2025 Coding and Payment Resource for Transition from Pediatric to Adult Health Care

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To support the delivery of recommended transition services in pediatric and adult care settings, Got Transition and the American Academy of Pediatrics have partnered to develop this Health Care Transition (HCT) resource.

The 2023 reaffirmation of the 2018 Clinical Report Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home, by the American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians, emphasizes the need for structured transitions starting in early adolescence. The report promotes Got Transition's Six Core Elements of Health Care Transition™, which define the basic components of a structured transition process and include customizable sample tools for each core element. The Six Core Elements can be adapted for different patient populations and care settings. The customizable packages and accompanying implementation guides for the following clinical settings can be downloaded from Got Transition's website:

Transitioning Youth to an Adult Health Care Clinician

Transitioning to an Adult Approach to Health Care Without Changing Clinicians

Integrating Young Adults into Adult Health Care

Contents

Open Bookmarks for Links to Sections

Transition-Related Services and Payment

CPT Code	Description	100% Medicare Payment, 2025		
		Non-Facility	Facility	RVUs (Non-Facility/Facility)
Office or Other Outpatient Visit, New Patient				
99202	Straightforward medical decision making or total time that meets or exceeds 15 minutes	$69.87	$45.29	2.16/1.40
99203	Low level of medical decision making or total time that meets or exceeds 30 minutes	$109.01	$79.25	3.37/2.45
99204	Moderate level of medical decision making or total time that meets or exceeds 45 minutes	$163.35	$129.06	5.05/3.99
99205	High level of medical decision making or total time that meets or exceeds 60 minutes	$215.75	$175.64	6.67/5.43
Office or Other Outpatient Visit, Established Patient				
99211	Evaluation and management (E/M) that may not require the presence of a physician or other qualified health care professional (QHP)	$22.64	$8.41	0.70/0.26
99212	Straightforward medical decision making or total time that meets or exceeds 10 minutes	$54.99	$33.96	1.70/1.05
99213	Low level of medical decision making or total time that meets or exceeds 20 minutes	$88.95	$63.72	2.75/1.97
99214	Moderate level of medical decision making or total time that meets or exceeds 30 minutes	$125.18	$93.80	3.87/2.90
99215	High level of medical decision making or total time that meets or exceeds 40 minutes	$175.64	$138.77	5.43/4.29
Synchronous Audio-Video Evaluation and Management Services, New Patient				
98000	Straightforward medical decision making or total time that meets or exceeds 15 minutes	$49.81	$43.67	1.54/1.35
98001	Low level of medical decision making or total time that meets or exceeds 30 minutes	$82.16	$75.37	2.54/2.33
98002	Moderate level of medical decision making or total time that meets or exceeds 45 minutes	$131.00	$122.27	4.05/3.78
98003	High level of medical decision making or total time that meets or exceeds 60 minutes	$173.70	$164.32	5.37/5.08
Synchronous Audio-Video Evaluation and Management Services, Established Patient				
98004	Straightforward medical decision making or total time that meets or exceeds 10 minutes	$38.49	$32.67	1.19/1.01
98005	Low level of medical decision making or total time that meets or exceeds 20 minutes	$67.28	$60.81	2.08/1.88
98006	Moderate level of medical decision making or total time that meets or exceeds 30 minutes	$99.30	$90.57	3.07/2.80
98007	High level of medical decision making or total time that meets or exceeds 40 minutes	$131.65	$122.27	4.07/3.78

Synchronous Audio-Only Evaluation and Management Services, New Patient				
98008	Straightforward medical decision making or total time that meets or exceeds 15 minutes, including more than 10 minutes of medical discussion	$47.23	$41.73	1.46/1.29
98009	Low level of medical decision making or total time that meets or exceeds 30 minutes, including more than 10 minutes of medical discussion	$78.28	$72.46	2.42/2.24
98010	Moderate level of medical decision making or total time that meets or exceeds 45 minutes, including more than 10 minutes of medical discussion	$121.95	$114.18	3.77/3.53
98011	High level of medical decision making or total time that meets or exceeds 60 minutes, including more than 10 minutes of medical discussion	$158.50	$150.09	4.90/4.64

Synchronous Audio-Only Evaluation and Management Services, Established Patient				
98012	Straightforward medical decision making or total time that meets or exceeds 10 minutes, including more than 10 minutes of medical discussion	$35.26	$30.73	1.09/0.95
98013	Low level of medical decision making or total time that meets or exceeds 20 minutes, including more than 10 minutes of medical discussion	$61.46	$55.96	1.90/1.73
98014	Moderate level of medical decision making or total time that meets or exceeds 30 minutes, including more than 10 minutes of medical discussion	$89.82	$82.81	2.78/2.56
98015	High level of medical decision making or total time that meets or exceeds 40 minutes, including more than 10 minutes of medical discussion	$130.68	$122.27	4.04/3.78

