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2022 Coding and Payment Tip Sheet for Transition from Pediatric to Adult Health Care

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New in 2022:

- Codes 99424, 99425, 99426, 99427 have been added. These codes are for principal care management services for a single high-risk disease. Services may be provided by a physician or other qualified health care professional (99424, 99425) or clinical staff (99426, 99427).
- Code 99437 has been added. This is an add-on code for code 99491. Code 99437 is reported for each additional 30 minutes of chronic care management services provided personally by a physician or other qualified health care professional.

The American Academy of Pediatrics has created guidance on coding during the COVID-19 public health emergency. Stay up-to-date on how to bill for telemedicine and other services here and here.

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 establishing an organized clinical process to prepare all youth to take a more active role in their own health and health care, transfer to a new adult clinician, and integrate into adult health care.

In 2018, the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians published an updated 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] This clinical report calls for a structured transition process based on the Six Core Elements of Health Care Transition™, which can be customized for use in a variety of primary and specialty care settings and are available at no cost from Got Transition®, the national resource center on health care transition. The Six Core Elements were updated in July 2020. The updated customizable packages and new accompanying implementation guides are available on Got Transition's website at www.GotTransition.org.

To support the delivery of recommended transition services in pediatric and adult care settings, Got Transition and the American Academy of Pediatrics partner each year to develop and update 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 2022. It also includes a set of clinical vignettes with recommended CPT and ICD coding as well as detailed CPT coding descriptions for each transition-related code.[2] Coding tips are included for selected codes, and these mostly come from the AAP's 2020 Coding for Pediatrics manual.[3] A supplemental table (see Appendix A) lists each code and who is able to report it. Appendix B compares the prolonged services codes and what codes they should be reported with. Also included in this tip sheet is a letter template that can be customized and sent to payers encouraging recognition of transition-related CPT codes (available in Appendix C and on Got Transition's website).

Additional health system transition payment strategies are available in a 2018 report, *Recommendations for Transition Value-Based Payment for Pediatric and Adult Health Care Systems*.[4] The report includes the recommendations of key stakeholders representing Medicaid and commercial payers, health plans/accountable care organizations, employers, health professional organizations, and family advocacy groups. A prioritized set of value-based payment options are presented with examples for their potential use, including enhanced fee-for-service, infrastructure investments, pay-for-performance, direct payments to consumers, episode of care or bundled payments, and per member per month. In addition, this report includes a set of prioritized quality measures that can be used with the value-based payment options. Another resource, *A Guide for Designing a Value-Based Payment Initiative for Pediatric-to-Adult Transitional Care,* offers a step-by-step approach for payers and managed care organizations (MCOs) interested in starting a VBP HCT initiative. Steps include 1) defining the HCT intervention, 2) identifying transition-aged populations for the initiative, 3) selecting accountable pediatric and adult sites, 4) choosing VBP and FFS options, 5) choosing quality metrics, and 6) getting started. Each step includes strategies to consider and real-life examples from MCOs.[5]

Transition Coding and Payment

Transition Related Services		100% Medicare Payment, 2022		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
Office or Other Outpatient Visit, New Patient[a]				
99202†	Straightforward medical decision making or 15-29 minutes	$74.06	$49.49	2.14/1.43
99203†	Low level of medical decision making or 30-44 minutes	$113.85	$84.44	3.29/2.44
99204†	Moderate level of medical decision making or 45-59 minutes	$169.57	$136.69	4.90/3.95
99205†	High level of medical decision making or 60-74 minutes	$224.25	$185.49	6.48/5.36
Office or Other Outpatient Visit, Established Patient[a]				
99211	Evaluation and management (E/M) that may not require the presence of a physician or other qualified health care professional (QHP)	$23.53	$9.00	0.68/0.26
99212†	Straightforward medical decision making or 10-19 minutes	$57.45	$36.68	1.66/1.06
99213†	Low level of medical decision making or 20-29 minutes	$92.05	$67.48	2.66/1.95
99214†	Moderate level of medical decision making or 30-39 minutes	$129.77	$98.97	3.75/2.86
99215†	High level of medical decision making or 40-54 minutes	$183.07	$147.08	5.29/4.25
Office or Other Outpatient Consultations, New or Established Patient[b]				
99241†	Self-limited or minor problem(s) and straightforward medical decision making, typically 15 minutes	$46.72	$32.18	1.35/0.93
99242†	Low severity problem(s) and straightforward medical decision making, typically 30 minutes	$88.25	$67.83	2.55/1.96
99243†	Moderate severity problem(s) and low complexity medical decision making, typically 40 minutes	$121.47	$95.51	3.51/2.76
99244†	Moderate to high severity problem(s) and moderate complexity decision making, typically 60 minutes	$180.99	$152.61	5.23/4.41
99245†	Moderate to high severity problem(s) and high complexity medical decision making, typically 80 minutes	$220.79	$188.95	6.38/5.46
Prolonged Services[c]				
99354†	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the usual service; first hour	$128.39	$120.08	3.71/3.47
99355†	Each additional 30 minutes	$92.74	$84.79	2.68/2.45
99358	Prolonged E/M services before and/or after direct patient contact; first hour	$110.74	$110.74	3.20/3.20
99359	Each additional 30 minutes	$53.99	$53.99	1.56/1.56
99417	Prolonged office or other outpatient E/M service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes	$22.84	$22.84	0.66/0.66
Medical Team Conference[d]				
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 (QHP)	$43.61	$42.57	1.25/1.22
99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	NA	$56.06	NA/1.62
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician QHP	NA	$37.33	NA/1.07

Transition Related Services		100% Medicare Payment, 2022		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
Preventive Medicine Services[e]				
99384	Initial comprehensive preventive medicine E/M, new adolescent patient; ages 12 through 17 years	$137.04	$102.09	3.96/2.95
99385	Ages 18 through 39 years	$132.89	$97.94	3.84/2.83
99394	Periodic comprehensive preventive medicine reevaluation and management of an established adolescent patient; ages 12 through 17 years	$116.28	$85.82	3.36/2.48
99395	Ages 18 through 39 years	$118.70	$88.25	3.43/2.55
Health Risk Assessment[f]				
96160	Administration of patient-focused health risk assessment instrument (e.g., transition readiness assessment) with scoring and documentation, per standardized instrument	$2.77	NA	0.08/NA
General Behavioral Health Integration Care Management[g]				
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other QHP, per calendar month	$44.64	$30.45	1.29/0.88
Care Management Services[h]				
99490	Chronic care management services with required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions that place the patient at significant risk of death, acute exacerbation/decomposition, 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	$64.02	$51.56	1.85/1.49
99439	Each additional 20 minutes	$38.38	$28.26	1.10/0.81
99491	Chronic care management services with the following required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other QHP, per calendar month	$81.63	$81.63	2.33/2.33
99437	Each additional 30 minutes	$81.63	$81.63	2.33/2.33
99487	Complex chronic care management services with the following required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions that 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	$134.27	$92.74	3.88/2.68
99489	Each additional 30 minutes	$70.60	$51.22	2.04/1.48

Transition Related Services		100% Medicare Payment, 2022		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
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	$83.40	$75.44	2.41/2.18
99425	Each additional 30 minutes	$60.21	$52.60	1.74/1.52
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 QHP, per calendar month	$63.33	$50.53	1.83/1.46
99427	Each additional 30 minutes	$48.45	$35.64	1.40/1.03
Hospital Transitional Care Management Services[i]				
99495[†]	Includes communication (direct contact, telephone, electronic) with the patient and/or 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	$209.02	$144.65	6.04/4.18
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	$281.69	$195.87	8.14/5.66
Telephone Services[j,‡]				
Physician or Other Qualified Health Care Professional[§]				
99441	Telephone E/M service provided by a physician or other QHP 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	$56.75	$35.99	1.64/1.04
99442	11-20 minutes of medical discussion	$91.71	$67.14	2.65/1.94
99443	21-30 minutes of medical discussion	$129.77	$98.97	3.75/2.86
Qualified Nonphysician Health Care Professional[§]				
98966	Telephone assessment and management service provided by a nonphysician QHP to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 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	$14.37	$12.48	0.38/0.33

