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# 2019 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care

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## **New in 2019:**

- Interprofessional consultation codes 99446-99449 now include electronic health record consultations in addition to telephone and internet consultations, and still require a concluding verbal report back to the requesting physician.
- Code 99451 for interprofessional telephone/internet/electronic health record assessment and management services provided by a consultative physician, including a written report to patient's treating/requesting physician/other qualified health professional and requires only a written, not verbal, report back to the requesting physician.
- Code 99452 for interprofessional telephone/internet/electronic health record referral services provided by a treating/requesting physician/qualified health professional.
- Code 99491 for chronic care management services provided personally by a physician or other qualified health care professional.
- Two new clinical vignettes with recommended coding suggestions.
- A table (Appendix A) that displays which health care provider can bill for each CPT code and whether the service can be delivered face-to-face or non-face-to-face.
- An updated letter template (Appendix B) that can be sent to payers advocating for recognition of transition-related codes.

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 provider, 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.<sup>1</sup> This updated 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 ([www.GotTransition.org](http://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 partnered to develop and update each year 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 2019. It also includes a set of clinical vignettes with recommended CPT and ICD coding and CPT coding descriptions for transition-related services with selected coding tips.<sup>2</sup> A supplemental table (Appendix A) categorizes these codes based on the type of providers able to report them and whether the service can be delivered face-to-face or non-face-to-face. Also included in this tip sheet is a letter template that can be customized and sent to payers calling for recognition of transition-related CPT codes (available [here](#) and in Appendix B).

Additional transition payment strategies are available in a 2018 report, *Recommendations for Transition Value-Based Payment for Pediatric and Adult Health Care Systems*.<sup>3</sup> This 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 payments, infrastructure investments, pay-for-performance payments, direct payments to consumers, episode of care or bundled payments, and per member per month payments. In addition, this report includes a set of prioritized quality measures that can be used with the value-based payment options.

## Transition Coding and Reimbursement

Transition Related Services		100% Medicare Payment, 2019		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
<b>Office or Other Outpatient Services, New Patient</b>				
99201 <sup>†</sup>	Self-limited or minor problem, typically 10 minutes	\$46.49	\$27.39	1.29/0.76
99202 <sup>†</sup>	Low to moderate severity problem, typically 20 minutes	\$77.48	\$51.54	2.15/1.43
99203 <sup>†</sup>	Moderate severity problem, typically 30 minutes	\$109.92	\$77.48	3.05/2.15
99204 <sup>†</sup>	Moderate to high severity problem, typically 45 minutes	\$166.86	\$131.18	4.63/3.64
99205 <sup>†</sup>	Moderate to high severity problem, typically 60 minutes	\$209.75	\$171.19	5.82/4.75
<b>Office or Other Outpatient Services, Established Patient</b>				
99211 <sup>†</sup>	Minimal presenting problems, typically 5 minutes	\$23.07	\$9.37	0.64/0.26
99212 <sup>†</sup>	Self-limited or minor problem, typically 10 minutes	\$45.77	\$25.95	1.27/0.72
99213 <sup>†</sup>	Low to moderate severity problem, typically 15 minutes	\$75.32	\$51.90	2.09/1.44
99214 <sup>†</sup>	Moderate to high severity problem, typically 25 minutes	\$110.28	\$80.01	3.06/2.22
99215 <sup>†</sup>	Moderate to high severity problem, typically 40 minutes	\$147.76	\$112.80	4.10/3.13
<b>Office or Other Outpatient Consultations, New or Established Patients<sup>a</sup></b>				
99241 <sup>†</sup>	Self-limited or minor problem, typically 15 minutes	\$48.29	\$33.16	1.34/0.92
99242 <sup>†</sup>	Low severity problem, typically 30 minutes	\$90.82	\$69.56	2.52/1.93
99243 <sup>†</sup>	Moderate severity problem, typically 40 minutes	\$124.33	\$97.31	3.45/2.70
99244 <sup>†</sup>	Moderate to high severity problem, typically 60 minutes	\$185.96	\$156.41	5.16/4.34
99245 <sup>†</sup>	Moderate to high severity problem, typically 80 minutes	\$226.69	\$193.53	6.29/5.37
<b>Care Plan Oversight Services<sup>b</sup></b>				
99339	Individual physician supervision of a patient requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian), and/or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	\$78.20	NA	2.17/NA
99340	30 minutes or more	\$109.92	NA	3.05/NA
<b>Prolonged Services<sup>c</sup></b>				
99354 <sup>†</sup>	Prolonged evaluation and management (E/M) or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting, with direct patient contact beyond the usual service; first hour	\$132.26	\$123.97	3.67/3.44
99355 <sup>†</sup>	Each additional 30 minutes	\$100.91	\$93.70	2.80/2.60
99358	Prolonged E/M services before and/or after direct patient contact; first hour	\$113.52	\$113.52	3.15/3.15
99359	Each additional 30 minutes	\$54.78	\$54.78	1.52/1.52