Brief Synchronous Communication Technology Service (eg, Virtual Check-In), Established Patient				
98016	Brief communication technology-based service (e.g., virtual check-in) by a physician or other QHP provided to an established patient, 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	$15.85	$14.56	0.49/0.45

Office or Other Outpatient Consultations, New or Established Patient				
99242	Straightforward medical decision making or total time that meets or exceeds 20 minutes	$72.46	$53.37	2.24/1.65
99243	Low level of medical decision making or total time that meets or exceeds 30 minutes	$109.33	$85.07	3.38/2.63
99244	Moderate level of medical decision making or total time that meets or exceeds 40 minutes	$155.59	$129.06	4.81/3.99
99245	High level of medical decision making or total time that meets or exceeds 55 minutes	$202.81	$173.05	6.27/5.35

Prolonged Services				
99358	Prolonged E/M services before and/or after direct patient contact; first hour	$86.37	$85.07	2.67/2.63
99359	Each additional 30 minutes	$36.55	$34.93	1.13/1.08
99417	Prolonged outpatient E/M service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time	$29.76	$28.79	0.92/0.89

Medical Team Conference				
99366	With interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more; participation by nonphysician QHP	$39.14	$38.17	1.21/1.18
99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician	$51.43	$51.43	1.59
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician QHP	$33.64	$33.64	1.04

Preventive Medicine Services				
99384	Initial comprehensive preventive medicine E/M, new adolescent patient; ages 12 through 17 years	$129.71	$94.45	4.01/2.92
99385	Ages 18 through 39 years	$126.15	$90.57	3.90/2.80
99394	Periodic comprehensive preventive medicine revaluation and management of an established adolescent patient, ages 12 through 17 years	$110.63	$79.90	3.42/2.47
99395	Ages 18 through 39 years	$113.86	$82.81	3.52/2.56

Health Risk Assessment				
96160	Administration of patient-focused health risk assessment instrument (e.g., transition readiness assessment) with scoring and documentation, per standardized instrument	$2.91	$2.91	0.09

Behavioral Health Integration Care Management				
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other QHP, per calendar month	$53.05	$41.40	1.64/1.28

Chronic Care Management				
99490	Chronic care management services with required elements: 2 or more chronic conditions expected to last at least 12 months, or until death, and that place the patient at significant risk of death, acute exacerbation/decomposition, or functional decline; comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other QHP, per calendar month	$60.49	$47.87	1.87/1.48
99439	Each additional 20 minutes	$45.43	$32.99	1.42/1.02
99491	Chronic care management services with required elements: 2 or more chronic conditions expected to last at least 12 months, or until death, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other QHP, per calendar month	$82.16	$72.46	2.54/2.24
99437	Each additional 30 minutes	$57.58	$47.87	1.78/1.48

Complex Chronic Care Management				
99487	Complex chronic care management services with required elements: 2 or more chronic conditions expected to last at least 12 months, or until death; chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored; moderate or high complexity medical decision-making; first 60 minutes of clinical staff time directed by a physician or other QHP, per calendar month	$131.65	$87.01	4.07/2.69
99489	Each additional 30 minutes	$70.52	$47.23	2.18/1.46

Principal Care Management				
99424	Principal care management services for a single high-risk disease with required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death; the condition requires development, monitoring, or revision of disease-specific care plan; the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities; ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other QHP, per calendar month	$80.87	$72.13	2.50/2.23
99425	Each additional 30 minutes	$58.87	$49.17	1.82/1.52
99426	Principal care management services for a single high-risk disease with required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death; the condition requires development, monitoring, or revision of disease-specific care plan; the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities; ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other QHP, per calendar month	$61.78	$47.55	1.91/1.47
99427	Each additional 30 minutes	$50.46	$34.29	1.56/1.06

Transitional Care Management				
99495	Transitional care management services with required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; at least moderate level of medical decision-making during the service period; and face-to-face visit within 14 calendar days of discharge	$201.20	$134.24	6.22/4.15
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; high level of medical decision-making during the service period; and face-to-face visit within 7 calendar days of discharge	$272.68	$182.43	8.43/5.64

Nonphysician Telephone Assessment and Management				
98966	Telephone assessment and management service provided by a nonphysician QHP 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	$12.94	$11.32	0.40/0.35
98967	11-20 minutes of medical discussion	$23.94	$22.00	0.74/0.68
98968	21-30 minutes of medical discussion	$32.99	$30.73	1.02/0.95