Transition Related Services		100% Medicare Payment, 2022		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
98967	11-20 minutes of medical discussion	$24.22	$22.15	0.70/0.64
98968	21-30 minutes of medical discussion	$34.26	$32.18	0.99/0.93
Online Digital Evaluation and Management Services[k]				
Physician or Other Qualified Health Care Professional				
99421	Online digital E/M service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	$15.23	$13.15	0.44/0.38
99422	11-20 minutes	$29.76	$25.95	0.86/0.75
99423	21 or more minutes	$48.45	$41.87	1.40/1.21
Qualified Nonphysician Health Care Professional‡				
98970	Nonphysician QHP online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	$11.77	$11.77	0.34/0.34
98971	11-20 minutes	$20.76	$20.42	0.60/0.59
98972	21 or more minutes	$32.18	$31.84	0.93/0.92
Interprofessional Telephone/Internet/Electronic Health Record (EHR) Consultations[l]				
99446	Interprofessional telephone/Internet/EHR 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	NA	$18.69	0.54/0.54
99447	11-20 minutes of medical consultative discussion and review	NA	$36.68	1.06/1.06
99448	21-30 minutes of medical consultative discussion and review	NA	$55.02	1.59/1.59
99449	31 minutes or more of medical consultative discussion and review	NA	$73.71	2.13/2.13
99451	Interprofessional telephone/Internet/EHR 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	$36.34	$36.34	1.05/1.05
99452	Interprofessional telephone/Internet/EHR referral service(s) provided by a treating/requesting physician or other QHP, 30 minutes	$37.03	$37.03	1.07/1.07
Digitally Stored Data Services/Remote Physiologic Monitoring[m]				
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	$19.03	$19.03	0.55/0.55
99454	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	$55.72	$55.72	1.61/1.61
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other QHP, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days	$56.41	$56.41	1.63/1.63
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and devise calibration	$11.77	$11.77	0.34/0.34
99474	Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other QHP, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient	$15.23	$9.00	0.44/0.26

Transition Related Services		100% Medicare Payment, 2022		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
Remote Physiologic Monitoring Treatment Management Services[n]				
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other QHP time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes	$50.18	$31.15	1.45/0.90
99458	Each additional 20 minutes	$40.84	$31.15	1.18/0.90
Education and Training for Patient Self-Management[o]				
98960[†]	Education and training for patient self-management by a nonphysician QHP using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	$29.42	NA	0.85/NA
98961[†]	2-4 patients	$13.84	NA	0.40/NA
98962[†]	5-8 patients	$10.38	NA	0.30/NA
Miscellaneous Services[p]				
99078	Physician or other QHP qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity or diabetic instructions)	NA	NA	NA/NA
Modifiers[q]				
25	Significant, separately identifiable E/M service by the same physician or other QHP on the same day of the procedure or other service	NA	NA	NA/NA
59	Distinct procedural service	NA	NA	NA/NA
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system	NA	NA	NA/NA

NA: Certain CPT codes do not have assigned RVUs.

[a-q]Full descriptions of these services can be found following the vignettes.

*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.

[†]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.

[‡]After the end of the public health emergency (PHE), there will be no separate payment for the audio-only E/M visit codes. At the conclusion of the PHE, CMS will assign a status of “bundled” and post the RUC-recommended RVUs for these codes in accordance with our usual practice.

[§]Nonphysician healthcare professionals are healthcare professionals who may report their services through their own National Provider Identifier (NPI) numbers but who otherwise typically would not report those Evaluation and Management services reported by physicians and QHPs. Such nonphysician healthcare professionals may include speech-language pathologists, physical therapists, occupational therapists, social workers, and dieticians.

Transition Clinical Vignettes

Vignette #1: Transition from Hospital to Outpatient Management

A 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. Primary care physician communicates with parent within 1 day of hospital discharge regarding recommended follow-up treatment. Primary care 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. Physician 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 hour to 5 hours 59 minutes, subsequent encounter)

Vignette #2: Routine Preventive Visit

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 youth and their parent separately complete a scorable transition readiness assessment form, which asks a set of questions about the youth's self-care skills. In addition to risk factor assessment and risk factor reduction counseling, the physician also reviews and discusses a few of the specific self-care skill needs identified by the youth and parent.

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

Vignette #3: Office Visit for Chronic Condition with Health Risk Assessment and Patient Education

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, knowing his symptoms, and appropriate emergency department usage. 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 cell phone given that patient often forgets to take his meds. The physician reviews the scorable 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 30 minutes. After the physician meets with the patient, the nurse, who is a qualified, nonphysician health care professional, 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 level of medical decision making or 30-39 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: Final Preventive Care Visit with Transfer Planning

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 20 minutes to re-assesses her depression and determines that a different medication is required. The physician reviews the last scorable 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. The day after 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 physician that includes an updated medical summary, updated plan of care, and scorable transition readiness assessment.

Coding: CPT 99395 (Preventive medicine visit, established visit, ages 18-39)
CPT 99213-25 (Office visit, established patient, low level of medical decision making or 20-29 minutes, with significant, separately identifiable E/M service above and beyond the service performed by the same physician or other qualified health care professional on the same day of the other service)
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)
F32.9 (Major depressive disorder, single episode, unspecified)

Vignette #5: Final Office Visit with Transfer Planning of Medically Complex Young Adult

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. She has a legal document to allow her parent in the room with her. 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 scorable 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 the selection of an adult physician. The physician discusses with the young adult and parent the actions they need to take place prior to the transfer, including coordinating transfer plans with her other physicians, preparing an updated medical summary and emergency care plan, and consulting with the new adult doctor. The pediatric physician calls the new adult physician about the pending transfer on the day of the visit to discuss the medical situation for 20 minutes. Three days after this last pediatric visit, the physician 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 level of medical decision making or 40-54 minutes)
	CPT 99417 (Prolonged office services on date of the primary service; each 15 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)
	G80.0 (Spastic quadriplegic cerebral palsy)

Vignette #6: Initial Adult Specialist Visit with New Young Adult

A 23-year-old female with pediatric-onset systemic lupus erythematosus with rash, arthritis, and renal disease on hydroxychloroquine, prednisone, and mycophenolate mofetil is transferred to an adult rheumatologist. Prior to the initial visit, the medical assistant makes a pre-visit call to determine need for special accommodations and offers an appointment reminder. During the visit, the new adult physician receives and reviews the transfer letter, plan of care, medical summary and emergency care plan, and transition readiness assessment from the pediatric rheumatologist. The nurse has her fill out a post-transfer self-care assessment form while waiting to see the adult rheumatologist. The adult physician spends 45-minutes 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 scorable post-transfer self-care assessment and reviews the skills the young adult still needs to focus on to manage their own health and health care. The physician also assesses if she needs 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. The insurer requires new prior authorizations for medications.

Coding:	CPT 99204 (Office visit, new patient, moderate level of medical decision making or 45-59 minutes)
	CPT 96160 (Patient-focused health risk assessment instrument)
ICD-10-CM:	M32.14 (Glomerular disease in systemic lupus erythematosus)

Vignette #7: Initial Primary Care Office Visit with New Young Adult

New adult office visit with a 22-year-old young adult male transitioning from his pediatric primary care physician, who he saw for a preventive office visit 6 months earlier. The young adult male comes with no previous medical records from the physician. The physician completes a medical history and a physical exam, noting his BMI is 27. The patient fills out a scorable post-transfer self-care assessment form, the physician and young adult jointly fill out a medical summary, and the physician assists the young adult to put his emergency contact information and key medical information into his phone. The physician spends a total of 45 minutes, including counseling the patient, reviewing and discussing needed self-care skills, interfacing with the pediatric practice, and discussing nutrition, exercise, and weight reduction strategies.