Transition Related Services		100% Medicare Payment, 2019		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
<b>Medical Team Conference<sup>d</sup></b>				
99366	With interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by nonphysician qualified health care professional	\$43.61	\$42.89	1.21/1.19
99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	NA	\$57.66	NA/1.60
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional	NA	\$37.48	NA/1.04
<b>Preventive Medicine Services<sup>e</sup></b>				
99384	Initial comprehensive preventive medicine E/M, new adolescent patient; ages 12 through 17 years	\$138.75	\$103.79	3.85/2.88
99385	Ages 18 through 39 years	\$134.07	\$99.47	3.72/2.76
99394	Periodic comprehensive preventive medicine reevaluation and management of an established adolescent patient; ages 12 through 17 years	\$118.57	\$88.66	3.29/2.46
99395	Ages 18 through 39 years	\$121.09	\$91.18	3.36/2.53
<b>Health and Behavior Risk Assessment<sup>f</sup></b>				
96160	Administration of patient-focused health risk assessment instrument (e.g., transition readiness assessment) with scoring and documentation, per standardized instrument	\$3.24	NA	0.09/NA
<b>General Behavioral Health Integration Care Management<sup>g</sup></b>				
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month	\$48.65	\$32.80	1.35/0.91
<b>Care Management Services<sup>h</sup></b>				
99487	Complex 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 place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; establishment or substantial revision of a comprehensive care plan; moderate or high complexity medical decision-making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	\$92.98	\$52.98	2.58/1.47
99489	Each additional 30 minutes	\$46.49	\$26.67	1.29/0.74
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decomposition, or functional decline; comprehensive care plan established, implemented, revised, or monitored	\$42.17	\$32.44	1.17/0.90

Transition Related Services		100% Medicare Payment, 2019		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
99491	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with required elements: multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored	\$83.97	\$83.97	2.33/2.33
<b>Transitional Care Management Services<sup>i</sup></b>				
99495 <sup>+</sup>	Includes communication (direct contact, telephone, electronic) with the patient/caregiver within 2 business days of discharge from an inpatient hospital setting; medical decision-making of at least moderate complexity during service period; and face-to-face visit within 14 calendar days of discharge	\$166.50	\$112.08	4.62/3.11
99496 <sup>+</sup>	Includes communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge from an inpatient hospital setting; medical decision-making of high complexity during the service period; and face-to-face visit, within 7 calendar days of discharge	\$234.97	\$162.54	6.52/4.51
<b>Telephone Services<sup>j</sup></b>				
99441	Telephone E/M service provided by a physician or other qualified health professional who may report E/M services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	\$14.06	\$12.97	0.39/0.36
99442	11-20 minutes of medical discussion	\$27.39	\$25.95	0.76/0.72
99443	21-30 minutes of medical discussion	\$40.36	\$38.92	1.12/1.08
<b>Online Medical Evaluation<sup>k</sup></b>				
99444	Online E/M service provided by physician or other qualified health care professional who may report E/M services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network	NA	NA	NA/NA
<b>Interprofessional Telephone/Internet/Electronic Health Record Consultations<sup>l</sup></b>				
99446	Interprofessional telephone/Internet/electronic health record assessment and management services provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	NA	\$18.38	NA/0.51
99447	11-20 minutes of medical consultative discussion and review	NA	\$36.40	NA/1.01
99448	21-30 minutes of medical consultative discussion and review	NA	\$54.78	NA/1.52
99449	31 minutes or more of medical consultative discussion and review	NA	\$73.16	NA/2.03

Transition Related Services		100% Medicare Payment, 2019		
CPT Code	Service Description	Office	Facility	RVUs (Non-Facility/Facility)*
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	\$37.48	\$37.48	1.04/1.04
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, > 16 minutes	\$37.48	\$37.48	1.04/1.04
<b>Education and Training for Patient Self-Management<sup>m</sup></b>				
98960 <sup>†</sup>	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	\$27.75	NA	0.77/NA
98961 <sup>†</sup>	2-4 patients	\$13.69	NA	0.38/NA
98962 <sup>†</sup>	5-8 patients	\$10.09	NA	0.28/NA
<b>Miscellaneous Services<sup>n</sup></b>				
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity or diabetic instructions)	NA	NA	NA/NA
<b>Modifiers<sup>o</sup></b>				
25	Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the other service	NA	NA	NA/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

\*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.

