



Coding for Care Management and Other Non-Direct Services

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

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Prolonged Non-Direct E/M Service

This is for reporting of time in the outpatient setting that is non-direct or when the patient is in the facility setting, but the physician spends time away from the patient and off the unit/floor. This is for prolonged time either on the same day of a direct E/M service (ie, face-to-face in-person or via synchronous audio-visual telemedicine) or on a day when the physician or other QHP (QHP) does not see the patient either in-person or via synchronous telemedicine. There are no diagnostic requirements for using these codes.

99358 Prolonged evaluation and management service before and/or after direct patient care; first hour

+ **99359** each additional 30 minutes (List separately in addition to code 99358)

- Report 99358-99359 for the total duration of non-face-to-face time spent by a physician or other QHP on a given date providing prolonged service, even if the time spent by the physician or other QHP on that date is not continuous.
- Code 99358 is only reported when 30 minutes of time has been met or exceeded on a single calendar date and is only reported once per date
- Do not report 99358-99359 when reporting a code from 99202-99215 or with 99417
- Not reported for time spent by clinical staff

Transition Care Management and Care Management

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

Transition Care Management

Transition care management (TCM) are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision-making (MDM) during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences on the date of discharge and continues for the next 29 days and requires a face-to-face visit, initial patient contact, and medication reconciliation within specified timeframes. Any additional E/M services provided after the initial may be reported separately. Refer to [table 1](#) for quick reference of timing of initial visit and MDM required. Refer to the *CPT* manual for complete details on reporting care management and TCM services.

- Do **not** report for patients "discharged" from the emergency department.

99495 Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making (MDM) of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision-making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge

Table 1 - TCM Table of MDM

Level of MDM	First face-to-face within 7 days of discharge	First face-to-face within 14 days of discharge
Moderate	99495	99495
High	99496	99495

Chronic Care Management Services

Codes are selected based on the amount of time spent by clinical staff of the physician or other QHP providing care coordination activities. CPT clearly defines what is care coordination activities. In order to report chronic care management (CCM) or complex chronic care management codes (CCCM), you must

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

For a brief overview of the CCM/CCCM services see [table 2](#).

For patients with only one chronic condition, refer to [Care Plan Oversight or Principal Care Management](#). Note these codes require time is spent by the provider, not clinical staff.

99490 Chronic care management services with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
- comprehensive care plan established, implemented, revised, or monitored;

first 20 minutes of clinical staff time directed by a physician or other QHP, per calendar month.

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

+ **99439** each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code 99490)

○ Chronic care management services of 60 minutes or more and requiring moderate or high complexity medical decision making may be reported using **99487, 99489**

○ Do not report **99439** more than twice per calendar month

○ Do not report **99490** and/or **99439** in the same calendar month as **99491**

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

- Do not report **99491** in the same calendar month as **99490** or **99439**

○ Do not report **99439, 99490** or **99491** in the same calendar month with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99605, 99606, 99607

○ Do not report **99439, 99490** or **99491** for time spent in other separately reportable services

Complex Chronic Care Management Services

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

1. receive three or more therapeutic interventions (eg, medications, nutritional support, respiratory therapy)
2. have two or more chronic continuous or episodic health conditions expected to last at least 12 months (or until death of the patient) and places the patient at significant risk of death, acute exacerbation or decompensation, or functional decline
3. commonly require the coordination of a number of specialties and services.

99487 Complex chronic care management services with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,

- chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline,
 - comprehensive care plan established, implemented, revised, or monitored,
 - moderate or high complexity medical decision making;
- first 60 minutes of clinical staff time directed by a physician or other QHP, per calendar month.

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

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

Table 2 – Overview of CCM/CCCM

CPT Code	Time (minimum)	Performing provider	Services
99490	20 m/month	Clinical staff w/ physician direction	CCM
+99439	Add'l 20 m/month beyond 99490	Clinical staff w/ physician direction	CCM
99491	20 m/month	Physician or other QHP	CCM
99487	60 m/month	Clinical staff w/ physician direction (may include physician or QHP time)	CCCM
+99489	Each add'tl 30 m/month beyond 99487	Clinical staff w/ physician direction (may include physician or QHP time)	CCCM

m, minute. + add on code.