Coding: CPT 99204 (Office visit, new patient, moderate level of medical decision making or 45-59 minutes)
CPT 96160 (Patient-focused health risk assessment instrument)
ICD 10-CM: E66.3 (Overweight and obesity)
Z71.89 (Persons encountering health services for other counseling and medical advice, not elsewhere classified)

Vignette #8: Non-Face-to-Face Services for Young Adult with Chronic Conditions Prior to Initial Adult Physician Visit

A new 24-year-old female patient with spina bifida and hydrocephalus is referred by her pediatric primary care physician to an adult primary care physician. The young adult requested that her records from her urologist, neurologist, neurosurgeon, physiatrist, and pediatric primary care physician be sent to the new adult physician's office prior to her initial visit. Upon receipt, the adult physician reviews the extensive medical records from all five physicians. The adult physician calls the pediatric primary care physician to clarify the lengthy plan of care. The total time spent reviewing the records and tests as well as discussing the case is reported as 60 minutes. A face-to-face appointment is scheduled in 2 weeks.

Coding: CPT 99358 (Prolonged service without direct patient contact, new patient, 60 minutes)
ICD-10-CM: Q05.2 (Lumbar spina bifida with hydrocephalus)

Vignette #9: Interprofessional Consultation between Adult and Pediatric Primary Care Physicians

After a patient's second visit to the adult primary care physician, the adult primary care physician asked the patient's previous pediatric physician for an interprofessional consultation on this 19-year-old with an established diagnosis of ADHD. The young adult presents with his mother to the adult physician for review of his pharmacologic management of ADHD. The young adult has signed a HIPAA form to allow his mother to be present during the visit. At the prior visit, the adult physician had prescribed a new medication, Adderall XR, but the young adult's focus had not improved. The mother and patient agree with the adult physician that an interprofessional consultation with the patient's former pediatric physician is warranted to determine subsequent management. The adult physician communicates by telephone with the consulting pediatric physician for this interprofessional consultation and states that there was only minimal improvement in the clinical course since Adderall XR 10 mg was added 1 month ago. The adult primary care physician also reviews that the patient (a college freshman) and mother notes inattentiveness, hyperactivity, forgetfulness, and persistent organizational weaknesses. Grades are Cs. The patient denies side effects to his medication. Psychosocial stressors are denied. The patient's extracurricular activities include pickup basketball, and he reports sleeping 6 hours nightly. The consulting pediatric physician spends 25 minutes via telephone discussing the patient with the adult physician along with making recommendations on pharmacologic and behavioral management and the importance of adequate sleep. Included in this time, the pediatric physician dictates a consultation report to be sent back to the adult physician and the adult physician contacts the patient with recommendations. Total physician time was 50 minutes: 25 minutes face-to-face with patient and 25 minutes for interprofessional consultation.

For the adult physician (if the face-to-face E/M visit with the young adult were on the same day as the interprofessional consultation with the pediatric physician):

Coding: CPT 99215 (Office visit, established patient, high level of medical decision making or 40-54 minutes; total physician time was 50 minutes – 25 minutes face-to-face with patient and 25 minutes for interprofessional consultation)

ICD-10-CM: F90.2 (Attention-deficit hyperactivity disorder, combined type)

For the adult physician (if the interprofessional consultation with the pediatric physician occurred on a different day than the adult physician's face-to-face E/M visit with the young adult):

Coding: CPT 99213 for the 25 minutes spent with the patient on the previous day (Office visit, established patient, low level of medical decision making or 20-29 minutes)
CPT 99452 (Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.) *(Note: The adult physician may report 99452 if spending at least 16 minutes that day preparing for the referral and communicating with the consultant. The CPT halfway point regarding time [according to CPT Professional Edition 2022]: "A unit of time is attained when the mid-point is passed. For example, 60 minutes is attained when 31 minutes have elapsed [more than midway between zero and 60 minutes].")*

ICD-10-CM: F90.2 (Attention-deficit hyperactivity disorder, combined type)

For the pediatric physician (regardless of what day the consultation was done):

Coding: CPT 99448 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review)

ICD-10-CM: F90.2 (Attention-deficit hyperactivity disorder, combined type)

Vignette #10: Initial Specialist Office Visit with New Young Adult

An adult rheumatologist provides a first evaluation and management visit via telehealth to a 19-year-old female college student with juvenile arthritis who is taking etanercept and methotrexate. Her last visit before leaving for college was with her pediatric rheumatologist and the two of them chose this adult rheumatologist to take over her care now that she is going to college. Although the patient scheduled a visit to the office of the adult rheumatologist just before spring break, her symptoms have deteriorated, and she requested this telehealth office visit with the college clinic as the originating site and the adult rheumatologist's office as the distant site. Prior to the telehealth visit, the rheumatologist's staff guides the patient through completion of an online scorable post-transition self-care skills assessment. Via a secure real-time, two-way audio-visual telehealth platform, the rheumatologist conducts a comprehensive history. The patient tells the adult rheumatologist she has been at college for 4 months and that her morning stiffness has returned in the past month and her hands are swollen in the morning making it difficult to take notes in class. She recently decided on her own to lower her methotrexate dose from eight 2.5 mg tablets to four tablets each week since she did not have a refill on her medications. She denies any side effects of her medications or any recent infections. Using the college clinic staff nurse as tele-presenter, the rheumatologist performs a comprehensive physical exam. The patient's vitals are normal and the adult rheumatologist can see that her hands are swollen and she cannot make a fist in both hands. The adult rheumatologist discusses the scorable post-transition self-care skills assessment with her that she took prior to the telemedicine visit and discusses how to get her methotrexate refilled at a local pharmacy. The adult rheumatologist also notes she needs to get her routine methotrexate monitoring lab tests as it has been 4 months since her last test at the pediatric rheumatologist's office. The adult rheumatologist discusses how she can get these at college, have the results faxed to the office, and that the office will let her know the results. The adult rheumatologist instructs her to increase the methotrexate dose back to 8 tablets a week, if the lab results are normal, and to continue her etanercept. The adult rheumatologist scheduled a follow-up visit in one month.

Coding: CPT 99204-95 (Office visit, new patient, moderate level of medical decision making or 45-59 minutes, service rendered via a real-time interactive audio and video telecommunications system)
CPT 96160 (Patient-focused health risk assessment instrument)
ICD-10-CM: M08.99 (Juvenile arthritis, unspecified, multiple sites)

Vignette #11: Telehealth Follow-Up Visit

A 20-year-old male patient has focal epilepsy since age 16 that has been well-controlled on oxcarbazepine over the past year. He is living at home and going to a local junior college and has not been seen by the pediatric neurologist for over a year. He is interested in stopping his medications and wants to transfer to an adult neurologist who practices in closer proximity. As his family lives over 5 hours away, a follow-up telehealth visit was arranged with the pediatric neurologist at the university health system where his original evaluation was performed. The visit was executed with the patient coming to his local pediatric primary care physician's office (hosting facility or originating site), while the treating pediatric neurologist conducted the visit from her university office setting (performing physician at distant site). The patient completed an online scorable transition readiness assessment, and issues discussed included need for an EEG, possible medication weaning, and subsequent transition to an adult neurologist's care. The pediatric neurologist spent 30 minutes communicating with the patient via real-time synchronous 2-way audio-visual communication. A follow-up 30-minute telehealth visit was arranged in one month.

