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

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Improving transition from pediatric to adult health care is a national priority, a medical home certification standard, and a meaningful use requirement for electronic health records. Health care transition encompasses 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, transferring youth to a new adult provider, and orienting and engaging young adults in adult 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 have recently been updated and are available at 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 summary of alternative payment methodologies followed by a listing of transition-related CPT codes and corresponding Medicare fees, effective as of 2016. A subsequent report will be released that provides a payment crosswalk for the Six Core Elements of Health Care Transition.

Innovative Transition Payment Models

In addition to knowing the appropriate CPT codes and fee-for-service (FFS) Medicare fees for pediatric-to-adult transition services, it is also important to become aware of alternative payment methodologies and to explore the feasibility of implementing these options with public and private payers to support the provision of recommended transition services. Payers are increasingly implementing alternative payment methods for medical home and care transitions (hospital to home) that replace or complement FFS methods and emphasize quality, outcomes, and cost containment. These include pay-for performance, capitation, bundled payments, shared savings arrangements, and administrative or infrastructure payments. Below is a brief overview of these payment models and how they can be applied to incentivize the delivery of transition services in both pediatric and adult settings.

1. Enhanced Fee-for-Service Payments

Fee-for-service (FFS) payments will continue to be important in supporting the delivery of recommended transition services. Reporting the appropriate CPT codes and ensuring that private and public payers are using the current associated values for each code form the foundation for appropriate payment in FFS arrangements. Many CPT codes important to transition, such as care plan oversight and telephone/internet consultations, are often not recognized by payers. Still, it is essential to code and accurately document these services. Payers could enhance FFS payments – for example, paying pediatric and adult office visit fees at 150% of Medicare rates for the year surrounding the transfer of a new patient, recognizing the added work involved in transferring and accepting patients. They could also increase fees for care plan oversight services to ensure the development and updating of the medical summary as well as of the plan of care.

2. Pay-for-Performance

Under pay-for-performance (P4P), physicians are paid based on agreed upon performance metrics for a defined population. Payers could, for example, offer pediatric practices a bonus payment for successfully transferring their patients before age 22 with complete medical records and evidence of communication with adult providers. Similarly, adult providers could receive a bonus for accepting a certain volume of new young adult patients, communicating with the referring pediatric provider, and ensuring a primary care visit is made within six months of transfer from the pediatric provider. P4P could also be structured based on improvements made or scores received on either the Current Assessment of Health Care Transition Activities (available here) or the Health Care Transition Process Measurement tool (available here).

3. Capitation

Monthly care coordination payments or capitation can provide a mechanism for reimbursing the added time involved in preparing youth and their families/caregivers for transfer to adult care, preparing the necessary transfer documents, ensuring coordination and communication between pediatric and adult care systems, and implementing outreach and follow-up strategies for new young adult patients. These monthly capitation payments could also be adjusted for patient complexity.

4. Bundled Payments

Bundled payments by definition include multiple services typically associated with an episode of care. The CPT code for transitional care management services (99495, 99496) is an example of a set of defined services provided by a physician or qualified health care professional for a patient with moderate to high complexity who is transitioning from hospital to community-based setting. These include a face-to-face visit, communication, education to support self-care, assessment of treatment and medication management, identification of community resources, referrals, and scheduling follow-up. *This code, however, does not extend to transition from pediatric to adult ambulatory health care, only from hospital to home.* Still, it would be possible to structure a bundled payment arrangement for a package of transfer services from pediatric to adult care, including an updated medical summary and emergency care plan, transition readiness assessment, plan of care, and other services listed under the CPT Transitional Care Management Services. Templates for each of these transition services are available in the Six Core Elements packages (www.gottransition.org).

5. Shared Savings

By ensuring a successful transfer from pediatric care to adult care at a cost below budgeted amounts, the resultant savings associated with reduced emergency room visits could be shared with pediatric and adult providers. This alternative payment arrangement generally follows a defined set of structural and quality standards. In the case of transition from pediatric to adult health care, a potential option would be to use the measurement tools described above under pay-for- performance.

6. Administrative or Infrastructure Payments

This payment mechanism has been used by Medicare to support adoption and meaningful use of electronic health record technology and by Medicaid to conduct administrative activities (e.g., outreach, planning, training) to implement a state's Medicaid plan. Demonstration grants and other infrastructure investment grants have been awarded to support system changes. In the case of transition, this administrative payment strategy could be considered for covering costs of customizing electronic health records to align with the recommended core elements of transition and for transition training of pediatric and adult providers, but not for direct services.