Online Digital Evaluation and Management				
99421	Physician or other QHP Online digital E/M service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	$14.56	$12.29	0.45/0.38
99422	11-20 minutes	$28.46	$24.58	0.88/0.76
99423	21 or more minutes	$44.96	$38.17	1.39/1.18
98970	Nonphysician QHP online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	$11.32	$11.32	0.35
98971	11-20 minutes	$21.35	$21.35	0.66
98972	21 or more minutes	$32.35	$32.02	1.00/0.99

Interprofessional Telephone/Internet/Electronic Health Record (EHR) Consultations				
99446	Interprofessional telephone/Internet/EHR assessment and management service provided by a consultative physician or other QHP, including a verbal and written report to the patient's treating/requesting physician or other QHP; 5-10 minutes of medical consultative discussion and review	$17.14	$17.14	0.53
99447	11-20 minutes of medical consultative discussion and review	$34.61	$34.61	1.07
99448	21-30 minutes of medical consultative discussion and review	$51.43	$51.43	1.59
99449	31 minutes or more of medical consultative discussion and review	$69.54	$69.54	2.15/2.15
99451	Interprofessional telephone/Internet/EHR assessment and management service provided by a consultative physician or other QHP, including a written report to the patient's treating/requesting physician or other QHP; 5 minutes or more of medical consultative time	$32.99	$32.99	1.02
99452	Interprofessional telephone/Internet/EHR referral service(s) provided by a treating/requesting physician or other QHP, 30 minutes	$33.64	$33.64	1.04

CMS issued a final rule in January 2023 stating that interprofessional consultation codes must involve a specialist. The codes cannot be used for consultation between two primary care clinicians. See here for the final rule.

Digitally Stored Data Services/Remote Physiologic Monitoring				
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	$19.73	$19.73	0.61
99454	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	$43.02	$43.02	1.33
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other QHP, qualified by education, training, licensure/regulation (when applicable), requiring a minimum of 30 minutes of time, each 30 days	$51.75	$51.75	1.60
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration	$13.91	$13.91	0.43
99474	Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other QHP, with report of average systolic and diastolic pressures, and subsequent communication of a treatment plan to the patient	$16.50	$8.41	0.51/0.26

Remote Physiologic Monitoring Treatment Management				
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other QHP time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes	$47.87	$28.79	1.48/0.89
99458	Each additional 20 minutes	$38.49	$28.79	1.19/0.89

Education and Training for Patient Self-Management				
98960	Education and training for patient self-management by a nonphysician QHP using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	$30.41	$30.41	0.94
98961	2-4 patients	$14.56	$14.56	0.45
98962	5-8 patients	$10.67	$10.67	0.33

Miscellaneous Services				
99078	Physician or other QHP qualified by education, training, licensure/regulation (when applicable), educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)	N/A	N/A	N/A

Modifiers	
25	Significant, separately identifiable E/M service by the same physician or other QHP on the same day of the procedure or other service
59	Distinct procedural service
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system

In some cases, payers may not use the Medicare total RVUs for a service in calculating physician payment. Instead, they may apply their own relative value adjustments.

Nonphysician healthcare professionals are healthcare professionals who may report their services through their own National Provider Identifier (NPI) numbers but who otherwise typically would not report those Evaluation and Management services reported by physicians and QHPs. Such nonphysician healthcare professionals may include speech-language pathologists, physical therapists, occupational therapists, social workers, and dieticians

Transition Clinical Vignettes

Vignette #1: Transition from Hospital to Outpatient Management

A 12-year-old male patient has just been released from the hospital after having had a traumatic brain injury with loss of consciousness caused by a serious car accident. The primary care physician communicates with the parent within 1 day of hospital discharge regarding recommended follow-up treatment. The primary care physician reviews discharge information and determines the necessary tests and physical therapy requirements. The physician's clinical staff communicates with a physical therapist to coordinate the treatment plan and contacts the youth's school to provide medical authorization for extended absence. The physician 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.

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)

Coding Tips:
Codes **99495** and **99496** for Transitional Care Management:

- Requires communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days after the date of discharge.
- Code selection is based on the level of MDM for the face-to-face visit, either moderate or high, and whether the visit takes place 7 or 14 days post-discharge.
- A visit more than 14 days post-discharge cannot be reported with TCM codes; refer to codes **99202** – **99215**.

Vignette #2: Routine Preventive Visit

Preventive medicine visit with a new 14-year-old female patient with no chronic conditions. Physician takes a medical history, completes a physical exam, and provides anticipatory guidance as part of the comprehensive preventive medicine examination. The youth and her parent separately complete a scorable transition readiness assessment form in the portal beforehand, 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.

