

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



2017 CPT CODING FACT SHEET FOR CARE MANAGEMENT, TELEPHONE, EMAIL, AND OTHER NON-FACE-TO-FACE SERVICES

Prolonged Non-Direct Services

These codes are reported when a minimum of 30 minutes is spent performing non-direct (ie, non-face-to-face) services for a patient on a single calendar date.

99358 Prolonged services without direct patient contact; first hour [\$113.41 (A)]

Note: This code is now valued on the Medicare physician fee schedule. Many private payers and Medicaid will follow suit and pay.

+**99359** each additional 30 min. [54.55 (A)]
(+ *designated add-on code, use in conjunction with 99358*)

Medical Team Conference

This code is reported when a minimum of 3 qualified healthcare professionals meet without the patient or family present in any setting.

99367 Medical team conference by physician with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more [57.06 (B)]

Telephone Services (Physicians)

Telephone services are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a physician or other qualified health care professional, who may report evaluation and management services. These codes are used to report episodes of patient care initiated by an established patient or guardian of an established patient.

99441 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion [\$14.00 (N)]

99442 11-20 minutes of medical discussion [\$27.28 (N)]

99443 21-30 minutes of medical discussion [\$40.20(N)]

Care Plan Oversight Services

Care plan oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility or domiciliary, or non-face-to-face services. The 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.

99374 **Supervision** of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and

multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, 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) (eg, 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 [\$71.06 (B)]

99375 30 minutes or more [\$105.87 (B)]

99377 **Supervision** of a hospice patient (patient not present) (Requires same as **99374-99375**)
15-29 minutes [\$71.06 (B)]

99378 30 minutes or more [\$105.87 (I)]

Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Plan Oversight Services

99339 Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, 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 [\$78.24 (B)]

99340 30 minutes or more [\$109.82 (B)]

Chronic Care Management Services

Chronic care management services are patient centered management and support services provided by physicians, other qualified health care professionals and clinical staff to an individual who resides at home or in a domiciliary, rest home, or assisted living facility. These services typically involve clinical staff implementing a care plan directed by the physician or other qualified health care professional. These services address the coordination of care 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 activities of daily living. Time spent is that of clinical staff.

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 the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline;
- comprehensive care plan established, implemented, revised, or monitored. [\$42.71 (A)]

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

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- chronic conditions place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline,
- establishment or substantial revision of a comprehensive care plan,
- moderate or high complexity medical decision making;
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. [\$93.67 (A)]

+ **99489** each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month [\$47.01 (A)]
(+designated add on code - List separately in addition **99487**)

Transitional Care Management Services

These services are for a new or established patient 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). These codes do not include "discharge" from emergency departments. May include newborn discharges if patient meets criteria. 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

99495 Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days of discharge [\$165.45(A)]

99496 Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
- Medical decision making of high complexity during the service period
- Face-to-face visit, within 7 calendar days of discharge [\$233.99 (A)]

Telephone Services (Non-Physician)

Telephone services are non-face-to-face assessment and management services provided by a qualified health care professional* to a patient using the telephone. These codes are used to report episodes of care by the qualified health care professional initiated by an established patient or guardian of an established patient.

98966 Telephone assessment and management service provided by a qualified nonphysician health care professional 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 [\$14.00 (N)]

98967 11-20 minutes of medical discussion [\$27.28 (N)]

98968 21-30 minutes of medical discussion [\$40.20 (N)]

The term "qualified healthcare professional" is defined as staff that can independently report services, such as physician therapists, speech therapists, occupational therapists, chiropractors, registered dietitians, etc. It excludes clinical staff such as RNs, LPNs or those who only work under the supervision of a physician or other qualified professional, but cannot bill on their own.

Medical Team Conference (Non-Physician)

This code is reported when a minimum of 3 qualified healthcare professionals meet with or without the patient or family present in any setting. Not to be reported by a physician.

99366 Medical team conference with interdisciplinary team of healthcare professionals, face-to-face with patient and/or family, 30 minutes or more, participation by a nonphysician qualified healthcare professional [\$43.43 (B)]

99368 Medical team conference with interdisciplinary team of healthcare professionals, patient and/or family not present, 30 minutes or more, participation by a nonphysician qualified healthcare professional [\$37.32 (B)]

Interprofessional Consultation

Interprofessional consultations are services requested by telephone or Internet by a physician or other qualified health care professional seeking a consultant's expert opinion without a face-to-face patient encounter with the consultant. To capture the service rendered, the specialist will report a code for interprofessional consultation. The codes are:

99446 Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician/qualified health care professional; 5-10 minutes of medical consultative discussion and review [N/A]

99447 11-20 minutes of medical consultative discussion and review [N/A]

99448 21-30 minutes of medical consultative discussion and review [N/A]

99449 31 minutes or more of medical consultative discussion and review [N/A]

On-Line Medical Evaluation

An on-line electronic medical evaluation is a non-face-to-face E/M service by a physician to a patient using Internet resources in response to a patient's on-line inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hard copy) of the encounter. A reportable service encompasses the sum of communication (eg, related telephone calls, prescription provision, laboratory orders) pertaining to the on-line patient encounter.

99444 Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management 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 [N/A]

*All values are based on the 2017 National Medicare Fee Schedule for the Non-Facility Setting.

A – Active status on the Medicare fee schedule (payable)

B – Service is bundled

I – Not valid for Medicare purposes

N – Non-Covered Services

N/A – No published RVUs