Principal (Single-Disease) Care Management Services

1. A single (1) chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
2. A condition that requires development, monitoring, or revision of disease-specific care plan,
3. A condition that requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities
4. Ongoing communication and care coordination between relevant practitioners furnishing care may be reported by different physicians or QHPs in the same calendar month for the same patient
5. Documentation in the patient's medical record should reflect coordination among relevant managing clinicians
6. Principal care management services are disease-specific management services. Even if a patient may have multiple chronic conditions they may receive principal care management if the reporting physician or other QHP is providing *single disease* rather than comprehensive care management

+ Codes are *add-on* codes, meaning they are reported separately in addition to the appropriate code for the service provided
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99424 Principal care management services, for a single high-risk disease, with the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
- the condition requires development, monitoring, or revision of disease-specific care plan,
- the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities,
- ongoing communication and care coordination between relevant practitioners furnishing care;

first 30 minutes provided personally by a physician or other QHP, per calendar month.

+ **99425** each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to **99424**)

99426 Principal care management services, for a single high-risk disease, with the following required elements:

- one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death,
- the condition requires development, monitoring, or revision of disease-specific care plan,
- the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities,
- ongoing communication and care coordination between relevant practitioners furnishing care;

first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.

+ **99427** each additional 30 minutes of clinical staff time directed by a physician or other QHP, per calendar month (List separately in addition to code 99426)

Table 3- Principal Care Management

Code	Staff Type	Minimum Time Required	Time Span	Max Per Month
99424	Physician or QHP	30 minutes	30-59 mins	1
+99425	Physician or QHP	60 mins (per 30 mins)	60-89 mins X 1 90-119 mins X 2 (etc)	No limit
99426	Clinical staff	30 mins	30-59 minutes	1
+99427	Clinical staff	60 mins (per 30 mins)	60-89 mins X 1 90-119 mins X 2	2

Care Plan Oversight (CPO)

The following per month codes are for physician time only. The patient only needs one chronic medical condition.

- 99339** Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
- 99340** 30 minutes or more
- 99374** Care plan oversight services requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports and related lab studies, communications, integration of new information into treatment plan, and/or adjustment of medical therapy, patient under care of home health agency, 15-29 min.
- 99375** 30 min. or more
- 99377** Care plan oversight services, patient under care of hospice, 15-29 min.
- 99378** 30 min. or more
- 99379** Care plan oversight, patient in a nursing facility, 15-29 min.
- 99380** 30 min. or more

Care Plan Oversight FAQ

Q. If time is spent by my clinical staff may I count that?

A. No CPO requires that the work be done by a physician or QHPs who may independently bill under their own name and NPI.

Q. If more than one physician or QHP works on a care plan in the same calendar month may they both bill for their time?

A. No, most payers consider physicians or QHPs who work in the same group practice in the same specialty to be the "same" therefore the time would have to be combined and billed only once per calendar month.

Online Digital Evaluation and Management Service

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

- Patient must be established (problem can be new)
- Services must be initiated through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms
- Reported once for the physician's or other QHP's (including all in the same group practice) cumulative time during a seven-day period

- The seven-day period begins with the physician's or other QHP's initial, personal review of the patient-generated inquiry.
- Online digital E/M services require permanent documentation storage (electronic or hard copy) of the encounter.
- Do not report these codes separately if the patient is seen within 7 days of the service for an issue related to the encounter.
- Your *date of service* will be the date the initiation of the e-visit began or the range of dates it took place because this service is cumulative time over 7 days.

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

99422 11-20 minutes

99423 21 or more minutes

- Do not report 99421, 99422, 99423 when using 99091, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489 for the same communication[s]
- Do not report 99421, 99422, 99423 on a day when the physician or other QHP reports E/M services [99202 – 99205, 99212 - 99215, 99241– 99245]

The following codes are reported by nonphysician providers who may independently bill such as physical therapists and psychologists, but are not reported for clinical staff (eg, RN) unless noted in writing by your payer.

98970 Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

98971 11-20 minutes

98972 21 or more minutes

Online Digital E/M FAQ

Q. Who is a “qualified nonphysician healthcare professional?”

A. This professional will be able to bill under his/her own NPI, but not be eligible to bill an E/M service. An example might be a psychologist.