<sup>†</sup>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.

NA: Certain CPT codes do not have assigned RVUs.

## Transition Clinical Vignettes

### Vignette #1

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

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

### Vignette #2

*Preventive medicine visit with new 14-year-old female patient with no chronic conditions. Physician updates medical history, completes physical exam, and provides anticipatory guidance as part of the comprehensive preventive medicine examination. The 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 with established 16-year-old male patient with moderate persistent asthma presenting with difficulties breathing and sleeping. He was recently in the ER for asthma complications due to inconsistent use of corticosteroids. While waiting for the physician, youth completes a scorable transition readiness assessment form. The physician provides counseling regarding medication adherence and knowing his symptoms, including ones that he quickly needs to see the doctor for instead of going to the ER. During the visit, the physician also updates the youth's medical summary with the youth so that he better understands his treatment and encourages the youth to add his medical information on his iPhone given patient often forgets to take his meds. The physician reviews the 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 25 minutes. After the physician meets with the patient, the nurse, who is a certified asthma educator, provides the patient with 20 minutes of education and training on asthma self-care using a standardized curriculum.*

Coding: CPT 99214 (Office visit, established patient, moderate severity problem, 25 minutes)  
CPT 96160 (Patient-focused health risk assessment instrument)  
CPT 98960 (Education and training of patient self-management)  
ICD-10-CM: J45.40 (Moderate persistent asthma, uncomplicated)

### **Vignette #4**

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

Coding: CPT 99395 (Preventive medicine visit, established visit, ages 18-39)  
CPT 99213-25 (Office visit, established patient, low to moderate severity, 15 minutes, with significant, separately identifiable E/M service above and beyond the service performed by the same 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)  
F41.8 (Other specified anxiety disorders)

### **Vignette #5**

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

Coding: CPT 99215 (Office visit, established patient, high severity problem, 40 minutes)  
CPT 96160 (Patient-focused health risk assessment instrument)  
CPT 99487 (Complex chronic care management service, 60 minutes)

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

### **Vignette #6**

*A 23-year-old 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, transition care plan, medical summary and emergency care plan, and scorable transition readiness assessment from the pediatric rheumatologist. The nurse has her fill out a scorable post-transition self-care assessment while waiting to see the adult rheumatologist. The adult physician spends more than 50% of the 45-minute visit discussing information about their practice and their consent and privacy approach and establishes a communication plan with the young adult. The physician also updates and shares the medical summary, including the medication reconciliation and plan of care, with the new young adult patient. The physician reviews the scorable post-transition self-care assessment and determines if the young adult is ready for an adult approach to care and if she can coordinate her primary and specialty care. She also assesses if she needs other care management support. The physician begins the process of identifying and contacting a new adult internist for primary care and additional subspecialists, including an adult nephrologist and ophthalmologist, for the young adult. The insurer requires new prior authorizations for medications.*

Coding: CPT 99204 (Office visit, new patient, moderate to high severity problem, 45 minutes)  
CPT 96160 (Patient-focused health risk assessment instrument)

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

**Vignette #7**

*New adult office visit with a 22-year-old young adult male transitioning from his pediatric provider, who he saw for a preventive office visit 6 months earlier. The young adult male comes with no previous medical records from the pediatrician. The physician completes a medical history and a physical exam, noting his BMI is 27. The patient fills out a scorable 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 > 50% of the 30-minute visit 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 99203 (Office visit, new patient, moderate problem, 30 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 counselling and medical advice, not elsewhere classified)

**Vignette #8**

*A new 24-year-old with spina bifida and hydrocephalus is referred by her pediatrician to an adult primary care provider. The young adult requested that her records from her urologist, neurologist, neurosurgeon, physiatrist, and primary care pediatrician be sent to the new internist's office prior to her initial visit. Upon receipt, the adult provider reviews the extensive medical records from all five physicians. The adult provider calls the pediatric primary care provider 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.*

