

Summary of Interim Final Rule with Comment Period

CMS promulgated an interim final rule with comment period (IFC) on March 30, 2020 that extends temporary regulatory waivers to health care providers in order to facilitate safe and effective care for the duration of the public health emergency. The regulations aim to increase hospital capacity, expand the health care workforce, improve access to telehealth services, and reduce the regulatory burden on providers. A link to the rule can be found [here](#). The regulations are retroactively applicable beginning March 1, 2020. Comments must be submitted within 60 days after published in the Federal Register.

The blanket waivers for health care providers (listed [here](#)) will assist health care systems in effectively managing potential surges and other challenges of treating COVID-19 patients. The agency also issued waivers (listed [here](#)) to address financial relationships and referrals between an entity and the physician, the physician organization, or the immediate family member of the physician as regulated by the Stark Law during the COVID-19 emergency. The blanket waivers are retroactively effective as of March 1, 2020 and are authorized under the Secretary's authority to grant waivers for the duration of the COVID-19 emergency declaration. For purposes of the IFC, CMS defines "Public Health Emergency" (PHE) at 42 CFR 400.200 as the nationwide PHE relating to the COVID-19 pandemic, which was established on January 31, 2020 and any subsequent renewals.

TELEHEALTH AND OTHER PAYMENT PROVISIONS

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (pg. 11)

Since March 17, CMS has been expanding access to telehealth services on a temporary and emergency basis pursuant to waiver authority granted in the Coronavirus Preparedness and Response Supplemental Appropriations Act. In the IFC, the agency is adding 80 services to the list of eligible telehealth services, eliminating frequency limitations and other requirements associated with particular telehealth services, and clarifying payment rules that apply to other services furnished through telecommunication technologies that can reduce exposure risk to COVID-19.

Site of Service Differential for Medicare Telehealth Services

Under the waiver authority, Medicare telehealth services can be furnished to patients wherever they are located, including in the patient's home. The agency recognizes that as physicians practices transition a significant portion of their services from in-person to telehealth services, the relative cost of providing services may not be significantly different than if these services were provided in-person (i.e. physicians' offices will continue to employ nursing staff just as they would have when providing in-person services). Therefore, the agency will assign the payment rate that would have been paid under the Physician Fee Schedule (PFS) as if the services were furnished in-person.

To implement this change on an interim basis, when billing for telehealth services, physicians and practitioners should report the point-of-service (POS) that would have been reported had the service been performed in-person. CMS also is finalizing on an interim basis the use of the CPT telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished by telehealth.

Adding Services to the List of Medicare Telehealth Services

CMS has an established process for adding or deleting services to the list of Medicare telehealth services covered under Sec. 1834(m)(4)(F)(ii). Services can fall into one of the following categories:

- Category 1: services that are similar to professional consultations, office visits and office psychiatry visits that are currently on the list of telehealth services.
- Category 2: services that are not similar to those on the current list of telehealth services but that demonstrate a clinical benefit to the patient.

CMS is adding over 80 services to the list of telehealth services for the duration of the PHE, for telehealth services with dates of service beginning on March 1, 2020. The following services are being added on an interim basis to category 2 (a full description of the CPT codes is in Appendix A):

- Emergency Department Visits:
 - CPT Codes 99281-99285
- Initial and Subsequent Observations, and Observation Discharge Day Management:
 - CPT Codes 99217-99220, 99224-99226, 99234-99236
- Initial Hospital Care and Hospital Discharge Day Management:
 - CPT Codes 99221-99223; 99238-99239
- Initial Nursing Facility Visits and Nursing Facility Discharge Day Management:
 - CPT Codes 99304-99306, 99315-99316
- Critical Care Services:
 - CPT Codes 99291-99292
- Domiciliary, Rest Home, or Custodial Care Services:
 - CPT Codes 99327-99328, 99334-99337
- Home Visits:
 - CPT Codes 99341-99345, 99347-99350
- Inpatient Neonatal and Pediatric Critical Care:
 - CPT Codes 99468-99469, 99471-99473, 99475-99476
- Initial and Continuing Intensive Care Services:
 - CPT Codes 99477-99480
- Care Planning for Patients with Cognitive Impairment:
 - CPT Code 99483
- Group Psychotherapy:
 - CPT Code 90853
- ESRD Services:
 - CPT Codes 90952-90953, 90959, 90962
- Psychological and Neuropsychological Testing:
 - CPT Codes 96130-96133, 96136-96139
- Therapy Services:
 - CPT Codes 97161-97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507
- Radiation Treatment Management Services:
 - CPT Code 77427