CPT
99384-25 (Preventive medicine visit, new patient, ages 12-17) (with significant, separately identifiable procedure performed by the same physician or other qualified healthcare professional on the same day as the preventative medicine or E/M service)
96160 (Patient-focused health risk assessment instrument)

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)

Coding Tips:

- If an abnormality is encountered or a preexisting problem is addressed during a 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 **99202**-**99205**, **99211**-**99215** should also be reported. A 25 modifier should be added to the problem-oriented service.
- Assessment tool documentation should include:
    - name of screener and score
    - clinical interpretation of the results

Vignette #3: Office Visit for Chronic Condition with Health Risk Assessment and Patient Education

Office visit with an 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, the youth completes a scorable transition readiness assessment form. The physician provides counseling on medication adherence, understanding his symptoms, and the appropriate use of the emergency department. 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 set an alarm reminder on his cell phone, given that the 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 40 minutes; 10 minutes of this time was spent interpreting and discussing the transition readiness assessment form. After the physician meets with the patient, a qualified, non-physician healthcare professional, such as a nurse, provides the patient with 20 minutes of education and training on asthma self-care using a standardized curriculum.

CPT

99214 (Office visit, established patient, moderate level of medical decision making)
96160 (Patient-focused health risk assessment instrument)
98960 (Education and training of patient self-management)

ICD 10 CM

Z71.87 (Encounter for pediatric-to-adult transition counseling)
J45.40 (Moderate persistent asthma, uncomplicated)

Coding Tip:

Codes **98960-98962** for Education and Training Services for Patient Self-Management:

- Must be prescribed by a physician or QHP.
- Service must be provided by a nonphysician QHP (example: RN, Registered Dietitian, or Licensed Clinical Social Worker) using a standardized curriculum to treat or delay illness or comorbidities.
- The standardized curriculum may be modified for clinical needs, cultural norms, and health literacy.
- The patient's diagnosis must support the education provided.

Vignette #4: Final Preventive Care Visit with Transfer Planning

Preventive medicine visit with an established 18-year-old female for her final pediatric visit before she attends 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 persistent sadness and high levels of stress associated with all the changes that are happening in her life. The physician takes an extra 20 minutes to reassess her depression and advises a medication change. 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. The day after 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 physician, which includes an updated medical summary, an updated plan of care, and a scorable transition readiness assessment.

CPT

99395 (Preventive medicine visit, established visit, ages 18-39)
99213-25 (Office visit, established patient, Low level of medical decision making or total time that meets or exceeds 30, 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)
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)
F32.9 (Major depressive disorder, single episode, unspecified)
Z71.87 (Encounter for pediatric-to-adult transition counseling)

Coding Tip:

Codes **99358, 99359** for prolonged E/M services before and/or a fter direct patient contact

- Applicable to prolonged services on a different date than a related E/M service that has or will happen in the future.
- The related E/M service can be any level of MDM or total time.
- The time spent should be on a given date, but does not have to be continuous.
- Code **99358** is used to report the first hour of prolonged service. Code **99359** is used to report each additional 30 minutes beyond the first hour.
- Prolonged service of less than 30 minutes total duration on a given date cannot be reported.

Vignette #5: Final Office Visit with Transfer Planning of Medically Complex Young Adult

Office visit with an established 20-year-old female patient with spastic quadriplegia and epilepsy. She depends on a motorized wheelchair for mobility, a speech assist device for communication, and a gastrostomy tube for nutrition. Her mother is with her and has legal guardianship. During this routine chronic care visit, the physician 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 orders medication monitoring labs for her anti-seizure medication. The physician discusses the timing of transfer and the selection of an adult physician with the young adult and their parent. The physician discusses with the young adult and their parent the actions that need to be taken before transfer, including coordinating transfer plans with their other physicians, preparing an updated medical summary and emergency care plan, and consulting with the new adult doctor. The pediatric physician calls the new adult physician on the day of the visit to discuss the pending transfer and the medical situation. He spends a total of 70 minutes working on this patient on the day of the visit. Three days after this last pediatric visit, the physician 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.

CPT

99215 (Office visit, established patient, high level of medical decision making, or total time that meets or exceeds 40 minutes)
99417 (Prolonged office services on date of the primary service; each 15 minutes)
96160 (Patient-focused health risk assessment instrument)
99487 (Complex chronic care management service, 60 minutes)

ICD 10 CM

G40.90 (Epilepsy, unspecified, not intractable)
Z93.1 (Gastrostomy status)
G80.0 (Spastic quadriplegic cerebral palsy)
Z71.87 (Encounter for pediatric-to-adult transition counseling)

Coding Tip:

Codes **99487** and **99489** for Complex Chronic Care Management:

- CCCM Requires:
    - Coordination of several specialties and services
    - An established, implemented, revised, or monitored comprehensive care plan
    - A minimum of 60 minutes of clinical staff time per month
- Clinical staff provides the care under the direction of a physician or other QHP.
- patients must 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.
- Patients' conditions must require moderate or high medical decision making as defined in the E/M guidelines.