Reference

[1] American Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians, Transitions Clinical Report Authoring Group. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2011;128(1):182-200.

Transition Coding and Reimbursement

Transition Related Services		100% Medicare Payment, 2016	
CPT Code	**Code Description**	**Office**	**Facility**
Office or Other Outpatient Services, New Patient			
99201	Self-limited or minor problem, 10 min	$44.43	$27.23
99202	Low to moderate severity problem, 20 min	$75.60	$50.88
99203	Moderate severity problem, 30 min	$109.28	$77.75
99204	Moderate to high severity problem, 45 min	$166.24	$131.49
99205	High severity problem, 60 min	$208.52	$170.90
Office or Other Outpatient Services, Established Patient			
99211	Minimal presenting problems, 5 min	$20.06	$9.32
99212	Self-limited or minor problem, 10 min	$44.07	$25.80
99213	Low to moderate severity problem, 15 min	$73.45	$51.59
99214	Moderate severity problem, 25 min	$108.20	$79.18
99215	Moderate to high severity problem, 40 min	$145.82	$111.78
Office or Other Outpatient Consultations, New or Established Patients[1]			
99241	Self-limited or minor problem, 15 min	$48.01	$32.96
99242	Low severity problem, 30 min	$90.29	$69.15
99243	Moderate severity problem, 40 min	$123.61	$96.74
99244	Moderate to high severity problem, 60 min	$184.87	$155.49
99245	Moderate to high severity problem, 80 min	$225.36	$192.40
Care Plan Oversight Services[2]			
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 to 29 minutes	$78.10	NA
99340	30 minutes or more	$109.63	NA
Prolonged Services[3]			
99354	Prolonged E/M or psychotherapy beyond the typical service time, in office or other outpatient setting, with direct contact beyond the usual service	$101.03	$93.87
99355	Each additional 30 min.	$98.17	$91.00
99358	Prolonged E/M services before and/or after direct patient contact; first hour	$109.55	$109.55
99359	Each additional 30 min.	$51.91	$51.91
Medical Team Conference[4]			
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	$43.32	$42.24

99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	NA	$56.97
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	$37.23	$37.23
Preventive Medicine Services[5]			
99384	Initial comprehensive preventive medicine, new adolescent patient; ages 12-17	$136.86	$103.54
99385	Ages 18-39	$132.56	$99.24
99394	Periodic comprehensive preventive medicine, established adolescent patient; ages 12-17	$116.80	$87.78
99395	Ages 18-39	$119.31	$90.29
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	$36.54	$24.72
99402	Approximately 30 minutes	$62.34	$50.88
99403	Approximately 45 minutes	$87.42	$75.60
99404	Approximately 60 minutes	$112.50	$101.03
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	$14.33	$12.54
99407	Intensive, greater than 10 minutes	$27.95	$26.15
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	$35.47	$33.68
99409	Greater than 30 minutes	$69.15	$67.36
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes	$16.47	$7.87
99412	Approximately 60 minutes	$21.48	$12.89
99420	Administration and interpretation of health risk assessment instrument[6]	$11.10	$0*
Health and Behavior Assessment/Intervention[7]			
96150	Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment	$21.86	$21.50
96151	Re-assessment	$20.78	$20.42
96152	Health and behavior intervention, each 15 minutes, face-to-face; individual	$20.06	$19.71
96153	For a group (2 or more patients)	$4.66	$4.66
96154	For a family (with the patient present)	$19.71	$19.35
96155	For a family (without the patient present)	$22.93	$22.93
Care Management Services[8]			
99487	Complex chronic care management services, 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	$0*	$0*
99489	Each additional 30 minutes	$0*	$0*
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	$40.84	$31.53
Transitional Care Management Services[9]			
99495	Includes communication (direct contact, telephone, electronic) with patient/caregiver withinin 2 business days of discharge; medical decision making of at least moderate complexity during service period; and face-to-face	$164.81	$111.42

	calendar days of hospital discharge		
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 2 business days of discharge	$232.52	$161.23
Telephone Services[10]			
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 to 10 minutes of medical discussion	$13.97	$12.90
99442	11-20 minutes of medical discussion	$27.23	$25.80
99443	21-30 minutes of medical discussion	$40.13	$38.69
On-line Medical Evaluation[11]			
99444	Online 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	$0*	$0*
Interprofessional Telephone/Internet Consultations[12]			
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	$0*	$0*
99447	11-20 minutes	$0*	$0*
99448	21-30 minutes	$0*	$0*
99449	31 minutes or more	$0*	$0*
Education and Training for Patient Self-Management[13]			
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 min; individual patient	$28.30	NA**
98961	2-4 patients	$13.61	NA**
98962	5-8 patients	$10.03	NA**
Miscellaneous Services[14]			
99078	Educational services rendered to patients by physician or other qualified health professional in a group setting (eg, obesity or diabetic instructions)	$0*	$0*

*$0 indicates that there are no RVUs assigned to this code.
**NA indicates that established values assigned to this code are not applicable in certain settings.

