ALLIANCE for CONNECTED CARE

Summary: Proposed Calendar Year 2022 Physician Fee Schedule

On July 13, 2021, CMS issued the proposed Calendar Year 2022 (CY2022) Physician Fee Schedule (PFS), which makes payment and policy changes under Medicare Part B.

CMS is proposing to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023 – December 31, 2023 – to allow for time to collect more information regarding utilization of these services during the pandemic, and provide stakeholders the opportunity to continue to develop support for the permanent addition of appropriate services to the telehealth list through the regular consideration process, which includes notice-and-comment rulemaking.

In addition, CMS is proposing to amend the current regulatory requirement for interactive telecommunications systems to include audio-only communication technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes. CMS is proposing to limit the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of using, or does not consent to, the use of two-way, audio/video technology.

Finally, CMS is proposing to require an in-person visit be provided by the physician or practitioner furnishing mental health telehealth services within six months prior to the initial telehealth service, and at least once every six months thereafter.

- CMS is seeking comment on whether a different interval may be necessary or appropriate for mental health services furnished through audio-only communication technology.
- CMS is also seeking comment on how to address scenarios where a physician or practitioner of the same specialty/subspecialty in the same group may need to furnish a mental health service due to unavailability of the beneficiary's regular practitioner.

CMS is also soliciting comment on: (1) whether additional documentation should be required in the patient's medical record to support the clinical appropriateness of audio-only telehealth; (2) whether or not CMS should preclude audio-only telehealth for some high-level services, such as level 4 or 5 E/M visit codes or psychotherapy with crisis; and (3) any additional guardrails CMS should consider putting in place in order to minimize program integrity and patient safety concerns.

Below is a summary of key payment and policy changes within the rule. **Comments are due by September 13, 2021.**

See the Fact Sheet and Proposed Rule.

II. Provisions of the Proposed Rule for the PFS

D. Telehealth and Other Services Involving Communications Technology and Interim Final Rule with Comment Period for Coding and Payment of Virtual Check-in Services – Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

1. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

- ***b. Requests to Add Services to the Medicare Telehealth Services List for CY 2022***
    - CMS found that none of the requests received by the February 10th submission deadline met Category 1 or Category 2 criteria for permanent addition to the Medicare

telehealth services list. As a reminder, Category 1 that the requested services are similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list, and that the criterion for adding services under Category 2 is that there is evidence of clinical benefit if provided as telehealth.

- ***c. Revised Timeframe for Consideration of Services Added to the Telehealth List on a Temporary Basis***
    - In the CY 2021 PFS final rule (85 FR 84506), in response to the PHE for COVID-19, CMS created a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis.
    - **CMS proposes to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023.** This will allow CMS time to collect more information regarding utilization of these services during the pandemic, and provide stakeholders the opportunity to continue to develop support for the permanent addition of appropriate services to the telehealth list through our regular consideration process, which includes notice-and-comment rulemaking.
    - CMS will facilitate the submission of requests to add services permanently to the Medicare telehealth services list for consideration in the CY 2023 PFS rulemaking process and for consideration in the CY 2024 PFS rule.
    - See Table 11 (appendix 1) for a list of services that were added to the Medicare telehealth services list on an interim basis to respond to the PHE for COVID-19, but **were not** extended on a temporary Category 3 basis in the CY 2021 PFS final rule. Under our current policy, these services will be removed from the Medicare telehealth services list as of the date that the PHE for COVID-19 ends.
    - **CMS is soliciting comment on whether any of the services that were added to the Medicare telehealth list for the duration of the PHE for COVID-19 should now be added to the Medicare telehealth list on a Category 3** basis to allow for additional data collection for submission for CMS to consider as part of the rulemaking process described in prior paragraphs.