Vignette #6: Initial Adult Specialist Visit with New Young Adult

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. Before the initial visit, the medical assistant makes a pre-visit call to determine the need for special accommodation and offers an appointment reminder. During the visit, the new adult physician receives and reviews the transfer letter, plan of care, medical summary, and emergency care plan, as well as the transition readiness assessment. The nurse has her fill out a post-transfer self-care assessment form while in the waiting room. The adult physician spends 45 minutes discussing information about their practice, their approach to consent and privacy, 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-transfer self-care assessment and identifies the skills the young adult still needs to focus on to manage their own health and healthcare. The physician also assesses if she needs other care management support. Over the next week, the physician begins the process of finding and contacting a new adult internist for primary care and other subspecialists, including an adult nephrologist and ophthalmologist. The insurer requires new prior authorizations for medications.

CPT

99205 (Office visit, new patient, high level of medical decision making, or total time that meets or exceeds 60 minutes)
99242 (Principal care management, first 30 minutes of physician or QHP time)
96160 (Patient-focused health risk assessment instrument)

ICD 10 CM

M32.14 (Glomerular disease in systemic lupus erythematosus)

Coding Tip:

Codes **99424 - 99427** for Principal Care Management:

- PCM focuses on the medical and/or psychological needs manifested by a single, complex chronic condition expected to last at least 3 months
- Requires an established, implemented, revised, or monitored comprehensive care plan
- **99424** and **99425** represent physician or QHP time
- **99426 99427 represents** clinical staff time

Vignette #7: Initial Primary Care Office Visit with New Young Adult

New adult office visit with a 22-year-old young adult male transitioning from his pediatric primary care physician, who he saw for a preventive office visit 6 months earlier. The young adult male comes with no previous medical records from the physician. 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 complete a medical summary, and the physician assists the young adult in entering his emergency contact information and key medical details into his phone. The physician spends a total of 45 minutes, including counseling the patient, reviewing and discussing needed self-care skills, interfacing with the pediatric practice, and discussing nutrition, exercise, and weight reduction strategies.

CPT

99204 (Office visit, new patient, moderate level of medical decision making, or total time that meets or exceeds 45 minutes)
96160 (Patient-focused health risk assessment instrument)

ICD 10 CM

E66.3 (Overweight and obesity)

Z71.89 (Persons encountering health services for other counseling and medical advice, not elsewhere classified)

Coding Tip:
Codes **99202 - 999205** for Office and other outpatient services, new patient guidelines:

- A patient who has not received any professional services from the physician/qualified health care professional (QHP) or another physician/QHP of the same specialty and subspecialty who belongs to the same group practice, within the past three years.
- If a patient is seen by a physician/QHP on call for or covering for another physician/QHP, the patient's encounter will be classified as it would have been by the physician/QHP who is not available.
- When advanced practice nurses and physician assistants are working with physicians in the same practice, they are considered to be working in the same specialty and same subspecialties as the physician.

Vignette #8: Non-Face-to-Face Services for A Young Adult with Chronic Conditions Before Initial Adult Physician Visit

A new 24-year-old female patient with spina bifida and hydrocephalus is referred by her pediatric primary care physician to an adult primary care physician. The young adult requested that her records from her urologist, neurologist, neurosurgeon, physiatrist, and pediatric primary care physician be sent to the new adult physician's office before her initial visit. Upon receipt, the adult physician reviews the extensive medical records from all five physicians. The adult physician calls the pediatric primary care physician 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. A face-to-face appointment is scheduled in 2 weeks.

CPT
99358 (Prolonged service without direct patient contact, new patient, 60 minutes) would be reported by both the pediatric and adult providers.