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 NEW**

*After a patient’s second visit to the adult primary care physician, the adult primary care physician asked the patient’s previous pediatrician 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. 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 pediatrician is warranted to determine subsequent management. The adult physician communicates by telephone with the consulting pediatrician 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, now a freshman in college, and mother note 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 states he sleeps 6 hours nightly. The adult physician communicates teacher and parent Vanderbilt Assessment Scoring to the consulting pediatrician. The consulting pediatrician spends 25 minutes via telephone discussing the patient with the adult physician along with making recommendations on pharmacologic and behavioral management. Included in this time, the pediatrician dictates a consultation report to be sent back to the adult physician.*

**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 provider):**

Coding: CPT 99214 (Office visit, established patient, moderate to high severity problem, 25 minutes)  
CPT 96160 x 2 units (Patient-focused health risk assessment instrument, e.g., Vanderbilt Assessment)

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

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

Coding: 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 half-way point regarding time [according to CPT Professional Edition 2019]: “A unit of time is attained when the mid-point is passed. For example, 30 minutes is attained when 16 minutes have elapsed [more than midway between zero and 30 minutes].”)

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

**For the pediatric consultant:**

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 NEW**

*An adult rheumatologist provides a first evaluation and management visit via telehealth to a 19-year-old 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 plans to visit the office of the adult rheumatologist later during summer 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 2.5mg 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.*

Coding: CPT 99204-95 (Office visit, new patient, moderate to severe problem, typically 45 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)

## CPT Description of Selected Transition-Related Codes<sup>2,4</sup>

<sup>a</sup>**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 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 service code 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 qualified health care professional who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician or other qualified health care professional who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician or other qualified health care professional 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 qualified health care professional who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

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

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

**°Prolonged Services**

*Prolonged service with direct patient contact* (99354, 99355) codes are used when a physician or other qualified health care professional provides prolonged service(s) involving direct patient contact that is provided beyond the usual service in an outpatient setting. This service is reported in addition to the primary procedure and any other services provided at the same session. Codes 99354 and 99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code 99354 is used to report the first hour of prolonged service on a given date, depending on the place of service. It should be used only once per date, even if the time spent by the physician or other qualified health care professional is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the E/M codes. 99355 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. It may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. The use of the time-based add-on codes 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 qualified health care professional, use 99415, 99416. Do not report 99354 or 99355 with 99415 or 99416.

*Prolonged service without direct patient contact* (99358, 99359) codes are used when a prolonged service is provided that is not face-to-face time in the office or outpatient setting and is beyond the usual physician or other qualified health care professional service time. This service is reported in relation to other physician or other qualified health care professional services, including E/M services at any level. This prolonged service may be reported on a different date than the primary service to which it is related. For example, extensive record review may relate to a previous E/M service performed earlier and commences upon receipt of past records. However, it must relate to a service or patient where (face-to-face) patient contact has occurred or will occur and relate to ongoing patient management. A typical time for the primary service need not be established within the CPT code set. Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by the physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or qualified health professional 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 regardless of the place of service. It may also be used to report the final 15 to 30 minutes of prolonged services on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately. Do not report 99358, 99359 for time spent in care plan oversight services (99339, 99340), home and outpatient International Normalized Ration (INR) monitoring (93792, 93793), medical team conferences (99366-99368), or online medical evaluations (99444).

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

**°Medical Team Conferences** (99366-99368) include face-to-face participation by a minimum of 3 qualified health care professionals from different specialties or disciplines (each of whom provide direct care to the patient), with or without the presence of the patient, family member(s), community agencies, surrogate decision maker(s) (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 qualified health care professionals who may report E/M services should report their time spent in a team conference with the patient and/or family present using E/M codes (and time as the key controlling factor for code selection when counseling and/or coordination of care dominates the 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 qualified health care professionals or agencies. Reporting participants shall document their participation in the team conference as well as their contributed information and subsequent treatment recommendations. No more than one individual from the same specialty may report 99366-99368 at the same encounter. Individuals should not report these codes 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 qualified health care professionals (e.g., speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians) report the team conference face-to-face code 99366.

<sup>e</sup>**Preventive Medicine Services** (99384, 99385, 99394, 99395) The extent and focus of the preventive medicine services will largely depend on the age of the patient. If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine E/M service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate office/outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the office/outpatient code to indicate that a significant, separately identifiable E/M service was provided on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported. 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 99201-99350. 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. Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests (e.g., vision, hearing, developmental) identified with a specific CPT code are reported separately.

