qualified health care professional, may include:

- communication (with patient, family members, guardian or caretaker, surrogate decision makers, and/or other professionals) regarding aspects of care;
- communication with home health agencies and other community services utilized by the patient;
- patient and/or family/caretaker education to support self-management, independent living, and activities of daily living;
- assessment and support for treatment regimen adherence and medication management;
- identification of available community and health resources;
- facilitating access to care and services needed by the patient and/or family.

Non-face-to-face services provided by the physician or other qualified health care professional may include:

- obtaining and reviewing the discharge information (e.g., discharge summary, as available, or continuity of care documents);
- reviewing need for or follow-up on pending diagnostic tests and treatments;
- interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
- education of patient, family, guardian, and/or caregiver;
- establishment or reestablishment of referrals and arranging for needed community services;
- assistance in scheduling any required follow-up with community providers and services.

TCM requires a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames. The first face-to-face visit is part of the TCM service and not reported separately. Additional E/M services provided on subsequent dates after the first face-to-face visit may be reported separately. TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic, or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit. These services address any needed coordination of care performed by multiple disciplines and

community service agencies. The reporting individuals provide or oversee the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living support by providing first contact and continuous success. Medical decision making and the date of the first face-to-face visit are used to select and report the appropriate TCM code. For 99496, the face-to-face visit must occur within 7 calendar days of the date of discharge, and medical decision making must be of high complexity. For 99495, the face-to-face visit must occur within 14 calendar days of the date of discharge and medical decision making must be of at least moderate complexity.

Medical decision-making is defined by the E/M service guidelines. The medical decision-making over the service period is used to define the medical decision-making of TCM. Documentation includes the timing of the initial post-discharge communication with the patient or caregivers, date of the face-to-face visit, and the complexity of medical decision-making. Only one individual may report these services and only once per patient within 30 days of discharge. Another TCM may not be reported by the same individual or group for any subsequent discharge(s) within the 30 days. The same individual may report hospital or observation discharge services and TCM. However, the discharge service may not constitute the required face-to-face visit. Same individual should not report TCM services provided in the post-operative period of a service that the individual reported. A physician or other qualified health care professional who reports codes 99495, 99496 may not report care plan oversight services, prolonged services without direct patient contact, anticoagulant management, medical team conferences, education and training, telephone services, end stage renal disease services, online medical evaluation services, preparation of special reports, analysis of data, complex chronic care coordination services, medication therapy management services during the time period covered by the transitional care management service codes.

⁹**Telephone Services** (99441-99443) are non-face-to-face E/M services provided to a patient using the telephone by a physician or other qualified health care professional, who may report E/M services. These codes are used to report episodes of patient care initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see that patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by that individual within the previous 7 days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous E/M service or procedure.

¹⁰**On-Line Medical Evaluation** (99444) An on-line electronic medical evaluation is a non-face-to-face E/M service for a physician to a patient using Internet resources in response to a patient's on-line inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. This service is reported only once for the same episode of care during a 7-day period, although multiple physicians could report their exchange with the same patient. If the on-line medical evaluation refers to an E/M service previously performed and reported by the physician within the previous 7 days (either physician requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the services are considered covered by the previous E/M service or procedure. A reportable service encompasses the sum of communication (e.g., related telephone calls, prescription provision, laboratory orders) pertaining to the on-line patient encounter.

¹¹**Interprofessional Telephone/Internet Consultations** (99446-99449) An interprofessional telephone/Internet consultation is an assessment and management service in which a patient's treating (e.g., 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 problems without the need for the patient's face-to-face contact with the consultant. These services are typically provided in complex and/or urgent situations where a timely face-to-face service with the consultant may not be feasible. These codes should not be reported by a consultant who has agreed to accept transfer of care before the telephone/Internet assessment, but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial interprofessional telephone/Internet consultation. The patient for whom the interprofessional telephone/Internet consultation is requested may be either a new patient to the consult or an established patient with the new problem or an exacerbation of an existing problem. However, the consultant should not have seen the patient in a face-to-face encounter within the last 14 days. When the telephone/Internet consultation leads to an immediate transfer of care or other face-to-face service within the next 14 days or next available appointment date of the consultant, these codes are not reported. Review of pertinent medical records, lab studies, imaging studies, medication profile, pathology specimens, etc. may be required and transmitted electronically by fax or by mail immediately before the telephone/Internet consultation or following the consultation. The review of this data is included in the telephone/internet consultation service and should not be reported separately. Most the service time reported (greater than 50%) must be devoted to the medical consultative verbal/Internet discussion. This service should not be reported more than once within a 7-day interval. If more than one telephone/Internet contact is required to complete the consultation request, the entirety of the service and the cumulative discussion and information review time should be reported with a single code. The written or verbal request for telephone/Internet advice by the treating/requesting physician or other qualified health care professional should be documented in the patient's medical record, including the reason for the request, and concludes with a verbal opinion report and written report from the consultant to the other treating/requesting physician or another qualified health care professional. Telephone/Internet consultations of less than 5 minutes should not be reported. When the sole purpose of the telephone/Internet communication is to arrange a transfer of care or other face-to-face services, these codes are not reported. The treating/requesting physician or other qualified health professional may report the prolonged service codes for the time spent on the Interprofessional telephone/internet discussion with the consult if the time exceeds 30 minutes beyond the typical time of the appropriate E/M service performed and the patient is present and accessible to the treating/requesting physician other qualified health care professional. If the Interprofessional telephone/Internet assessment and management service occurs when the patient is not present or on-site, and the discussion of time exceeds 30 minutes beyond the typical time of the appropriate E/M service performed, then the non-face-to-face prolonged service codes 99358, 99359 may be reported by the treating/requesting physician other qualified health care professional.

¹²**Education and Training Services for Patient Self-Management** (98960-98962) The following codes are used to report educational and training services prescribed by a physician or other qualified health care professional and provided by a qualified, nonphysician health care professional using a standardized curriculum to an individual or a group of patients for the treatment of established illness(es)/disease(s) or to delay comorbidity(s). Education and training for patient self-management may be reported with these codes only when using a standardized curriculum. The curriculum may be modified as necessary for the clinical needs, cultural norms and health literacy of the individual patient(s). The purpose of the educational and training services is to teach the patient (may include caregiver) how to effectively self-

manage the patient’s illness(s)/disease(s) or delay disease comorbidity(s) in conjunction with the patient’s professional health care team. Education and training related to subsequent reinforcement or due to changes in the patient’s condition or treatment plan are reported in the same manner as the original education and training. The type of education and training provided for the patient’s clinical condition will be identified by the appropriate diagnosis code(s) reported. The qualifications of the nonphysician healthcare professionals and the content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society, nonphysician healthcare professional society/association, or other appropriate source.

¹³**Miscellaneous Services** (99078) Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., obesity or diabetic instruction).

¹⁴**Modifiers** (25) It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding Modifier 25 to the appropriate level of E/M service.

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