ICD 10 CM
Q05.2 (Lumbar spina bifida with hydrocephalus)

Coding Tip:
See Vignette #4

Vignette #9: Interprofessional Consultation between Adult Primary Care Physician and Pediatric Developmental Behavioral Specialist

After the patient's second visit to the adult primary care physician, the physician requested an interprofessional consultation with the patient's previous pediatric physician regarding 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. The young adult has signed a HIPAA form, allowing his mother to be present during the visit. 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 pediatric physician is warranted to determine subsequent management. The adult physician communicates by telephone with the consulting pediatric physician for this interprofessional consultation and reviews the medication situation. The adult primary care physician also reviews that the patient (a college freshman) and mother note inattentiveness, hyperactivity, forgetfulness, and persistent organizational weaknesses. Grades are Cs. The patient denies experiencing any side effects from the medication. Psychosocial stressors are denied. The patient's extracurricular activities include pickup basketball, and he reports sleeping 6 hours nightly. The consulting pediatrician spends 25 minutes discussing the patient via telephone with the adult physician, making recommendations on pharmacological and behavioral management, and emphasizing the importance of adequate sleep. Included in this

time, the pediatric physician dictates a consultation report to be sent back to the adult physician, and the adult physician contacts the patient with recommendations. The total adult physician time was 50 minutes, consisting of 25 minutes face-to-face with the patient and 25 minutes for an interprofessional consultation. The total pediatric physician time was 35 minutes, consisting of 25 minutes for interprofessional consultation and 10 minutes for report dictation.

For the adult physician (if the face-to-face E/M visit with the young adult was on the same day as the interprofessional consultation with the pediatric physician):

CPT
99215 (Office visit, established patient, high level of medical decision making, or total time that meets or exceeds 40 minutes). The total physician time was 50 minutes, consisting of 25 minutes face-to-face with the patient and 25 minutes for interprofessional consultation.

ICD 10 CM
Z71.87 (Encounter for pediatric-to-adult transition counseling)
F90.2 (Attention-deficit hyperactivity disorder, combined type)

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

CPT
99213 for the 25 minutes spent with the patient on the previous day (Office visit, established patient, low level of medical decision making, or total time that meets or exceeds 30)
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 halfway point regarding time [according to CPT Professional Edition 2023]: "A unit of time is attained when the mid-point is passed. For example, 60 minutes is attained when 31 minutes have elapsed [more than midway between zero and 60 minutes]."**)**

ICD 10 CM
Z71.87 (Encounter for pediatric-to-adult transition counseling)
F90.2 (Attention-deficit hyperactivity disorder, combined type)

For the pediatric physician (regardless of what day the consultation was done):

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)

Coding Tips:

Codes for Interprofessional Telephone/Internet/Electronic Health Record Consultations **99446**-**99449**, and **99451**, **99452**:

- Do not require a face-to-face visit from the consultant offering their opinion.
- If a transfer of care occurs, the consultant cannot report this service.
- This service is requested by the treating physician for an opinion on how to treat the patient. The consulting physician must have required specialty expertise to care for the patient.
- The requesting physician may report 99452 if spending at least 16 minutes that day preparing for the referral and communicating with the consultant.
- Both verbal and written reports are required for completion of the services represented by 99446–99449.
- A written report is the only communication required for 99451.

Vignette #10: Initial Telehealth Specialist Office Visit with New Young Adult

An adult rheumatologist provides a first evaluation and management visit via telehealth to a 19-year-old female 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 had scheduled a visit to the office of an adult rheumatologist just before spring break, her symptoms had deteriorated, and she requested this telehealth office visit with an adult rheumatologist. Before the telehealth visit, the rheumatologist's staff guides the patient through completing an online scorable post-transition self-care skills assessment, and the patient provides consent for the telehealth appointment, including assurance that she is in a HIPAA-secure environment. Via a secure, real-time, two-way audio-visual telehealth platform, the rheumatologist conducts a comprehensive history and exam. The patient tells the adult rheumatologist that she has been in college for 4 months and that her morning stiffness has returned over the past month. Additionally, her hands are swollen in the morning, making it difficult for her to take notes in class. She recently decided on her own to lower her methotrexate dose from eight 2.5 mg 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. The rheumatologist can see that her hands are swollen, and she is unable to make a fist in either hand. The adult rheumatologist discusses the scorable post- transition self-care skills assessment that she completed prior to the telemedicine visit, and explains how to refill her methotrexate 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 obtain these at college, have the results faxed to the office, and that the office will notify her of the results. The adult rheumatologist instructs her to increase the methotrexate dose back to 8 tablets per week, if the lab results are normal, and to continue her etanercept treatment. The adult rheumatologist scheduled a follow-up visit in one month.

CPT

99204-95 (Office visit, new patient, moderate level of medical decision making or total time that meets or exceeds 45 minutes; service rendered via a real-time interactive audio and video telecommunications system)
Or
98002 (Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded)

96160 (Patient-focused health risk assessment instrument)

ICD 10 CM

M08.99 (Juvenile arthritis, unspecified, multiple sites)

Coding Tips:

Code selection for telemedicine services

- 99204-95 and 98002 represent the same service.
- Due to Medicare not including the new telemedicine codes as a covered CPT code, and choosing to continue the use of existing codes and modifiers, some Medicaid and commercial payers have chosen to follow suit.
- 96160 may be reported for each separate screening tool completed.
- Medicare has an edit that prevents more than 3 units of any screening code being paid on a single date of service. Review payer policies as their guidance may differ from that of Medicare.