A full list of services, including the additions made in the IFC, can be located on the CMS website at: <https://www.cms.gov/Medicare/Medicare-GeneralInformation/Telehealth/index.html>.

Telehealth Modalities and Cost-sharing (pg. 48)

Clarifying Telehealth Technology Requirements

CMS is revising the regulatory definition of interactive telecommunication systems at Sec. 410.78(a)(3) to add an exception for the duration of the PHE, by adding the following language:

“Exception. For the duration of the public health emergency as defined in § 400.200 of this chapter, Interactive telecommunications system means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.”

The agency also re-iterates that the Office of Civil Rights (OCR) is exercising enforcement and waiving penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the PHE. For more information, see <https://www.hhs.gov/hipaa/forprofessionals/special-topics/emergency-preparedness/index.html>.

Beneficiary Cost-sharing

On March 17, the Office of Inspector General (OIG) issued a [policy statement](#) that notified physicians and other practitioners that they will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations that Medicare beneficiaries may owe for telehealth services furnished consistent with the then applicable coverage and payment rules. This policy applies to a number of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.

Communication Technology-Based Services (CTBS) (pg. 50)

Under the PFS, Medicare routinely pays for services furnished by telecommunications technology that are not considered telehealth services. These Communications Technology-Based Services (CTBS) include certain kinds of remote patient monitoring, and interpretations of diagnostic tests when furnished remotely.

In the IFC, the agency is finalizing on an interim basis that these services can be furnished to both new and established patients, and that consent can be documented by auxiliary staff under general supervision on an annual basis and it may be obtained at the time of service. CMS is retaining the prior requirement that if the brief CTBS originates from a related E/M service provided in the prior 7 days, then the service should be considered bundled and not separately billable.

The agency will allow the following codes to be billed for new and established patients for the duration of the PHE:

- CPT codes 99421, 99422, 99423
- HCPCS codes G2061, G2062, G2063

For HCPCS codes G2061-G2063, the agency clarifies the types of providers who are able to bill for these services to include licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, or speech language therapists. For the duration of the PHE, these providers can also provide services for HCPCS codes G2010 and G2012. **The agency seeks comment on other providers who are providing these services in response to the COVID-19 pandemic.**

In order to facilitate billing of the CTBS services by these therapists, the agency is designating HCPCS codes G2010, G2012, G2061, G2062, or G2063 as CTBS CMS-1744-IFC 55 “sometimes therapy” services that would require the private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN therapy modifier on claims for these services. CTBS therapy services include those furnished to a new or established patient that the occupational therapist, physical therapist, and speech language pathologist practitioner is currently treating under a plan of care.

Direct Supervision by Interactive Telecommunications Technology (pg. 55)

Many services paid under the PFS can be paid when provided under a level of physician or nonphysician practitioner (NPP) supervision rather than personal performance. In many cases, the supervision requirements in physician office settings necessitate the presence of the physician or NPP in a particular location, usually in the same location as the beneficiary when the service is provided.

The agency recognizes that in certain cases, technology will allow appropriate supervision without the physical presence of a supervising physician. In the context of the PHE, given the risks of exposure, the immediate potential risk to needed medical care, the increased demand for health care professionals, and the widespread use of telecommunications technology, the agency finds that individual practitioners are in the best position to make decisions based on their clinical judgement in particular circumstances.