Coding: CPT 99214-95 (detailed history, moderate level of medical decision making or 30-39 minutes; modifier 95: synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system)
CPT 96160 (Patient-focused health risk assessment instrument)
ICD-10-CM: G40.209 (focal epilepsy, not intractable)

CPT Description of Selected Transition-Related Codes[2,3]

[a]**Office or Other Outpatient Services** are evaluation and management (E/M) services provided to new patients (99202-99205) or established patients (99211-99215) in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a health care facility occurs. Codes 99202-99205 and 99212-99215 require a medically appropriate history and/or examination. Code 99211 may not require the presence of a physician/QHP. For new patients, if services are 75 minutes or longer, use prolonged services code 99417. For established patients, if services are 55 minutes or longer, use prolonged services code 99417.

> **Coding Tip** A new patient is one who has not received any professional services from the physician/ qualified health care professional (QHP) or another physician/QHP of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the physician/QHP or another physician/QHP of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. In the instance where a physician/QHP is on call for or covering for another physician/QHP, the patient's encounter will be classified as it would have been by the physician/QHP who is not available. When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician.

[b]**Office or Other Outpatient Consultations** (99241-99245) are a type of E/M service provided at the request of another physician or 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 (e.g., physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist, social worker, lawyer, or insurance company), is not reported using the consultation codes but may be reported using the office visit, home service, or domiciliary/rest home care 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), modifier 32 should also 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 services code for the site of service should be reported. In the office setting, the consultant should use the appropriate office or other outpatient consultation codes and then the established patient office or other outpatient services codes.

> **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 QHP who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician or other QHP who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician or other QHP transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician or other QHP 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, regardless of site of service.

[c]**Prolonged Services**

Prolonged service with direct patient contact (99354, 99355) codes are used when a physician or other QHP provides prolonged service(s) involving direct patient contact that is provided beyond the usual service in an outpatient setting, except with office or other outpatient services (99202-99205, 99212-99215). Direct patient contact is face-to-face. This service is reported in addition to the primary procedure. Codes 99354 and 99355 are used to report the total duration of face-to-face time spent by a physician or other QHP on a given date providing prolonged service in the outpatient setting, even if the time spent by the physician or other QHP on that date is not continuous. Time spent performing separately reported services other than the E/M or psychotherapy service is not counted toward the prolonged services time. Code 99354 is used to report the first hour of prolonged service on a given date. It should be used only once per date, even if the time spent by the physician or other QHP is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported. Code 99355 is used to report each additional 30 minutes beyond the first hour. 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. The use of the time-based add-on code requires that the primary E/M service has a typical or specified time published in the CPT codebook.

> **Coding Tip** For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other QHP, use 99415, 99416. Do not report 99354 or 99355 with 99415, 99416, or 99417. For prolonged total time in addition to office or other outpatient services (i.e., 99205, 99215), use 99417.

Prolonged service without direct patient contact (99358, 99359) codes are used when a prolonged service is provided that is not face-to-face time in the outpatient, inpatient, or observation setting. Codes 99358, 99359 may be used during the same session of an E/M service, except office or other outpatient services (99202-99205, 99212-99215). For prolonged total time in addition to office or other outpatient services (i.e., 99205, 99215) on the same date of service without direct patient contact, use 99417. Codes 99358, 99359 may also be used for prolonged services on a date other than the date of a face-to-face encounter. This service is to be reported in relation to other physician or other QHP 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 at an earlier date. However, it must relate to a service or patient where face-to-face patient care has occurred or will occur and relate to ongoing patient management. Codes 99358 and 99359 are used to report 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 QHP on that date 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. It may also be used to report the final 15 to 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. Do not report 99358, 99359 for time without direct patient contact reported in other services such as care plan oversight services (99339, 99340, 99374-99380), chronic care management by a physician or other QHP (99491), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), interprofessional telephone/Internet/EHR consultations (99446-99449, 99451, 99452), online digital E/M services (99421, 99422, 99423), or principal care management services (99424).

> **Coding Tip** The prolonged service must relate to a service and patient where direct (face-to-face) patient care has occurred or will occur and to ongoing patient management. The primary service may be an E/M service (with or without an assigned average time), a procedure, or other face-to-face service.

Prolonged service with or without direct patient contact on the date of an office or other outpatient service (99417) is used to report prolonged total time (i.e., combined time with and without direct patient contact) provided by the physician or other QHP on the date of office or other outpatient services (i.e., 99205, 99215). Code 99417 is only used when the office or other outpatient service has been selected using time alone as the basis and only after the minimum time required to report the highest-level service (i.e., 99205 or 99215) has been exceeded by 15 minutes. To report a unit of 99417, 15 minutes of additional time must have been attained. Do not report 99417 for any additional time increment of less than 15 minutes. The listed time ranges for 99205 (i.e., 60-74 minutes) and 99215 (i.e., 40-54 minutes) represent the complete range of time for which each code may be reported. Therefore, when reporting 99417, the initial time unit of 15 minutes should be added once the minimum time in the primary E/M code has been surpassed by 15 minutes. For example, to report the initial unit of 99417 for a new patient encounter (99205), do not report 99417 until at least 15 minutes of time has been accumulated beyond 60 minutes (i.e., 75 minutes) on the date of the encounter. For an established patient encounter (99215), do not report 99417 until at least 15 minutes of time has been accumulated beyond 40 minutes (i.e., 55 minutes) on the date of the encounter. Time spent performing separately reported services other than the E/M service is not counted toward the time to report 99205, 99215 and prolonged services time. For prolonged services on a date other than the date of a face-to-face encounter, including office or other outpatient services (99202-99205, 99212-99215), see 99358, 99359. For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other QHP, see 99415, 99416. Do not report 99417 in conjunction with 99354, 99355, 99358, 99359, 99415, 99416. Prolonged services of less than 15 minutes total time is not reported on the date of office or other outpatient service when the highest level is reached (i.e., 99205, 99215).

[d]**Medical Team Conference** (99366-99368) codes include face-to-face participation by a minimum of 3 QHPs 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 services 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 QHPs 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 service). 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 QHPs 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 should not report 99366-99368 when their participation in the medical team conference 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 (99374-99380), home, domiciliary, or rest home care plan oversight (99339, 99340), prolonged services (99354-99359), psychotherapy, or any E/M service. For team conferences where the patient is present for any part of the duration of the conference, nonphysician QHPs (e.g., speech-language pathologists, physical therapists, occupational therapists, social workers, dieticians) report the team conference face-to-face code 99366. Do not report 99366 for the same time reported for 99424, 99425, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491. Do not report 99367, 99368 during the same month with 99424, 99425, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491.

[e]**Preventive Medicine Services** (99384, 99385, 99394, 99395) are used to report the preventive medicine E/M of adolescents and adults. 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 99202-99205, 99211-99215 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. An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine E/M service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported. The "comprehensive" nature of the preventive medicine services codes reflects an age- and gender-appropriate history/exam and is **not** synonymous with the "comprehensive" examination required in E/M codes 99202-99350. Codes 99384, 99385, 99394, 99395 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination.

[f]**Health Risk Assessment** (96160) Code 96160 will allow reporting administration of a patient-focused health risk assessment instrument 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.[6]

> **Coding Tip** CPT 96160 can be used to report transition readiness assessments conducted with youth and parents/caregivers, and self-care assessments conducted with young adults. A standardized, scorable instrument must be used and recorded in the clinical documentation for the encounter. The transition readiness assessment 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, parent/caregiver or young adult during the patient's medical encounter. Physician services, reported separately via the 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 96160 should be separately reported when performed in conjunction with a preventive medicine service or an office outpatient service (i.e., E/M codes). The CMS 1500 Claim Form allows for reporting of multiple same-procedure units on a single CPT line item, but some payers may prefer separate, individual line items for the additional procedures along with an appropriate, differentiating modifier (such as 59).