Vignette #11: Medical Team Conference

An 18-year-old with spina bifida attends a multi-disciplinary follow-up with his parents. He and his care team have decided that this will be his last visit with his pediatric care team, after which he will transfer to adult healthcare providers. He sees the neurologist, neurosurgeon, PM&R physician, and physical therapist. A week later, at the monthly multi-disciplinary spina bifida conference, the neurologist, neurosurgeon, PM&R physician, and therapists discuss the patient's current management, organize his medical history, and confirm the logistics of his transfer to corresponding adult specialists. The discussion of his case takes 35 minutes.

CPT

Each physician (neurologist, neurosurgeon, PM&R): **99367** (Medical team conference, not face-to-face)

Physical therapist: **99368** (Medical team conference, nonphysician QHP, not face-to-face)

ICD10 CM

Q05.7 (Lumbar spina bifida without hydrocephalus)

Coding Tips:

Medical Team Conference codes:

- Include face-to-face participation by a minimum of 3 QHPs from different specialties or disciplines.
- Require clinicians to be actively involved in the development, revision, coordination, and implementation of health care services needed by the patient; if not, these codes should not be reported for payment.
- 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 the total time reported. Time reported for medical team conferences may not be used in determining the time for other services.

References

- White P, Cooley C, Transitions Clinical Report Authoring Group, American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Supporting the health care transition from adolescence to adulthood in the medical home. Pediatrics. 2023;142(5):e20182587.
- American Medical Association. 2025 CPT Professional Edition. Chicago, IL: AMA, 2025.
- Committee on Coding and Nomenclature. Coding for Pediatrics 2025. Itasca, IL: American Academy of Pediatrics, 2025.

Appendix A: Characteristics of Services Specific to Physician Designation

CPT Code	Physician or Other QHP[1]		Clinical Staff Member[2]	
	F2F[3]	Non-F2F[4]	F2F[3]	Non-F2F[4]
Office or Other Outpatient Services, New Patient				
99202	X			
99203	X			
99204	X			
99205	X			
Office or Other Outpatient Services, Established Patient				
99211	X			
99212	X			
99213	X			
99214	X			
99215	X			
Synchronous Audio-Video E/M Services, New Patient				
98000	X			
98001	X			
98002	X			
98003	X			
Synchronous Audio-Video E/M Services, Established Patient				
98004	X			
98005	X			
98006	X			
98007	X			
Synchronous Audio-Only E/M Services, New Patient				
98008	X			
98009	X			
98010	X			
98011	X			
Synchronous Audio-Only E/M Services, Established Patient				
98012	X			
98013	X			
98014	X			
98015	X			
Brief Synchronous Communication Technology Service (eg, Virtual Check-In)				
98016	X			
Office or Other Outpatient Consultations, New or Established Patient				
99242	X			
99243	X			
99244	X			
99245	X			
Prolonged Services				
99358		X		
99359		X		
99417	X	X		
Medical Team Conference				
99366	X			
99367		X		
99368		X		
Preventive Medicine Services				
99384	X			
99385	X			
99394	X			
99395	X			

CPT Code	Physician or Other QHP[1]		Clinical Staff Member[2]	
	F2F[3]	Non-F2F[4]	F2F[3]	Non-F2F[4]
Health Risk Assessment				
96160	X	X	X	X
General Behavioral Health Integration Care Management				
99484			X	X
Care Management Services				
99490			X	X
99439			X	X
99491		X		
99437		X		
99487			X	X
99489			X	X
99424		X		
99425		X		
99426			X	X
99427			X	X
Hospital Transitional Care Management Services				
99495	X	X	X	X
99496	X	X	X	X
Telephone Services				
98966		X		
98967		X		
98968		X		
Online Digital Evaluation and Management Services				
99421		X		
99422		X		
99423		X		
98970		X		
98971		X		
98972		X		
Interprofessional Telephone/Internet/EHR[5] Consultations				
99446		X		
99447		X		
99448		X		
99449		X		
99451		X		
99452		X		
Digitally Stored Data Services/Remote Physiologic Monitoring				
99453		X		
99454		X		
99091		X		
99473		X		
99474		X		
Remote Physiologic Monitoring Treatment Management Services				
99457	X		X	
99458	X		X	
Education and Training for Patient Self-Management				
98960	X			
98961	X			
98962	X			
Miscellaneous Services				
99078	X			

[1] The American Medical Association distinguishes a qualified health care professional (QHP) from a clinical staff member in terms of which physicians may report services. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within their scope of practice and independently reports that professional service. In addition to physicians, other qualified healthcare professionals include, but are not limited to, clinical nurse specialists, nurse practitioners, physician assistants, and clinical social workers.