<sup>f</sup>**Health and Behavior Risk Assessment** (96160) Code 96160 will allow reporting patient risk-assessment instrument administered to either the patient or the caregiver/parent in order to assess the risk of conditions, such as mental disorders, when performed in conjunction with an E/M visit. The separately reported E/M service includes interpreting the rating scale, discussing the results with the patient and/or caregiver, documenting the patient/caregiver discussion in the patient’s medical record, and providing any referrals to the parent’s or caregiver’s primary care provider or mental health provider.<sup>5</sup>

*Coding Tip:* CPT 96160 can be used to report transition readiness assessments conducted with youth and parents, and self-care assessments conducted with young adults. This service is intended to evaluate youth and young adults' understanding of their own health and how to effectively use health care. It can be administered with new and established patients with and without chronic conditions. Clinical staff typically administer, score, and document the results of the standardized transition readiness or self-care assessment form completed by the youth, parent 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). Modifier 25 should be appended to the E/M code when both codes are reported on the same day. A standardized, scorable instrument must be used and recorded in the clinical documentation for the encounter. Two scorable general instruments are the transition readiness assessment (for youth and parents) and self-care assessment (for young adults) instruments that can be downloaded from the Six Core Elements of Health Care Transition Packages available at [www.GotTransition.org](http://www.GotTransition.org). Other standardized scorable tools include the Transition Readiness Assessment Questionnaire (TRAQ), On TRAC, UNC TRxANSITION SCALE, STARx Questionnaire, and the Patient Activation Measure.

<sup>g</sup>**General Behavioral Health Integration Care Management** (99484) services are reported by the supervising physician or other qualified health care professional. 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 (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.

<sup>h</sup>**Care Management Services** (99487, 99489, 99490, 99491) are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, or may be provided personally by a physician or other qualified health care professional, 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. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living. A plan of care must be documented and shared with the patient and/or caregiver. A care plan is based on a physical, mental, cognitive, social, functional, and environmental assessment. It is a comprehensive plan of care for all health problems. It typically includes, but is not limited to, the following elements: problem list, expected outcome and prognosis, measurable treatment

goals, symptom management, planned interventions, medication management, community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identification of the individuals responsible for each intervention, requirements for periodic review, and, when applicable, revision of the care plan. Codes 99487, 99489, 99490, 99491 are reported only once per calendar month and may only be reported by the single physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month. For 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 professionals is counted. Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient. For 99491, only count the time personally spent by the physician or other qualified health care professional. Do not count any of the clinical staff time spent on the day of an initiating visit (the creation of the care plan, initial explanation to the patient and/or caregiver, and obtaining consent). Care management activities performed by clinical staff, or personally by the physician or other qualified health care professional, typically include:

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

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

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

E/M services may be reported separately by the same physician or other qualified health care professional during the same calendar month. A physician or other qualified health care professional who reports codes 99487, 99489, 99490, may not report care plan oversight services (99339, 99340), prolonged services without direct patient contact (99358, 99359), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), education and training (98960-98962, 99071, 99078), telephone services (99366-99368, 99441-99443), online medical evaluation (98969, 99444), preparation of special reports (99080), analysis of data (99091), transitional care management services (99495, 99496), medication therapy management services (99605-99607), and, if performed, these services may not be reported separately during the month for which 99487, 99489, and 99490 are reported. All other services may be reported. Do not report 99487, 99489, 99490, 99491 if reporting end-stage renal disease services (90951-90970) during the same month. If the care management services are performed within the postoperative period of a reported surgery, the same individual may not report 99487, 99489, 99490, 99491. Care management may be reported in any calendar month during which the clinical staff time or physician or other qualified health care professional personal time requirements are met. If care management resumes after a discharge during a new month, start a new period or report transitional care management services (99495, 99496) as appropriate. If discharge occurs in the same month, continue the reporting period or report transitional care management services. Do not report 99487, 99489, 99490 for any post-discharge care management services for any days within 30 days of discharge, if reporting 99495, 99496. 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, 99491) 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 99491 is reported when 30 minutes of physician or other qualified health care professional personal time is spent in care management activities. Do not report 99490 in the same month as 99491.