- ***d. Implementation of Provisions of the Consolidated Appropriations Act, 2021 (CAA)***
    - **CMS is seeking comment on whether they should adopt a claims-based mechanism to distinguish between the mental health telehealth services that are within the scope of the CAA amendments and those that are not** (in other words, the services for which payment was newly authorized by the CAA amendments, and those for which payment was authorized before the CAA amendments), and if so, what that mechanism should be. In the event that CMS needs to distinguish between the mental health telehealth services that are within the scope of the CAA amendments and those that are not CMS is also seeking comment on whether a clarification should be added to the regulation.
    - **CMS is also seeking comment on whether the required in-person, non-telehealth service could also be furnished by another physician or practitioner of the same specialty and same subspecialty within the same group as the physician or practitioner who furnishes the telehealth service.** CMS notes that the language in the CAA states that the physician or practitioner furnishing the in-person, non-telehealth service must be the same person as the practitioner furnishing the telehealth service. There are several circumstances, however, under which CMS have historically treated the billing

practitioner and other practitioners of the same specialty or subspecialty in the same group as if they were the same individual
    - CMS is interested in comments regarding the extent to which a patient routinely receiving mental health services from one practitioner in a group might have occasion to see a different practitioner of the same specialty in that group for treatment of the same condition.
    - CMS is seeking comments on an alternative policy to also allow the prerequisite in-person, non-telehealth service for certain mental health telehealth services to be furnished by a practitioner in the same specialty/subspecialty in the same group when the physician or practitioner who furnishes the telehealth service is unavailable or the two professionals are practicing as a team
- **CMS is proposing to require that an in-person, non-telehealth service must be furnished by the physician or practitioner at least once within 6 months before each telehealth service furnished for the diagnosis, evaluation, or treatment of mental health disorders by the same practitioner, other than for treatment of a diagnosed SUD or co-occurring mental health disorder**, and that the distinction between the telehealth and non-telehealth services must be documented in the patient's medical record. CMS chose this interval because they are concerned that an interval less than 6 months may impose potentially burdensome travel requirements on the beneficiary, but that an interval greater than 6 months could result in the beneficiary not receiving clinically necessary in-person care/observation.
    - CMS is seeking comment on whether a different interval, whether shorter, such as 3-4 months or longer, such as 12 months, may be appropriate to balance program integrity and patient safety concerns with increased access to care
- **CMS is proposing to identify the home of a beneficiary as an originating site for telehealth services for the diagnosis, evaluation, or treatment of a mental health disorder**, effective for services furnished on or after the first day after the end of the PHE; and to provide that payment will not be made for a telehealth service furnished under this paragraph unless the physician or practitioner has furnished an item or service in person, without the use of telehealth, for which Medicare payment was made within 6 months of the telehealth service.
- **CMs is also proposing to specify that the geographic restrictions do not apply to telehealth services furnished for the diagnosis, evaluation, or treatment of a mental health disorder**, effective for services furnished on or after the first day after the end of the PHE.
- **Rural Emergency Hospital –** CMS is proposing to confirm with the statutory change to include rural emergency hospitals as telehealth originating sites beginning in CY 2023.

- ***e. Payment for Medicare Telehealth Services Furnished Using Audio-Only Communication Technology***
    - CMS is proposing to revise the regulatory definition of "interactive telecommunications system" to permit use of audio-only communications technology for mental health telehealth services under certain conditions when provided to beneficiaries located in their home.
        - CMS is seeking comment on whether it would be appropriate to establish a different interval for these telehealth services, for the diagnosis, evaluation, or treatment of mental health disorders, other than for treatment of diagnosed

SUD or co-occurring mental health disorder, when furnished as permitted through audio-only communications technology.

- **CMS is also proposing to adopt a similar ongoing requirement that an in-person item or service must be furnished within 6 months of such a mental health telehealth service.**
- **CMS is also proposing to limit payment for audio-only services** to services furnished by physicians or practitioners who have the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communication technology in an instance where the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology.
    - **CMS is proposing to create a service-level modifier that would identify mental health telehealth services furnished to a beneficiary in their home using audio-only communications technology.** CMS explains that this modifier would serve to certify that the audio-only telehealth service meets the proposed requirements that the furnishing physician or practitioner has the capacity to furnish the service using interactive two-way, real-time audio/video communication technology, but instead used audio-only due to beneficiary choice or limitations.
- CMS is proposing to specify that an interactive telecommunications system can include interactive, real-time, two-way audio-only technology for telehealth services furnished for the diagnosis, evaluation, or treatment of a mental health disorder **under the following conditions:** the patient is located in their home at the time of service; the distant site physician or practitioner has the technical capability at the time of the service to use an interactive telecommunications system that includes video; and the patient is not capable of, or does not consent to, the use video technology for the service.
    - CMS is seeking comment on these proposals, as well as what, if any, additional documentation should be required in the patient's medical record to support the clinical appropriateness of providing audio-only telehealth services for mental health in the event of an audit or claims denial. Additional required documentation could include information about the patient's level of risk and any other guardrails that are appropriate to demonstrate clinical appropriateness, and minimize program integrity and patient safety concerns.
    - CMS is also seeking comment on whether, for purposes of the proposed audio-only mental health telehealth services exception, CMS should exclude certain higher-level services, such as level 4 or 5 E/M visit codes, when furnished alongside add-on codes for psychotherapy, or codes that describe psychotherapy with crisis. CMS is seeking comment on whether the full scope of service elements for these codes could be performed via audio-only communication technology.