[g]**General Behavioral Health Integration Care Management** (99484) services are reported by the supervising physician or other QHP. The services are performed by clinical staff for a patient with a behavioral health (including substance use) condition that requires care management services (face-to-face or non-face-to-face) of 20 or more minutes in a calendar month. A treatment plan as well as the specified elements of the service description is required. The assessment and treatment plan is not required to be comprehensive and the office/practice is not required to have all the functions of chronic care management (99439, 99487, 99489, 99490). Code 99484 may be used in any outpatient setting, as long as the reporting professional has an ongoing relationship with the patient and clinical staff and as long as the clinical staff is available for face-to-face services with the patient. The reporting professional must be able to perform the E/M services of an initiating visit. General behavioral integration care management (99484) and chronic care management services may be reported by the same professional in the same month, as long as distinct care management services are performed. Behavioral health integration care management (99484) and psychiatric collaborative care management (99492-99494) may not be reported by the same professional in the same month. Behavioral health care integration clinical staff are not required to have qualifications that would permit them to separately report

services (e.g., psychotherapy), but, if qualified and they perform such services, they may report such services separately, as long as the time of the service is not used in reporting 99484.

[h]**Care Management Services** (99490, 99439, 99491, 99437, 99487, 99489, 99424, 99425, 99426, 99427) are management and support services provided by clinical staff, under the direction of a physician or other QHP, or may be provided personally by a physician or other QHP, to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services 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. Care management services improve care coordination, reduce avoidable hospital services, improve patient engagement, and decrease care fragmentation. The physician or other QHP provides or oversees the management and/or coordination of care management services, which 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.

There are three general categories of care management services: chronic care management (99437, 99439, 99490, 99491), complex chronic care management (99487, 99489), and principal care management (99424, 99425, 99426, 99427). Complex chronic care management addresses all of the patient's medical conditions, and principal care management services address a single condition. Each of the three categories is further subdivided into those services that are personally performed by the physician or other QHP and those services that are performed by the clinical staff and overseen by the physician or other QHP. Code selection for these services is based on time in a calendar month, and time used in reporting these services may not represent time spent in another reported service. Chronic care management services do not require moderate or high-level medical decision making and may be reported for a shorter time threshold than complex chronic care management services. Both chronic care and complex chronic care management address, as needed, all medical conditions, psychosocial needs, and activities of daily living. Principal care management services are disease-specific management services. A patient may have multiple chronic conditions of sufficient severity to warrant complex chronic care management but may receive principal care management if the reporting physician or other QHP is providing single disease rather than comprehensive care management.

Care Planning:
A plan of care for health problems is based on a physical, mental, cognitive, social, functional, and environmental evaluation. It is intended to provide a simple and concise overview of the patient, and his or her medical condition(s) and be a useful resource for patients, caregivers, health care professionals, and others, as necessary. A typical plan of care is not limited to, but may include: problem list, expected outcome and prognosis, measurable treatment goals, cognitive assessment, functional assessment, symptom management, planned interventions, medical management, environmental evaluation, caregiver assessment, interaction and coordination with outside resources and other health care professionals and others, as necessary, and summary of advance directives. These elements are intended to be a guide for creating a meaningful plan of care rather than a strict set of requirements, so each should be addressed only as appropriate for the individual. The plan of care should include specific and achievable goals for each condition and be relevant to the patient's well-being and lifestyle. When possible, the treatment goals should also be measurable and time bound. The plan should be updated periodically based on status or goal changes. The entire care plan should be reviewed, or revised as needed, but at least annually. An electronic and/or printed plan of care must be documented and shared with the patient and/or caregiver.

Codes 99424, 99426, 99487, 99490, 99491 are reported only once per calendar month. Codes 99427, 99439 are reported no more than twice per calendar month. Codes 99437, 99439, 99487, 99489, 99490, 99491 may only be reported by the single physician or other QHP who assumes the care management role with a particular patient for the calendar month. Codes 99424, 99425, 99426, 99427 may be reported by different physicians or QHPs in the same calendar month for the same patient, and documentation in the patient's medical record should reflect coordination among relevant managing clinicians.

For 99426, 99427, 99439, 99487, 99489, 99490, the face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals, and agencies; creating, 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 professional is counted, and the reporting professional's time is additionally included only if he or she is not otherwise reporting his or her care management time with another service. Only count the time of one clinical staff member or physician or other QHP when two or more are meeting about the patient at the same time. For 99424, 99425, 99437, 99491, only count the time personally spent by the physician or other QHP. Time spent by the physician or other QHP that does not meet the threshold to report 99424, 99425, 99437, 99491 may be used toward the time necessary to report 99426, 99427, 99439, 99487, 99489, 99490. Do not count clinical staff time spent as part of a separately reported service.

Care management activities performed by clinical staff, or personally by the physician or other QHP, 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 (99495, 99496)
- Ongoing review of patient 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 or disease-specific (as applicable) care plan

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

- Provide 24/7 access to physicians or other QHPs 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 EHR system for timely access to clinical information
- Be able to engage and educate patients and caregivers as well as coordinate and integrate care among all service professionals, as appropriate for each patient
- Reporting physician or other QHP oversees activities of the care team
- All care team members providing services are clinically integrated

Each minute of service time is counted toward only one service. Do not count any time and activities used to meet criteria for another reported service. However, time of clinical staff and time of a physician or other QHP are reported separately when each provides distinct services to the same patient at different times during the same calendar month. If the care management services are performed within the postoperative period of a reported surgery, the same individual may not report 99439, 99487, 99489, 99490, 99491. When behavioral or psychiatric collaborative care management services are also provided, 99484, 99492, 99493, 99494 may be reported in addition.

Chronic Care Management Services (99490, 99439, 99491, 99437) 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 two 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. Code 99439 is reported in conjunction with 99490 for each additional 20 minutes of clinical staff time spent in care management activities during the calendar month up to a maximum of 60 minutes total time (i.e., 99439 may only be reported twice per calendar month). Code 99491 is reported for at least 30 minutes of physician or other QHP time personally spent in care management during the calendar month. Code 99437 is reported in conjunction with 99491 for each additional minimum 30 minutes of physician or other QHP time. If reporting 99437, 99491 do not include any time devoted to the patient and/or family on the date that the reporting physician or other QHP also performed a face-to-face E/M encounter.

Complex Chronic Care Management Services (99487, 99489) are services that require at least 60 minutes of clinical staff time, under the direction of a physician or other QHP. Complex chronic care management services require moderate or high medical decision making as defined in the E/M guidelines. 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 a caregiver, and/or repeat admissions or emergency department visits. Typical adult patients who receive complex chronic care management services are treated with three or more prescription medications and may be receiving other types of therapeutic interventions (e.g., physical therapy, occupational therapy). Typical pediatric patients receive three or more therapeutic interventions (e.g., medications, nutritional support, respiratory therapy). All patients have two 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 the 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 comorbidities (e.g., dementia and COPD or substance abuse and diabetes) that complicate their care; and/or social support requirements or difficulty with access to care.

Coding Tip Chronic care management (CCM) codes were 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 EHR. Health plans may adopt the CMS requirement for use of an EHR that meets certification requirements for Medicare and Medicaid EHR incentive programs and/or MIPS in place on December 31 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. 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 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. Check with payers for the level of supervision required.

To report code 99490, physicians must meet the required practice capabilities 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 CCM when provided on a date

when no face-to-face service was provided. CCM may be reported even if no substantial revision is made to the care plan (e.g., management is limited to review of care plan, change of medication dose, or education to patient/caregiver).