[2] A "clinical staff member" is a person working under the supervision of a physician or other QHP; they are allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but do not individually report the service. Clinical staff include, but are not limited to, medical assistants and licensed practical nurses.

[3] F2F = face-to-face services. Physical face-to-face presence and synchronous real-time audio-visual face-to-face are considered equivalent. Note this statement from 2023 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."

[4] Non-F2F = non-face-to-face services

[5] EHR = electronic health record

Appendix B: Letter Template to Payers Regarding Recognition of Codes Related to Pediatric-to-Adult Transition Services

Instructions:
This letter can be customized and sent to payers to advocate for payment of the transition-related services included in this guide. The table on the next page should be edited to list the CPT codes not currently recognized. Download the customizable letter here.

Address to Insurance Carrier Claims Review Department
Address to Insurance Carrier Medical Director

Dear (to be individually addressed on practice or chapter letterhead):

I am writing to object to [Carrier Name's] policy of [select as appropriate: either not covering, bundling, or inadequately paying for] CPT codes related to the transition from pediatric to adult care. Transition services are designed to be integrated into 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 payer may otherwise deny the services. The specific CPT codes listed below are necessary for reporting the additional time and work associated with transition services and should be paid accordingly.

These transition-related codes align with the pediatric and adult patient-centered medical home model of care[1] and the AAP/AAFP/ACP Clinical Report on Transition to Adulthood,[2] which calls for a structured transition process that begins early in adolescence and continues 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 process improves adherence to care, consumer satisfaction, utilization of adult ambulatory care services, and disease-specific outcomes.[3,4] A complete list of transition-related codes with corresponding Medicare fees, relative value units, and clinical vignettes was published in 2025.[5]

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 for the practice's reference)]**.

We urge you to recognize and pay appropriately for these services related to the transition from pediatric to adult care. We look forward to your response regarding your coverage and payment policy for these healthcare transition-related CPT codes. If you have any questions or require further information, please do not hesitate to contact **[include contact information]**.

Sincerely,
X

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[1] McManus M, White P, Borden C. *Incorporating Pediatric-to-Adult Transition into NCQA Patient-Centered Medical Home Recognition: 2019 Update.* Washington, DC: Got Transition®, October 2019.
[2] 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.
[3] 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.* 2017; 188:263-269.
[4] Schmidt A, Ilango S, McManus M, Rogers K, White P. Outcomes of pediatric to adult health care transition interventions: An updated systematic review. *Journal of Pediatric Nursing*. 2020; 51:92-107.
[5] Schmidt A, McManus M, White P, Muntean-Turner S, Lalor K. *2025 Coding and Payment Resource for Transition from Pediatric to Adult Health Care.* Washington, DC: Got Transition® and American Academy of Pediatrics, October 2025.

Summary Listing of CPT Codes Related to Transition

Applicable Transition CPT Codes	Service Descriptions
99202-99205, 99211-99215	Office or other outpatient visit
98000-98016	Telemedicine services
99242-99245	Office or other outpatient consultations
99358, 99359, 99417	Prolonged services
99366-99368	Medical team conference
99384, 99385, 99394, 99395	Preventive medicine services
96160	Health risk assessment (e.g., transition readiness/self-care assessment)
98966-98968	Telephone services
99421-99423, 98970-98972	Online digital evaluation and management services
99446-99449, 99451, 99452	Interprofessional telephone/Internet/electronic health record assessment and management services
99487, 99489	Complex chronic care management services
99424-99427	Principal care management services for managing a patient with a single, complex problem
99490, 99439, 99491, 99437	Chronic care management services
99484	General behavioral health integration care management
99495, 99496	Hospital transitional care management services
99453, 99454, 99091, 99473, 99474	Digitally stored data services/remote physiologic monitoring
99457, 99458	Remote physiologic monitoring treatment management services
98960-98962	Education and training for patient self-management services
99078	Miscellaneous services
25, 59, 95	Modifiers

Clinical Resources

Got Transition

Six Core Elements of Health Care Transition
Six Core Elements Implementation Guides
Six Core Elements Measurement Tools

American Academy of Pediatrics Clinical Report

Supporting the Health Care Transition From Adolescence to Adulthood in the Medical Home

Coding and Payment Resources

American Academy of Pediatrics:

Child Health Finance & Payment Strategy Website
Coding and Valuation Website
Coding and Payment Hotline

American Medical Association:

E/M Coding Resources
Tools for proper payment & appeals
Downcoding Website

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