Q. If a parent or patient within the 7 days of initiation of an online E/M service brings up a new problem, does the “clock” start over -meaning I can bill for 2 distinct online digital E/M services?

A. No. Unfortunately, the “clock” runs for the full 7 days from initiation of the digital service. Therefore, only one online digital E/M service may be billed per 7 days, regardless of how many conditions are addressed. If, however, after the 7 days a new portal or other electronic communication is started to address a new or existing issue, the clock may begin again and you can report another online digital E/M service so long as the patient is not seen in the office or via telemedicine.

Q. We have a mom who reached out to our physician via a portal. Four days later the patient had a related telemedicine service that we billed for. Can we still report the online digital E/M service?

A. No – you cannot bill the digital online E/M service separately.

Q. A patient was seen 8 days prior for an incision and drainage. The code we reported has a 10-day global. Can we still separately report the online digital E/M encounter that was related to the procedure since it was more than 7 days later?

A. No – you are still within the global period and per CPT “If the online digital inquiry is related to a surgical procedure and occurs during the postoperative period of a previously completed procedure, then the online digital E/M service is not reported separately.

Q. A patient initiated an online inquiry with our physician about a new medical concern. The patient was seen 5 days ago for an ankle injury and today’s encounter was addressing a trunk rash. May we bill the time separately?

A. Yes. Per CPT “If the patient generates the initial online digital inquiry for a *new* problem within seven days of a previous E/M visit that addressed a different problem, then the online digital E/M service may be reported separately.”

Q. If there is more than one provider involved in the message thread, do you add them up and bill under one provider or do each separately? If one provider, how do you pick which one?

A. Per CPT “All professional decision making, assessment, and subsequent management by physicians or other QHPs in the same group practice contribute to the cumulative service time of the patient’s online digital E/M service.” Therefore, you only bill under one. How you determine which physician will be up to your practice policy or if you could bill under the practice instead.

Telephone Care Services

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

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

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

The following codes are reported by nonphysician providers who may independently bill such as physical therapists and psychologists, but are not reported for clinical staff (eg, RN) unless noted in writing by your payer.

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

98967 11-20 minutes of medical discussion

98968 21-20 minutes of medical discussion

Telephone Care FAQ

Q. If a mom calls and speaks with provider A in the morning and calls back later that same day and speaks to the same of different provider, may we report the telephone care code twice? Would it matter if the services were related or unrelated?

A. In this case you would combine the time and report only one telephone care service regardless of providers (so long as they are in the same group practice/specialty) or issues addressed. The calls happened on the same calendar day and payers will most likely deny the 2 separate calls. While you could submit with two distinct ICD-10-CM codes, most payers will deny.

Interprofessional Telephone/Internet/Electronic Health Record Consultations

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

- The patient may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem
- Patient cannot have been seen by the consultant within the last 14 days
- If the ITC leads to a transfer of care, these codes cannot be used if the consultant sees the patient (eg, visit or surgery) within the next 14 days or soonest available appointment of the consult.
- Codes include a review of pertinent medical records, laboratory and/or imaging studies, medication profile, pathology specimens, etc , however, for codes 99446-99449 the majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion.
- Codes 99446-99449, 99451 should not be reported more than once within a seven-day interval, therefore if time is spent over multiple days, count the total time and report one code.
- A summary table is included to help navigate the appropriate use of the codes. See [table 3](#)

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

99447 11-20 minutes of medical consultative discussion and review

99448 21-30 minutes of medical consultative discussion and review

99449 31 minutes or more of medical consultative discussion and review

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

99452 Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other QHP, 30 minutes

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

Table 3 - ITC Summary Table

ITC Code	Time	Written Report	Verbal report	Who Reports?
99446	5-10m	√	√	Consultative physician
99447	11-20m	√	√	Consultative physician
99448	21-30m	√	√	Consultative physician
99449	>30m	√	√	Consultative physician
99451	5m >	√		Consultative physician
99452	16m>	√		Treating/Requesting provider

Medical Team Conference

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

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

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

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

- Do not report 99366, 99367, 99368 during the same month with 99439, 99487, 99489, 99490, 99491