2. Other Non-Face-to-Face Services Involving Communications Technology under the PFS

a. Expiration of PHE Flexibilities for Direct Supervision Requirements

- **CMS continues to seek information on whether this flexibility should be continued beyond the later of the end of the PHE for COVID-19 or CY 2021.** Specifically, CMS is

seeking comment on the extent to which the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology is being used during the PHE, and whether physicians and practitioners anticipate relying on this flexibility after the end of the PHE.

- **CMS is seeking comment on whether this flexibility should potentially be made permanent**, meaning that we would revise the definition of "direct supervision" to include immediate availability through the virtual presence of the supervising physician or practitioner using real-time, interactive audio/video communications technology without limitation after the PHE for COVID-19, or if CMS should continue the policy in place for a short additional time to facilitate a gradual sunset of the policy.
- CMS is soliciting comment on whether the current timeframe for continuing this flexibility, which is currently the later of the end of the year in which the PHE for COVID-19 ends or December 31, 2021, remains appropriate, or if this timeframe should be extended through some later date to facilitate the gathering of additional information in recognition that, due to the ongoing nature of the PHE for COVID-19, practitioners may not yet have had time to assess the implications of a permanent change in this policy.
- CMS is seeking comment regarding the possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time audio/video technology for only a subset of services, as we recognize that it may be inappropriate to allow direct supervision without physical presence for some services, due to potential concerns over patient safety if the practitioner is not immediately available in-person.
- CMS is also seeking comment on, were this policy to be made permanent, if a service level modifier should be required to identify when the requirements for direct supervision were met using two-way, audio/video communications technology

E. Valuation of Specific Codes

(37) Remote Therapeutic Monitoring (CPT codes 989X1, 989X2, 989X3, 989X4, and 989X5)

In recent years, CMS has finalized seven codes in the Remote Physiological Monitoring (RPM) family that include services similar to the new RTM codes. Based upon their analysis, the services and code structure of RTM resemble those of RPM. For example, the RTM codes reflect similar staff and physician work, although the specific equipment used is different.

CMS identified an issue that disallows physical therapists and other practitioners, who are not physicians or NPPs, to bill the RTM codes. By modeling the new RTM codes on the RPM codes, "incident to" services became part of the three direct practice expense-only (PE-only) codes (that is, CPT codes 989X1, 989X2, and 989X3) as well as the two professional work codes (that is, CPT codes 989X4 and 989X5). As a result, the RTM codes as constructed currently cannot be billed by, for example, physical therapists.

In addition, CMS designated the treatment management RPM codes (that is, CPT codes 99457 and 99458) as care management services (84 FR 62697 through 62698), which allow general supervision rather than direct supervision for incident to services.

- **CMS is seeking comment on how they might remedy the issues related to the RTM code construction in order to permit practitioners who are not physicians or NPPs to bill the RTM codes.**

(38) Principal Care Management and Chronic Care Management (CPT codes 99490, 99439, 99491, 99X21, 99487, 99489, 99X22, 99X23, 99X24, and 99X25)

For CY 2022, the RUC resurveyed the CCM code family, including Complex Chronic Care Management (CCCM) and Principal Care Management (PCM), and added five new CPT codes.

- CMS is seeking comment on whether keeping professional PCM and CCM at the same value creates an incentive to bill CCM instead of billing PCM when appropriate.

