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# 2017 Medicare Coding Changes and Values

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## Prolonged Service Without Direct Patient Contact

Typical Patient: An 85-year-old new patient with multiple complicated medical problems has relocated near her family. She is brought to a new physician's office by her daughter to be examined. The physician indicated that past medical records would be obtained from the patient's prior physicians' and that (s)he will communicate further with the daughter upon review of them.

Code	Description	2017 Payment	Required Elements	CPT Guidelines	CMS Guidelines	Service Period	Do Not Report With
99358*	Prolonged evaluation and management service before and/or after direct patient care; first hour.	\$113.41	Used to report non-face-to-face prolonged service time beyond the usual physician service time.	<p>May be reported on a different date than the primary service to which is it related.</p> <p>Must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.</p> <p>Does not need to be continuous.</p> <p>Time can not be counted more than once towards the provision 99358 and any other PFS service.</p>	Same as CPT guidelines.	Report only once per date of service.	99487 99489 99490 99495 99496 G0506
+99359*	; each additional 30 minutes (List separately in addition to code for prolonged service).	\$54.55	Used to report non-face-to-face prolonged service time beyond the usual physician service time.	<p>May be reported on a different date than the primary service to which is it related.</p> <p>Must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.</p> <p>Does not need to be continuous.</p> <p>Time can not be counted more than once towards the provision 99358 and any other PFS service.</p>	Same as CPT guidelines.	Must be reported with 99358.	99487 99490 99495 99496 G0506

‡ Indicates new code for 2017

\* Indicates existing codes, newly payable under Medicare

† Indicates add-on code, report in conjunction with an appropriated base code (not separately reportable)

## Care Management Services

99490 Typical Patient: A 75-year-old man with diabetes, claudication, and mild congestive heart failure, status post-myocardial infarction with mild dementia who had a peripheral arterial stent placed six weeks ago during a hospitalization for treatment of a foot ulcer. He lives with his daughter, participates in remote monitoring programs, and is being treated by two specialists in addition to his primary care physician.

99487 Typical Patient: An 83-year-old woman with congestive heart failure and early cognitive dysfunction, who has been hospitalized twice in the prior 12 months, is becoming increasingly confused and refuses an office visit. She has a certified nursing assistant supervised by a home care agency, participates in a remote weight and vital signs monitoring program, and sees a cardiologist and neurologist.

99489 Typical Patient: Same as 99487

Code	Description	2017 Payment	Required Elements	CPT Guidelines	CMS Guidelines	Service Period	Do Not Report With
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/ decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.	\$42.71	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 or death, acute exacerbation/ decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.	CCM services of less than 20 minutes duration, in a calendar month, are not reported separately.  Only the time of the clinical staff time is counted.	A given beneficiary is eligible to receive either complex or non-complex CCM during a given service period (calendar month), not both, and only one professional claim can be submitted to PFS for CCM for that service period by one practitioner.	Once per calendar month.	90951 – 90970 98960 – 98962 98966 – 98969 99071 99078 99080 99090 99091 99339 99340 99358 99359 99362 99364 99366 – 99368 99374 – 99380 99441 – 99444 99495 99496 99605-99607

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## Care Management Services (continued)

Code	Description	2017 Payment	Required Elements	CPT Guidelines	CMS Guidelines	Service Period	Do Not Report With
99487*	Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline, 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	Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline; establishment or substantial revision of a comprehensive care plan moderate or high complexity MDM 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	Complex CCM services of less than 60 minutes' duration, in a calendar month, are not reported separately.  Only the time of the clinical staff time is counted.	A given beneficiary is eligible to receive either complex or non-complex CCM during a given service period (calendar month), not both, and only one professional claim can be submitted to PFS for CCM for that service period by on practitioner.	Once per calendar month.	See 99490.

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## Care Management Services (continued)

Code	Description	2017 Payment	Required Elements	CPT Guidelines	CMS Guidelines	Service Period	Do Not Report With
+99489*	;each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).	\$47.01	See 99487.	Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.  Only the time of the clinical staff time is counted.	A given beneficiary is eligible to receive either complex or non-complex CCM during a given service period (calendar month), not both, and only one professional claim can be submitted to PFS for CCM for that service period by on practitioner.	Once per calendar month.	See 99490.
•+G0506	Comprehensive assessment and care planning for patients requiring chronic care management services (billed separately from monthly care management services).	\$63.88	The care plan that the practitioner must create in order to bill G0506 would be subject to the same requirements as the care plan included in the monthly CCM services (99490 or 99487).	N/A	Report G0506 when extensive assessment and care planning outside of the usual effort described by the billed E/M code is performed by the billing practitioner.	Once per billing practitioner for a given beneficiary at the onset of CCM.	Work reported under G0506 can not also be reported under or counted towards the reporting or any other billed code, including monthly CCM code.

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## Cognitive Impairment Assessment and Care Planning

Typical Patient: An elderly male with hypertension, diabetes, arthritis, and coronary artery disease presents with confusion, weight loss, and failure to maintain his house, in which he lives alone.

Code	Description	2017 Payment	Required Elements	CPT Guidelines	CMS Guidelines	Service Period	Do Not Report With
•G0505	Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office or other outpatient setting or home or domiciliary or rest home.	\$238.30	<p>Cognition-focused evaluation including a pertinent history and exam.</p> <p>MEM of moderate or high complexity.</p> <p>Functional assessment including decision-making capacity.</p> <p>Use of standardized instruments to stage dementia.</p> <p>Medication reconciliation and review for high-risk medications, if applicable.</p> <p>Evaluation for neuropsychiatric and behavioral symptoms.</p> <p>Evaluation of safety, including motor vehicle operation, if applicable</p> <p>Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and willingness of caregiver to take on caregiving tasks.</p> <p>Address palliative care needs, if applicable and consistent with beneficiary preference.</p> <p>Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed; care plan shared with the patient and /or caregiver with initial education and support.</p>	N/A	Only those practitioners eligible to report E/M services should report the service. Outside of the specified elements, the regular incident-to rules apply consistent with other E/M services.	Not specified. Subject to carrier coverage policies.	90785 90791 90792 96103 92610 96127 99201 – 99215 99341 – 99350 99366 – 99368 99497 99498 99374 G0506

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## Telehealth Critical Care Services

Typical Patient: A 63-year-old woman with severe aplastic anemia after initiating treatment with a new anti-epileptic drug regimen. The patient's hospital course was further complicated by an intracranial hemorrhage, leading to a prolonged course in the intensive care unit.

Code	Description	2017 Payment	Required Elements	CPT Guidelines	CMS Guidelines	Service Period	Do Not Report With
•G0508	Telehealth consultation, critical care, physicians typically spend 60 minutes communicating with the patient and providers via telehealth (initial).	\$153.24	Subject to CMS requirements for telemedicine including distant site practitioners, modality reimbursement limitations, geographic limitations, and originating site requirements.	CPT defines a critical illness or injury as an illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.	Subject to CMS requirements for telemedicine including distant site practitioners, modality reimbursement limitations, geographic limitations, and originating site requirements.	Once per date of service.	Not specified.
•G0509	Telehealth consultation, critical care, physicians typically spend 50 minutes communicating with the patient and providers via telehealth (subsequent).	\$146.50	Subject to CMS requirements for telemedicine including distant site practitioners, modality reimbursement limitations, geographic limitations, and originating site requirements.	CPT defines a critical illness or injury as an illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.	Subject to CMS requirements for telemedicine including distant site practitioners, modality reimbursement limitations, geographic limitations, and originating site requirements.	Once per date of service.	Not specified.

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