Principal Care Management (99424, 99425, 99426, 99427) represents services that focus on the medical and/or psychological needs manifested by a single, complex chronic condition expected to last at least 3 months and includes establishing, implementing, revising, or monitoring a care plan specific to that single disease. Code 99424 is reported for at least 30 minutes of physician or other QHP personal time in care management activities during a calendar month. Code 99425 is reported in conjunction with 99424, when at least an additional 30 minutes of physician or other QHP personal time is spent in care management activities during the calendar month. Code 99426 is reported for the first 30 minutes of clinical staff time spent in care management activities during the calendar month. Code 99427 is reported in conjunction with 99426, when at least an additional 30 minutes of clinical staff time is spent in care management activities during the calendar month.

[i]**Hospital Transitional Care Management Services (TCM)** (99495, 99496) are for new or established 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 timeframes, in combination with non-face-to-face services that may be performed by the physician or other QHP and/or licensed clinical staff under his or her direction. Non-face-to-face services provided by clinical staff, under the direction of the physician or other QHP, 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 QHP 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 QHPs 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 resources
- 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 2 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 individual provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activity of daily living support by providing first contact and continuous access. 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 Services Guidelines. The medical decision-making over the service period reported 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. The same individual should not report TCM services provided in the post-operative period of a service that the individual reported.

[j]**<u>Telephone Services</u>**
Codes 99441-99443 are non-face-to-face E/M services provided to a patient using the telephone by a physician or other QHP 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 the 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) is considered part of that previous E/M service or procedure. (Do not report 99441-99443, if 99421, 99422, or 99423 have been reported by the same provider in the previous 7 days for the same problem.)

Codes 98966-98968 are non-face-to-face assessment and management services provided by a nonphysician QHP to a patient using the telephone. These codes are used to report episodes of care by the QHP initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or the next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent assessment and management service, procedure, and visit. Likewise, if the telephone call refers to a service performed and reported by the QHP within the previous seven days (either QHP 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 service or procedure. (Do not report 98966-98968 if reporting 98966-98968 performed in the previous seven days.) Do not report 98966-98968 during the same month with 99426, 99427, 99439, 99487, 99489, 99490, 99491.

Note: After the end of the public health emergency (PHE), there will be no separate payment for the audio-only E/M visit codes. At the conclusion of the PHE, CMS will assign a status of "bundled" and post the RUC-recommended RVUs for these codes in accordance with our usual practice.

[k]**<u>Online Digital Evaluation and Management Services</u>**
Codes 99421-99423 are patient-initiated services with physicians or other QHPs. Online digital E/M services require physician or other QHP's evaluation, assessment, and management of the patient. These services are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. While the patient's problem may be new to the physician or other QHP, the patient is an established patient. Patients initiate these services through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms, such as EHR portals, secure email, or other digital applications, which allow digital communication with the physician or other QHP.

Online digital E/M services are reported once for the physician's or other QHP's cumulative time devoted to the service 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. Physician's or other QHP's cumulative service time includes review of the initial inquiry, review of patient records or data pertinent to assessment of the patient's problem, personal physician or other QHP interaction with clinical staff focused on the patient's problem, development of management plans, including physician or other QHP generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication, which does not otherwise represent a separately reported E/M services. 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. Online digital E/M services require permanent documentation storage (electronic or hard copy) of the encounter.

If within seven days of the initiation of an online digital E/M service, a separately reported E/M visit occurs, then the physician or other QHP work devoted to the online digital E/M service is incorporated into the separately reported E/M visit (e.g., additive of visit time for a time-based E/M visit or additive of decision-making complexity for a key component-based E/M visit). This includes E/M visits and procedures that are provided through synchronous telemedicine visits using interactive audio and video telecommunication equipment, which are reported with modifier 95 appended to the E/M service code. If the patient initiates an online digital inquiry for the same or a related problem within seven days of a previous E/M service, then the online digital visit is not reported. 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. 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. If the patient presents a new, unrelated problem during the seven-day period of an online digital E/M service, then the physician's or other QHP's time spent on evaluation, assessment, and management of the additional problem is added to the cumulative service time of the online digital E/M service for the seven-day period.

Report 99421, 99422, 99423 once per 7-day period. Clinical staff time is not calculated as part of cumulative time for 99421, 99422, 99423. Do not report online digital E/M services for cumulative service time less than 5 minutes. Do not count 99421, 99422, 99423 time otherwise reported with other services. 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). Do not report 99421-99423 when using 99091, 99339, 99340, 99374, 99375, 99377- 99380, 99424-99427, 99437, 99487, 99489, 99491, 99495, 99496, for the same communication(s).

Codes 98970-98972 are patient-initiated digital services with nonphysician QHPs that require nonphysician QHP patient evaluation and decision making to generate an assessment and subsequent management of the patient. These services are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. While the patient's problem may be new to the nonphysician QHP, the patient is an established patient. Patients initiate these services through HIPAA-compliant, secure platforms, such as through the EHR portal, email, or other digital applications, which allow digital communication with the nonphysician QHP.

Nonphysician QHP online digital assessments are reported once for the nonphysician QHP's cumulative time devoted to the service during a seven-day period. The seven-day period begins with the nonphysician QHP's initial, personal review of the patient-generated inquiry. Nonphysician QHP cumulative service time includes review of the initial inquiry, review of patient records or data pertinent to assessment of the patient's problem, personal nonphysician QHP interaction with clinical staff focused on the patient's problem, development of management plans, including nonphysician QHP generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication. All nonphysician QHPs in the same group practice who are involved in the online digital assessment contribute to the cumulative service time devoted to the patient's online digital assessment. Nonphysician QHPs online digital assessments require visit documentation and permanent storage (electronic or hard copy) of the encounter.

If the patient generates the initial online digital inquiry within seven days of a previous treatment or E/M service and both services relate to the same problem, or the online digital inquiry occurs within the postoperative period of a previously completed procedure, then the nonphysician QHP's online digital assessment may not be reported separately. If the patient generates an initial online digital inquiry for a new problem within seven days of a previous service that addressed a different problem, then the nonphysician QHP online digital assessment is reported separately. If a separately reported evaluation service occurs within seven days of the nonphysician QHP's initial review of the online digital assessment, codes 98970, 98971, 98972 may not be reported. If the patient presents a new, unrelated problem during the seven-day period of an online digital assessment, then the nonphysician QHP's time spent assessing the additional problem is added to the cumulative service time of the online digital assessment for that seven-day period. Report 98970, 98971, 98972 once per 7-day period. Do not report online digital E/M services for cumulative visit time less than 5 minutes. Do not count 98970, 98971, 98972 time otherwise reported with other service. Do not report 98970, 98971, 98972 when using 99091, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99426, 99427, 99437, 99439, 99487, 99489, 99490, 99491, for the same communication.

Interprofessional Telephone/Internet/Electronic Health Record Consultations (99446-99449, 99451, 99452) are assessment and management services in which a patient's treating (e.g., 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 for whom the interprofessional telephone/Internet/EHR consultation is requested may be either a new patient to the consultant or an established patient with a 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/EHR consultation leads to a transfer of care or other face-to-face service (e.g., a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported.

Review of pertinent medical records, laboratory studies, imaging studies, medication profile, pathology specimens, etc. is included in the telephone/Internet/EHR consultation service and should not be reported separately when reporting 99446, 99447, 99448, 99449, 99451. The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion. If greater than 50% of the time for the service is devoted to data review and/or analysis, 99446, 99447, 99448, 99449 should not be reported. However, the service time for 99451 is based on total review and interprofessional-communication time. If more than one telephone/Internet/EHR contact(s) is required to complete the consultation request (e.g., discussion of test results), the entirety of the service and the cumulative discussion and information review time should be reported with a single code. Codes 99446, 99447, 99448, 99449, 99451 should not be reported more than once within a seven-day interval. The written or verbal request for telephone/Internet/EHR advice by the treating/requesting physician or other QHP should be documented in the patient's medical record, including the reason for the request. Codes 99446, 99447, 99448, 99449 conclude with a verbal opinion report and written report from the consultant to the treating/requesting physician or other QHP. Code 99451 concludes with only a written report.