In addition to the proposals on the values for CCM codes, CMS is interested in understanding more about the standard practice used by practitioners to obtain beneficiary consent for these services. CMS notes that they have received questions from stakeholders regarding the consent requirements for CCM services. CMS believes that these questions have arisen because of the many flexibilities allowed in response to the PHE for COVID-19. In particular, during the PHE for COVID-19, CMS allowed stakeholders to obtain beneficiary consent for certain services under general supervision (85 FR 19230, April 6, 2020). Before the PHE for COVID-19, CMS required that beneficiary consent be obtained either by or under the direct supervision of the primary care practitioner.

- CMS is interested in understanding how billing practitioners furnishing CCM at different service sites (for example, physician office settings, RHCs, FQHCs) have been obtaining beneficiary consent over the past year and how different levels of supervision impact this activity.
- CMS is seeking comment on the issue, specifically on what levels of supervision are necessary to obtain beneficiary consent when furnishing CCM services and will consider such comments in future rulemaking.

III. Other Provisions of the Proposed Rule

B. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) - Telecommunications Technology

1. Revising the Definition of an RHC and FQHC Mental Health Visits

a. Payment Rules for RHC and FQHC Visits and for Medicare Telehealth Services

- For CY 2022, CMS is proposing to revise the regulatory requirement that an RHC or FQHC mental health visit must be a face-to-face (that is, in person) encounter between an RHC or FQHC patient and an RHC or FQHC practitioner to also include encounters furnished through interactive, real-time telecommunications technology, but only when furnishing services for the purposes of diagnosis, evaluation, or treatment of a mental health disorder.
- Furthermore, in order to align with proposals related to use of audio-only telecommunications technology to furnish similar mental health services under the PFS, CMS is proposing to allow RHCs and FQHCs to furnish mental health visits using audio-only interactions in cases where beneficiaries are not capable of, or do not consent to, the use of devices that permit a two-way, audio/video interaction.
- In order to track utilization of mental health visits furnished using communication technology, CMS is proposing that RHCs and FQHCs would append the 95 modifier (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) in instances where the service was furnished using audio-video communication technology or a new service level modifier in cases where the service was furnished audio-only.
    i. CMS is seeking comment on whether to include a similar 6-month in-person requirement prior to the furnishing of telecommunications service e and that an in-person service (without the use of telecommunications technology) be

provided at least every 6 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders when services are furnished by RHCs and FQHCs, or whether this requirement may be especially burdensome for beneficiaries receiving treatment at RHCs and FQHCs, particularly in rural areas.

VII. Regulatory Impact Analysis

D. Effect of Proposed Changes Related to Telehealth Services

As discussed in section II.D. of this proposed rule, CMS is proposing to amend the regulatory definition of interactive telecommunications system for purposes of Medicare telehealth services to include audio-only communication technology under certain circumstances for mental health services furnished to established patients in their homes. CMS anticipates that this policy will increase utilization of Medicare telehealth mental health services relative to utilization that would occur without the change. The estimated cost impact on overall Medicare services is unclear, though these changes would largely maintain current policies and access to the specific mental health services that are available to beneficiaries during the PHE.

CMS is proposing to require that, as a condition of payment for a telehealth service described in section 1834(m)(7) of the Act, the billing physician or practitioner must have furnished an in-person, non-telehealth service to the beneficiary within the 6-month period before the date of service of a telehealth service as specified in section 1834(m)(7)(B)(i) of the Act. CMS is also seeking comment on whether the required in-person, non-telehealth service could also be furnished by another physician or practitioner of the same specialty and same subspecialty within the same group as the physician or practitioner who furnishes the telehealth service. Given that the removal of the geographic and site of service restrictions for telehealth will expand the availability of mental health services, CMS anticipates that utilization of these mental health services will be comparable to observed utilization for mental health services during the COVID-19 PHE.

With regard to the proposal to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023, CMS believes the proposals would provide clarity to the stakeholder community but will have a negligible impact on PFS expenditures. **For example, services that have already been added to the permanent telehealth services list are furnished via telehealth, on average, less than 0.1 percent of the time they are reported.**

The statutory payment requirements for Medicare telehealth services under section 1834(m) of the Act, such as the originating site requirements related to geographic location and site of service, have limited increases in utilization outside of the COVID-19 PHE; however, CMS believes there is value in allowing physicians to furnish services added to the Medicare telehealth services list on a category 3 basis, and for patients to receive broader access to this care through telehealth.