CPT DESCRIPTION OF SEELCTED CODES

[1]**Office or Other Outpatient Consultations** (99241-99245) 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. 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 (eg, by a third party payer), modifier 32 should be reported. 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*: 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) 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. They are for 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 phone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decisions maker(s) (eg, legal guardian) and/or key caregiver(s) involved in a patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month.

[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. This service is reported in addition to the primary procedure (ie, 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. These codes are used to report the first hour of prolonged service on a given date, depending on the place of service. Either code 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.

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 neither 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 (eg, telephone services).

[4]**Medical Team Conferences** (99366 – 99368) 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) (eg, 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 (eg, 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, 99401-4*, 99406-9, 99411, 99412) 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. *Initial comprehensive preventive medicine (99384, 99385) and periodic comprehensive preventive medicine (99394, 99395)* include age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures. *Counseling Risk Factor Reduction and Behavior Change Intervention* (99401 – 4, 99406, 99411, 99412) are used to report services provided face-to-face by a physician or other qualified health care professional for the purpose of promoting health and preventing illness or injury. They are distinct from E/M services that may be reported separately with modifier 25 when performed. Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment. Preventive medicine counseling and risk factor reduction interventions will vary with age and should address such issues as family problems, diet and exercise, substance use, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter. Behavior change interventions are for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse, or obesity. Behavior change services may be reported when performed as part of the treatment of condition(s) related to or potentially exacerbated by the behavior or when performed to change the harmful behavior that has not yet resulted in illness. Any E/M services reported on the same day must be distinct and reported with modifier 25, and time spent providing these services may not be used as a basis for the E/M code selection. Behavior change services involve specific validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up. For counseling groups of patients with symptoms of established illness, use 99078.

[6]**Administration and Interpretation of Health Risk Assessment** (99420) can be used to report transition readiness assessments conducted with youth and self-care assessments conducted with young adults. This service is 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. Code 99420 should be separately reported when performed in conjunction with a preventive medicine service or an office outpatient service (ie, 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. If the 99420 assessment result indicates the need for an intervention on a subsequent date of service, the preventive medicine counseling codes for individuals (99401-99405) or for individuals in a group setting (99411,99412) may be reported. 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]**Health and Behavior Assessment/Intervention** (96150 – 5) are used to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments. The focus of the intervention is to improve the patient's health and well-being utilizing cognitive, behavioral, social, and/or psychophysiological procedures designed to ameliorate specific disease-related problems. Codes 96150 – 5 describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the biopsychosocial factors related to the patient's health status. These services do not represent preventive medicine counseling and risk factor reduction interventions. For patients that require psychiatric services as well as health and behavior assessment/intervention, report the predominant service performed. Do not report 96150-96155 in conjunction with 90785-90899 on the same date. E/M codes (including Counseling Risk Factor Reduction and Behavior Change Intervention (99401-12) should not be reported on the same day.

[8]**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, measureable 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, 99490 are reported only once per calendar month and may only 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 outcome 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 evacuation, 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 moth 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 (eg, 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 chromic 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, and/or social support requirements or difficulty with access to care. *Coding Tip:* Time of care management with the emergency department is reportable using 99489 and 99490, but time while the patient is inpatient or admitted as observation is not.

[9]**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 day. 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 (eg, 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 provides or oversees 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. 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.

[10]**Telephone Services** (99441 – 99443) are non-face-to-face E/M services provided 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.

[11]**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 serve or procedure. A reportable service encompasses the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the on-line patient encounter.

[12]**Interprofessional Telephone/Internet Consultations** (99446-49) An Interprofessional telephone/Internet consultation 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 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. The majority of 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 other 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 may be reported by the treating/requesting physician other qualified health care professional.

[13]**Education and Training Services for Patient Self-Management** (98960 – 62) These codes 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. 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).

[14]**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 (eg, obesity or diabetic instruction).

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