Telephone/Internet/EHR consultations of less than five minutes should not be reported. Consultant communications with the patient and/or family may be reported using 98966, 98967, 98968, 99421, 99422, 99423, 99441, 99442, 99443, and the time related to these services is not used in reporting 99446-99449. Do not report 99358, 99359 for any time within the service period, if reporting 99446, 99447, 99448, 99449, 99451. When the sole purpose of the telephone/Internet/EHR communication is to arrange a transfer of care or other face-to-face service, these codes are not reported.

The treating/requesting physician or other QHP may report 99452 if spending 16-30 minutes in a service day preparing for the referral and/or communicating with the consultant. Do not report 99452 more than once in a

14-day period. The treating/requesting physician or other QHP may report the prolonged service codes 99354-99357 for the time spent on the interprofessional telephone/Internet/EHR discussion with the consultant (e.g., specialist) if the time exceeds 30 minutes beyond the typical time of the appropriate E/M service performed and the patient is present (on-site) and accessible to the treating/requesting physician or other QHP. If the interprofessional telephone/Internet/EHR assessment and management service occurs when the patient is not present and the time spent in a day exceeds 30 minutes, then the non-face-to-face prolonged service codes 99358, 99359 may be reported by the treating/requesting physician or other QHP.

> **Coding tip** The CPT half-way point regarding time (according to CPT Professional Edition 2022): "A unit of time is attained when the mid-point is passed. For example, a half hour is attained when 16 minutes have elapsed (more than midway between zero and 30 minutes)."

[m]**Digitally Stored Data Services/Remote Physiologic Monitoring** (99453, 99454, 99091, 99473, 99474). Codes 99453 and 99454 are used to report remote physiologic monitoring services (e.g., weight, blood pressure, pulse oximetry) during a 30-day period. To report 99453, 99454, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other QHP. Code 99453 may be used to report the set-up and patient education on use of the device(s). Code 99454 may be used to report supply of the device for daily recording or programmed alert transmissions. Codes 99453, 99454 are not reported if monitoring is less than 16 days. Do not report 99453, 99454 when these services are included in other codes for the duration of time of the physiologic monitoring service (e.g., 95250 for continuous glucose monitoring requires a minimum of 72 hours of monitoring).

Code 99091 should be reported no more than once in a 30-day period to include the physician or other QHP time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to patient and/or caregiver), and associated documentation. If the services described by 99091 or 99474 are provided on the same day the patient presents for an E/M service to the same provider, these services should be considered part of the E/M service and not reported separately. Do not report 99091 for time in the same calendar month when used to meet the criteria for care plan oversight services (99374, 99375, 99377, 99378, 99379, 99380), home, domiciliary, or rest home care plan oversight services (99339, 99340), remote physiologic monitoring services (99457, 99458), or personally performed chronic or principal care management (99424, 99425, 99426, 99427, 99437, 99491). Do not report 99091 if other more specific codes exist (e.g., 93227, 93272 for cardiographic services; 95250 for continuous glucose monitoring). Do not report 99091 for transfer and interpretation of data from hospital or clinical laboratory computers.

Code 99453 is reported for each episode of care. For coding remote monitoring of physiologic parameters, an episode of care is defined as beginning when the remote monitoring physiologic service is initiated and ends with attainment of targeted treatment goals.

[n]**Remote Physiologic Monitoring Treatment Management Services** (99457, 99458) are provided when clinical staff/physician/other QHP use the results of remote physiological monitoring to manage a patient under a specific treatment plan. To report remote physiological monitoring, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other QHP. Do not use 99457, 99458 for time that can be reported using more specific monitoring services. Codes 99457, 99458 may be reported during the same service period as chronic care management services (99437, 99439, 99487, 99489, 99490, 99491), principal care management services (99424, 99425, 99426, 99427), transitional care management services (99495, 99496), and behavioral health integration services (99484, 99492, 99493, 99494). However, time spent performing these services should remain separate and no time should be counted twice toward the required time for any services in a single month. Codes 99457, 99458 require a live, interactive communication with the patient/caregiver. The interactive communication contributes to the total time, but it does not need to represent

the entire cumulative reported time of the treatment management service. For the first completed 20 minutes of clinical staff/physician/other QHP time in a calendar month report 99457, and report 99458 for each additional completed 20 minutes. Do not report 99457, 99458 for services of less than 20 minutes. Report 99457 one time regardless of the number of physiologic monitoring modalities performed in a given calendar month. Do not count any time on a day when the physician or other QHP reports an E/M service. Do not count any time related to other reported services.

[o]**Education and Training Services for Patient Self-Management** (98960-98962) codes are used to report educational and training services prescribed by a physician or other QHP and provided by a nonphysician QHP using a standardized curriculum to an individual or a group of patients for the treatment of established illness(s)/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. This 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[s]) how to effectively self-manage the patient's illness(s)/disease(s) or delay disease comorbidity(s) in conjunction with the patient's professional healthcare 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 health care 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.

[p]**Miscellaneous Services** (99078) Physician or other QHP qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity or diabetic instructions).

[q]**Modifiers**
(25) Significant, Separately Identifiable E/M Service by the Same Physician or Other QHP on the Same Day of the Procedure or Other Service: 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.

(59) Direct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate inclusion/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

(95) Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System: Synchronous telemedicine service is defined as a real-time interaction between a physician or other QHP and a patient who is located at a distant site from the physician or other QHP. The totality of the communication of information exchanged between the physician or other QHP and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. Modifier 95 may only be appended to services that are typically performed face-to-face but may be rendered via real-time (synchronous) interactive audio and video telecommunications system (Appendix P of the 2022 CPT codebook)

References

1. White P, Cooley C, Transitions Clinical Report Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics*. 2018;142(5):e20182587.
2. American Medical Association. *2022 CPT Professional Edition*. Chicago, IL: AMA, 2021.
3. Committee on Coding and Nomenclature. *Coding for Pediatrics 2020*. Itasca, IL: American Academy of Pediatrics, 2019.
4. McManus M, White P, Schmidt A. *Recommendations for Value-Based Transition Payment for Pediatric and Adult Health Care Systems: A Leadership Roundtable Report.* Washington, DC: The National Alliance to Advance Adolescent Health, September 2018.
5. McManus M, White P, Schmidt A. *A Guide for Designing a Value-Based Payment Initiative for Pediatric-to-Adult Transitional Care.* Washington, DC: The National Alliance to Advance Adolescent Health, January 2022.
6. American Medical Association. *CPT Assistant.* Chicago, IL: AMA, 2016;26(11).

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Appendix A: Characteristics of Services Specific to Physician Designation

CPT Code	Physician or Other Qualified Health Care Professional[1]		Clinical Staff Member[2]	
	F2F[3]	Non-F2F[4]	F2F[3]	Non-F2F[4]
Office or Other Outpatient Services, New Patient				
99202	X			
99203	X			
99204	X			
99205	X			
Office or Other Outpatient Services, Established Patient				
99211	X			
99212	X			
99213	X			
99214	X			
99215	X			
Office or Other Outpatient Consultations, New or Established Patient				
99241	X			
99242	X			
99243	X			
99244	X			
99245	X			
Prolonged Services				
99354	X			
99355	X			
99358		X		
99359		X		
99417	X	X		
Medical Team Conference				
99366	X			
99367		X		
99368		X		
Preventive Medicine Services				
99384	X			
99385	X			
99394	X			
99395	X			
Health Risk Assessment				
96160	X	X	X	X
General Behavioral Health Integration Care Management				
99484			X	X
Care Management Services				
99490			X	X
99439			X	X
99491		X		
99437		X		
99487			X	X
99489			X	X
99424		X		
99425		X		
99426			X	X
99427			X	X