Additionally, for services added to the Medicare telehealth list on a Category 3 basis, outside of the circumstances of the PHE for COVID-19, all of the statutory restrictions under section 1834(m) of the Act will also apply to these services; therefore, CMS does not anticipate any significant increase in utilization.

APPENDIX 1: TABLE 11: Services Added to the Medicare Telehealth Services List for the Duration of the PHE for COVID-19 but were not Added to the Medicare Telehealth Services List on a Category 3 Basis

Code Family	HCPCS	Long Descriptor	Category
Radiation Oncology	77427	Radiation treatment management, 5 treatments	2
Ophthalmological Services	92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	2
	92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits	2
	92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient	2
	92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits	2
Speech, Language, and Audiology Services	92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	2
	92526	Treatment of swallowing dysfunction and/or oral function for feeding	2
	92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	2
	92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	2
	92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	2
	92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	2
	92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	2
	92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	2

	92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	2
	92550	Tympanometry and reflex threshold measurements	2
	92552	Pure tone audiometry (threshold); air only	2
	92553	Pure tone audiometry (threshold); air and bone	2
	92555	Speech audiometry threshold;	2
	92556	Speech audiometry threshold; with speech recognition	2
	92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined	2
	92563	Tone decay test	2
	92565	Stenger test, pure tone	2
	92567	Tympanometry (impedance testing)	2
	92568	Acoustic reflex testing, threshold	2
	92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	2
	92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)	2
	92609	Therapeutic services for the use of speech-generating device, including programming and modification	2
	92610	Evaluation of oral and pharyngeal swallowing function	2
	92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	2
	92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	2
	92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (List separately in addition to code for primary procedure)	2

	S9152	Speech therapy, re-evaluation	2
Cardiological Services	93750	Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (e.g., drivelines, alarms, power surges), review of device function (e.g., flow and volume status, septum status, recovery), with programming, if performed, and report	2
	93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	2
	93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	2
Ventilation Assistance Management	94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day	2
	94003	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day	2
	94004	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day	2
	94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more	2
	94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device	2
Neurological Services	95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	2
	95971	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet	2

		mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	
	95972	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (e.g., sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	2
	95983	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional	2
	95984	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)	2
	96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour	2

Behavioral Health Services	90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	2
	96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	2
	96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	2
	96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (List separately in addition to code for primary procedure)	2
	96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face times administering tests to the patient and time interpreting these test results and preparing the report	2
	96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	2
	96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	2
	96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	2
	96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)	2
	97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules,	2

		initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	
	97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)	2
	97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and nonface-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	2
	97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes	2
	97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes	2
	97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes	2
	97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	2
	97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	2
	97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	2

	97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes	2
	0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior	2
	0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior	2
	G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, approximately 45 to 50 minute	2
Physical, occupational, and speech therapy	97150	Therapeutic procedure(s), group (2 or more individuals)	2
	97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	2
	97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes	2
Hospital inpatient services	99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit	2
	99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s)	2

		requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	
	99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	2
Observation care services	99218	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit	2
	99219	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	2
	99220	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	2

	99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.	2
	99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	2
	99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.	2
Nursing facility services	99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit	2

	99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.	2
	99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.	2
	99324	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver	2
	99325	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.	2
	99326	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with	2

		the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.	
	99327	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.	2
	99328	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.	2
	G9685	Physician service or other qualified health care professional for the evaluation and management of a beneficiary's acute change in condition in a nursing facility. this service is for a demonstration project	2
Home Services	99341	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	2
	99342	Home visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.	2

		Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	
	99343	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.	2
	99344	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.	2
	99345	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.	2
Office/Outpatient services *	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	2
	99442	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	2

		previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	
	99443	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; 21-30 minutes of medical discussion	2
Critical care services	99468	Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger	2
	99471	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age	2
	99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration	2
	99475	Initial inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age	2
	99477	Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or younger, who requires intensive observation, frequent interventions, and other intensive care services	2
Cardiac and Pulmonary Rehabilitation	G0422	Intensive cardiac rehabilitation; with or without continuous ecg monitoring with exercise, per session	2
	G0423	Intensive cardiac rehabilitation; with or without continuous ecg monitoring; without exercise, per session	2
	G0424	Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day	2