*Complex Chronic Care Management Services* (99487, 99489) are provided during a calendar month that includes criteria for chronic care management services as well as establishment or substantial revision of a comprehensive care plan; medical, functional, and/or psychosocial problems requiring medical decision-making of moderate or high complexity; and clinical staff care management services for at least 60 minutes, under the direction of a physician or other qualified health care professional. Physicians or other qualified health care professionals may not report complex chronic care management services if the care plan is unchanged or requires minimal change (e.g., only a medication is changed or an adjustment in a treatment modality is ordered). Medical decision-making as defined in the E/M guidelines is determined by the problems addressed by the reporting individual during the month. Patients who require complex chronic care management services may be identified by practice-specific or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for caregiver, and/or repeat admissions or emergency department visits. Typical adult patients who receive complex chronic care management services are treated with 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) code 99490 was developed to align with the Centers for Medicare & Medicaid Services (CMS) benefit specifications for Medicare coverage of CCM. The CMS has outlined specific coverage criteria that may be adopted by Medicaid and private health plans, including 2 points of consideration for physicians who wish to provide CCM services.

1. Practices providing CCM services must have certain capabilities, including use of an EHR. Health plans may adopt the CMS requirement for use of an EHR that meets certification requirements for Medicare and Medicaid EHR incentive programs in place on December 13 of the prior year.
2. Chronic care management activities are provided by clinical staff under the supervision of the physician or qualified health professional reporting CCM services. Check with payers for the level of supervision required. CMS has allowed an exception to the requirement for direct supervision (i.e., physician presence in the office suite when staff perform activities) for CCM services provided to Medicare patients. This 99490 exception allows staff to perform CCM activities under the physician's or qualified health professional's general supervision (i.e., supervising provider is available as needed by phone) as long as all other incident-to requirements are met.

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

**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 qualified health care professional 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 qualified health care professional, may include:

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

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

- obtaining and reviewing the discharge information (e.g., discharge summary, as available, or continuity of care documents);
- reviewing need for or follow-up on pending diagnostic tests and treatments;
- interaction with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems;
- education of patient, family, guardian, and/or caregiver;
- establishment or reestablishment of referrals and arranging for needed community 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 Service 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. A physician or other qualified health care professional who reports codes 99495, 99496 may not report care plan oversight services (99339, 99340), prolonged services without direct patient contact (99358, 99359), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), education and training (98960-98962, 99071, 99078), telephone services (98966-98968, 99441-99443), end-stage renal disease services (90951-90970), online medical evaluation services (98969, 99444), preparation of special reports (99080), analysis of data (99091), complex chronic care coordination services (99487-99489), medication therapy management services (99605-99607) during the time period covered by the transitional care management services codes.

**Telephone Services** (99441-99443) are non-face-to-face E/M services provided to a patient using the telephone by a physician or other qualified health care professional, who may report E/M services. These codes are used to report episodes of patient care initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see 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) are considered part of that previous E/M service or procedure. (Do not report 99441-99443 if 99441-99444 have been reported by the same provider in the previous 7 days.)

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

**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 qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician or other qualified health care professional in the diagnosis and/or management of the patient's problem without patient face-to-face contact with the consultant. The patient for whom the interprofessional telephone/Internet/electronic health record 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/electronic health record 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/electronic health record 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/electronic health record 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/electronic health record advice by the treating/requesting physician or other qualified health care professional should be documented in the patient's medical record, including the reason for the request. Codes 99446, 99447, 99448, 99449 conclude with a verbal opinion report and written report from the consultant to the treating/requesting physician or other qualified health care professional. Code 99451 concludes with only a written report.

Telephone/Internet/electronic health record consultations of less than five minutes should not be reported. Consultant communications with the patient and/or family may be reported using 98966-98969, 99441-99444, 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/electronic health record 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 qualified health care professional 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 qualified health care professional may report the prolonged service codes 99354-99357 for the time spent on the interprofessional telephone/Internet/electronic health record 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 qualified health care professional. If the interprofessional telephone/Internet/electronic health record 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 qualified health care professional.

Coding tip: The CPT half-way point regarding time (according to CPT Professional Edition 2019): *“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).”*

**<sup>m</sup>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 qualified health care professional and provided by a qualified, nonphysician health care professional using a standardized curriculum to an individual or a group of patients for the treatment of established illness(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.

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

**<sup>o</sup>Modifiers**

(25) It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the

procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding Modifier 25 to the appropriate level of E/M service.

(59) 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 is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. 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. 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 2019 CPT codebook).