CPT Code	Physician or Other Qualified Health Care Professional[1]		Clinical Staff Member[2]	
	F2F[3]	Non-F2F[4]	F2F[3]	Non-F2F[4]
Hospital Transitional Care Management Services				
99495	X	X	X	X
99496	X	X	X	X
Telephone Services				
99441		X		
99442		X		
99443		X		
98966		X		
98967		X		
98968		X		
Online Digital Evaluation and Management Services				
99421		X		
99422		X		
99423		X		
98970		X		
98971		X		
98972		X		
Interprofessional Telephone/Internet/EHR[5] Consultations				
99446		X		
99447		X		
99448		X		
99449		X		
99451		X		
99452		X		
Digitally Stored Data Services/Remote Physiologic Monitoring				
99453		X		
99454		X		
99091		X		
99473		X		
99474		X		
Remote Physiologic Monitoring Treatment Management Services				
99457	X		X	
99458	X		X	
Education and Training for Patient Self-Management				
98960	X			
98961	X			
98962	X			
Miscellaneous Services				
99078	X			

[1] The American Medical Association distinguishes a qualified health care professional (QHP) from a clinical staff member in terms of which physicians may report services. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. In addition to a physician, other qualified health care professionals include, but are not limited to, clinical nurse specialists, nurse practitioners, physician assistants, and clinical social workers.

[2] A "clinical staff member" is a person working under the supervision of a physician or other QHP; they are allowed by law, regulation, and facility policy to perform or assist in performance of a specified professional service but do not individually report the service. Clinical staff include, but are not limited to, medical assistants and licensed practical nurses.

[3] F2F = face-to-face services. Physical face-to-face presence and synchronous real-time audio-visual face-to-face are considered equivalent. Note this statement from 2022 CPT regarding modifier 95: "The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction."

[4] Non-F2F = non-face-to-face services

[5] EHR = electronic health record

Appendix B: Comparison of Prolonged Services Codes Table

Code	Patient Contact	Minimum Reportable Prolonged Services Time (Single Date of Service)	Use in Conjunction With	*Do Not Report With	Other Prolonged Service(s) Reportable On Same Date Of Service
+99354	F2F[1] Only	30 minutes (Beyond listed typical time)	90837, 90847, 99241-99245, 99324-99337, 99341-99350, 99483	99202-99205, 99212-99215, 99415, 99416, 99417	99358, 99359
+99355	F2F Only	Each additional 15 minutes (Beyond 99354)	99354	99202-99205, 99212-99215, 99415, 99416, 99417	99358, 99359
+99356	F2F and Unit/Floor Time	30 minutes (Beyond listed typical time)	90837, 90847, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310		99358, 99359
+99357	F2F and Unit/Floor Time	Each additional 15 minutes (Beyond 99356)	99356		99358, 99359
99358	Non-F2F[2] Only	30 minutes	Must relate to a service where face-to-face care has or will occur. This is not an add-on code and is not used in conjunction with a base code.	99202-99205, 99212-99215, 99417 *On same date of service*	99354, 99356
+99359	Non-F2F Only	Each additional 15 minutes (Beyond 99358)	99358	99202-99205, 99212-99215, 99417 *On same date of service*	99354, 99356
+99417	F2F and/or Non-F2F	Reported with 99205: 75 minutes or more Reported with 99215: 55 minutes or more *(Total time on the date of encounter)*	99205, 99215	99354, 99355, 99358, 99359, 99415, 99416	N/A
*Do not count the time of any separately reported service as prolonged services time 99355 is for prolonged services time beyond 99354 and may be reported in multiple units 99357 is for prolonged services time beyond 99356 and may be reported in multiple units 99359 is for prolonged services time beyond 99358 and may be reported in multiple units 99417 is for prolonged services time beyond 99205 or 99215 and may be reported in multiple units of at least 15 minutes.					

[1]F2F = face-to-face services
[2]Non-F2F = non-face-to-face services

Appendix C: Letter Template to Payers Regarding Recognition of Codes Related to Pediatric-to-Adult Transition Services

Address to Insurance Carrier Claims Review Department
Address to Insurance Carrier Medical Director

Dear (to be individually addressed on practice or chapter letterhead):

I am writing to object to [*Carrier Name's*] policy of [*select as appropriate: either not covering or bundling, or inadequately paying for*] CPT codes related to transition from pediatric to adult care. Transition services are intended to be part of routine preventive, primary, and chronic care for all adolescents and young adults. Our physicians and their clinical staff are appropriately reporting CPT codes even though the services may otherwise be denied by the payer. The specific CPT codes listed below are necessary to report the additional time and work for transition services and should be paid appropriately.

These transition-related codes align with the pediatric and adult patient-centered medical home model of care[1] and the AAP/AAFP/ACP Clinical Report on Transition to Adulthood,[2] which calls for a structured transition process beginning early in adolescence and continuing through transfer to adult care. Recognizing these codes would enable physicians and their clinical staff to provide recommended services for transition planning, transfer assistance, and integration into adult care. Evidence shows that a structured transition process improves adherence to care, consumer satisfaction, use of adult ambulatory care services, and disease-specific outcomes.[3,4] A complete list of transition-related codes with corresponding Medicare fees, relative value units, and clinical vignettes was published in 2022.[5]

The CPT codes related to transition that are at issue include the following: ***[please select those codes that the practice is addressing (a listing of CPT codes related to transition is attached for the practice's reference)]***.

We urge you to recognize and pay appropriately for these services related to transition from pediatric to adult care. We look forward to your response on your coverage and payment policy for these health care transition-related CPT codes. If you have any questions or need additional information, please contact ***[include contact information]***.

Sincerely,
X

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[1] McManus M, White P, Borden C. *Incorporating Pediatric-to-Adult Transition into NCQA Patient-Centered Medical Home Recognition: 2019 Update.* Washington, DC: Got Transition®, October 2019.
[2] White P, Cooley C, Transitions Clinical Report Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. *Pediatrics*. 2018;142(5):e20182587.
[3] Gabriel P, McManus M, Rogers K, White P. Outcome evidence for structured pediatric to adult health care transition interventions: a systematic review. *Journal of Pediatrics.* 2017;188:263-269.
[4] Schmidt A, Ilango S, McManus M, Rogers K, White P. Outcomes of pediatric to adult health care transition interventions: An updated systematic review. *Journal of Pediatric Nursing*. 2020;51:92-107.
[5] Schmidt A, McManus M, White P, Slade R, Salus T, Bradley J. *2022 Coding and Payment Tip Sheet for Transition from Pediatric to Adult Health Care.* Washington, DC: Got Transition® and American Academy of Pediatrics, May 2022.

Summary Listing of CPT Codes Related to Transition

Applicable Transition CPT Codes	Service Descriptions
99202-99205, 99211-99215	Office or other outpatient visit
99241-99245	Office or other outpatient consultations
99354, 99355, 99358, 99359, 99417	Prolonged services
99366-99368	Medical team conference
99384, 99385, 99394, 99395	Preventive medicine services
96160	Health risk assessment (e.g., transition readiness/self-care assessment)
99441-99443, 98966-98968	Telephone services
99421-99423, 98970-98972	Online digital evaluation and management services
99446-99449, 99451, 99452	Interprofessional telephone/Internet/electronic health record assessment and management services
99487, 99489	Complex chronic care management services
99424-99427	Principal care management services for managing a patient with a single, complex problem
99490, 99439, 99491, 99437	Chronic care management services
99484	General behavioral health integration care management
99495, 99496	Hospital transitional care management services
99453, 99454, 99091, 99473, 99474	Digitally stored data services/remote physiologic monitoring
99457, 99458	Remote physiologic monitoring treatment management services
98960-98962	Education and training for patient self-management services
99078	Miscellaneous services
25, 59, 95	Modifiers

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