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)]

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Time</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99375</td>
<td>Supervision of a hospice patient (patient not present) (Requires same as 99374-99375)</td>
<td>15-29 minutes</td>
<td>$71.06 (B)</td>
</tr>
<tr>
<td>99377</td>
<td>Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Plan Oversight Services</td>
<td>30 minutes or more</td>
<td>$105.87 (B)</td>
</tr>
<tr>
<td>99378</td>
<td>Chronic Care Management Services</td>
<td>15-29 minutes</td>
<td>$78.24 (B)</td>
</tr>
<tr>
<td>99487</td>
<td>Complex chronic care management services, with the following required elements:</td>
<td>60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.</td>
<td>$93.67 (A)</td>
</tr>
<tr>
<td>99490</td>
<td>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:</td>
<td>multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;</td>
<td>$42.71 (A)</td>
</tr>
</tbody>
</table>
+ 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 dieticians, 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.
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)]

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:

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]

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

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

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.

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