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Appendix A: Characteristics of Services Specific to Provider Designation

CPT Code	Physician or Other Qualified Health Professional <sup>1</sup>		Clinical Staff Member <sup>2</sup>		CPT Code	Physician or Other Qualified Health Professional <sup>1</sup>		Clinical Staff Member <sup>2</sup>	
	Face-to-Face <sup>3</sup>	Non-Face-to-Face	Face-to-Face <sup>3</sup>	Non-Face-to-Face		Face-to-Face <sup>3</sup>	Non-Face-to-Face	Face-to-Face <sup>3</sup>	Non-Face-to-Face
<b>Office or Other Outpatient Services, New Patient</b>					<b>Care Management Services</b>				
99201	X				99487			X	X
99202	X				99489			X	X
99203	X				99490			X	X
99204	X				99491		X		
99205	X				<b>Transitional Care Management Services</b>				
<b>Office or Other Outpatient Services, Established Patient</b>					99495	X	X	X	X
99211	X				99496	X	X	X	X
99212	X				<b>Telephone Services</b>				
99213	X				99441		X		
99214	X				99442		X		
99215	X				99443		X		
<b>Office or Other Outpatient Consultations, New or Established Patients</b>					<b>Online Medical Evaluation</b>				
99241	X				99444		X		
99242	X				<b>Interprofessional Telephone/Internet/Electronic Health Record Consultations</b>				
99243	X				99446		X		
99244	X				99447		X		
99245	X				99448		X		
<b>Care Plan Oversight Services</b>					99449		X		
99339		X			99451		X		
99340		X			99452		X		
<b>Prolonged Services</b>					<b>Education and Training for Patient Self-Management</b>				
99354	X				98960	X			
99355	X				98961	X			
99358		X			98962	X			
99359		X			<b>Miscellaneous Services</b>				
<b>Medical Team Conference</b>					99078	X			
99366	X				<sup>1</sup> The American Medical Association distinguishes a qualified health care professional from a clinical staff member in terms of which providers may report services. 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. <sup>2</sup> A “clinical staff member” is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and faculty policy to perform or assist in the performance of a specified professional service, but who does not individually report the professional service. Clinical staff include, but are not limited to, medical assistants and licensed practical nurses. <sup>3</sup> Physical face-to-face presence and synchronous real-time audio-visual face-to-face are considered equivalent. Note this statement from 2019 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.”				
99367		X							
99368		X							
<b>Preventive Medicine Services</b>									
99384	X								
99385	X								
99394	X								
99395	X								
<b>Health and Behavior Risk Assessment</b>									
96160	X	X	X	X					
<b>General Behavioral Health Integration Care Management</b>									
99484			X	X					

## Appendix B: 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 letter head):

I am writing to object to [*Carrier Name*] 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<sup>1</sup> and the AAP/AAFP/ACP Clinical Report on Transition to Adulthood,<sup>2</sup> 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 to adult care improves adherence to care, consumer satisfaction, and use of adult ambulatory care services.<sup>3</sup> A complete list of transition codes with corresponding Medicare fees, relative value units, and clinical vignettes was published in 2019.<sup>4</sup>

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 in Table 1 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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<sup>1</sup> Harwood C, McManus M, White P. *Incorporating Pediatric-to-Adult Transition into NCQA Patient-Centered Medical Home Recognition*. Washington, DC: Got Transition, June 2017.

<sup>2</sup> 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.

<sup>3</sup> 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*. June 2017.

<sup>4</sup> McManus M, White P, Schmidt A, Kanter D, Salus T. *2019 Coding and Reimbursement Tip Sheet for Transition from Pediatric to Adult Health Care*. Washington, DC: Got Transition and American Academy of Pediatrics, February 2019.

**Table 1. Sample listing of CPT codes related to transition**

Applicable Transition CPT Codes	Service Descriptions
99241-99245	Office or other outpatient consultations
99339, 99340	Care plan oversight services
99354, 99355, 99358, 99359	Prolonged services
99366-99368	Medical team conference
96160	Health and behavior risk assessment (e.g., transition readiness/self-care assessment)
99441-99443	Telephone services
99444	Online medical evaluation
99446-99449, 99451, 99452	Interprofessional telephone/Internet/electronic health record assessment and management services
99487, 99489	Complex chronic care management services
99490, 99491	Chronic care management services
99495, 99496	Transitional care management services
98960-98962	Education and training for patient self-management services



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