AMERICAN ACADEMY OF NEUROLOGY®

Care Management Service Codes

Chronic Care Management Services

Transitional Care Management Services

Cognitive Impairment Assessment and Care Planning

Advance Care Planning

2018 payment amounts are based on the national Medicare Physician Fee Schedule and are subject to regional variance

Chronic 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	2018 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.	$42.84	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, acurte exacerbation/ decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.	CCM sevices 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 on 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

Chronic Care Management Services (Continued)

Code	Description	2018 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.	$94.68	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, acurte 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.

Chronic Care Management Services (Continued)

Code	Description	2018 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).	$47.16	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).	$64.44	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.

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

Transitional Care Management Services

Typical Patient: A six year old who is neurologically impaired and developmentally delayed and has a chronic seizure disorder is discharged from the hospital after an admission for breakthrough seizures.

Code	Description	2018 Payment	Required Elements	CPT Guidelines	CMS Guidelines	Service Period	Do Not Report With
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	$167.04	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge	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 oir 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 postoperative period of a service that the individual reported.	Health care professionals who may furnish the services include: Physicians *Non-physician practitioners: -Certified nurse-midwives -Clinical nurse specialists -Nurse practitioners -Physician assistants	Once per 30-day period.	In conjunction with 93792, 93793 Do not report 90951 – 90970 98960 – 98962 98966 – 98969 99071 99078 99080 99090 99091 99339 99340 99358 99359 99366 – 99368 99374 – 99380 99441 – 99444 99487 – 99489 99605 – 99604 when performed during the service time of codes 99495 or 99496

*In this context NPPs refer to those non-physician practitioners who are legally authorized and qualified to provide the services in the State in which they are furnished.

Transitional Care Management Services (continued)

Typical Patient: A 93-year-old man is discharged after hospitalization for a myocardial infarction, complicated by hyperglycemia and delirium.

Code	Description	2018 Payment	Required Elements	CPT Guidelines	CMS Guidelines	Service Period	Do Not Report With
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	$236.52	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	See 99495	See 99495	See 99495	See 99495.

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	2018 Payment	Required Elements	CPT Guidelines	CMS Guidelines	Service Period	Do Not Report With
•99483	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.	$241.92	Cognition-focused evaluation including a pertinent history and exam. MEM of moderate or high complexity. Functional assessment including decision-making capacity. Use of standardized instruments to stage dementia. Medication reconciliation and review for high-risk medications, if applicable. Evaluation for neuropsychiatric and behavioral symptoms. Evaluation of safety, including motor vehicle operation, if applicable Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and willingness of caregiver to take on caregiving tasks. Address palliative care needs, if applicable and consistent with beneficiary preference. Creation of a care plan, including initial plans to address any neuropscychiatric symptoms and referral to community resources as needed; care plan shared with the patient and /or caregiver with initial education and support.	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

•Indicates new code for 2018

Advance Care Planning

99497 Typical Patient: A 68-year -old male with heart failure and diabetes on multiple medications is seen with his wife to discuss advanced care planning.
99498 Typical Patient: A 68-year-old male with heart failure and diabetes on multiple medications who was recently discharged from the intensive care unit is seen with his wife to discuss advance care planning.

Code	Description	2018 Payment	Required Elements	CPT Guidelines	CMS Guidelines	Service Period	Do Not Report With
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	$86.04	This code is used to report the face-to-face service between a physician or other qualified healthcare professional and a patient, family member, or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms.	When using codes 99497, 99498, no active management of the problem(s) is undertaken during the time period reported.	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	No limits on the number of times ACP can be reported for a given beneficiary in a given time period	Do not report 99497 and 99498 on the same date of service as 99291 99292 99468 99469 99471 99472 99475 99476 99477 99478
+99498	each additional 30 minutes (List separately in addition to code for primary procedure)	$75.96	See 99497	See 99497	See 99497	See 99497	See 99497

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