Therefore, CMS is revising the definition of direct supervision to allow, for the duration of the PHE, direct supervision to be provided using real-time interactive audio and video technology. **The agency seeks comments on whether there should be any guardrails and what kind of risk this policy might introduce for beneficiaries while reducing risk of COVID-19 spread.** This change is limited to only the manner in which the supervision requirement can be met, and does not change the underlying payment or coverage policies related to the scope of Medicare benefits, including Part B drugs.

Supervision changes for certain Hospital and CAH Diagnostic and Therapeutic Services

The agency is adopting a similar change in the regulations at § 410.28(e)(1), which address the supervision of diagnostic services furnished directly or under arrangement in the hospital or in an on-campus or off-campus outpatient department of the hospital.

In addition, with respect to pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services described in the regulations at §§ 410.47 and 410.49, the agency is adopting a similar change under § 410.27(a)(1)(iv)(D) to specify that direct supervision for these services includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider.

Remote Physiologic Monitoring (pg. 119)

CMS has seven CPT codes for remote physiologic monitoring (RPM) services:

- CPT code 99091 (Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation requiring a minimum of 30 minutes of time)
- CPT code 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)
- CPT code 99454 (Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days)
- CPT code 99457 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes))
- CPT code 99458 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes)
- CPT code 99473 (Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration)
- CPT code 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 qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient)

The typical patient receiving RPM services are patients with chronic conditions, such as diabetes, high blood pressure, and COPD. In this rule, CMS clarifies that the RPM codes listed above can be used for physiologic monitoring of patients with acute and/or chronic conditions.

RPM services are considered to be communication technology-based services (CTBS) and historically, these services are billable for only established patients, however during the COVID-19 public health emergency, CMS is allowing these services to be delivered to new patients as well. Practitioners must receive verbal consent from Medicare beneficiaries to provide CTBS and RPM services. This requirement will prevent scenarios where beneficiaries are unexpectedly surprised by copays for services that do not involve the typical in-person, face-to-face service that a patient receives during an office visit. During the COVID-19 emergency, CMS is finalizing that consent to receive RPM services can be obtained once annually, including at the time services are furnished. CMS suggests that the practitioner review consent information with the beneficiary, obtain verbal consent, and then document that verbal consent was obtained.

Telephone Evaluation and Management (E/M) Services (pg. 122)

During CY 2008 rulemaking, the CPT Editorial Panel created the following CPT codes to describe E/M services furnished by a physician or a qualified healthcare professional via telephone or online:

- CPT code 98966 (Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)
- CPT code 98967 (Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion)
- CPT code 98968 (Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and CMS-1744-IFC 123 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; 21-30 minutes of medical discussion)
- CPT code 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)
- CPT code 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 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)
- CPT code 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)

CMS had assigned a status indicator of “N” to indicate that they are “noncovered” services, however CMS will cover these services in light of the COVID-19 public health emergency. CMS recognizes that these services do not describe full E/M services; they are similar to the virtual check-in services.

In the effort of reducing exposure risks in association with the COVID-19 public health emergency, CMS believes there are certain circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate. CMS believes that the existing telephone E/M codes listed above are the best way to recognize the relative resources to furnish these services. Therefore, CMS is finalizing payment for CPT codes 98966-98968 and CPT codes 99441-99443.

CMS is finalizing the following work RVUs which were included in the CY 2008 PFS final rule (72 CFR 66371):

| CPT Code | Work RVUs |
|----------|-----------|
| 98966 | 0.25 |
| 98967 | 0.50 |
| 98968 | 0.75 |
| 99441 | 0.25 |
| 99442 | 0.50 |
| 99443 | 0.75 |

These services can be billed for new and established patients during the COVID-19 public health emergency and therefore, CMS will not conduct review to determine whether these services were provided to established patients.

CPT codes 98966-98968 describe assessment and management services performed by practitioners who cannot bill separately for E/M services. CMS notes that these services may be furnished by, among others, LCSWs, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists when the visit pertains to a service that falls within the benefit category of those practitioners.

Application of Certain National Coverage Determination and Local Coverage Determination Requirements During the PHE for the COVID-19 Pandemic (pg. 127)

Some National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) include clinical conditions that must be met for coverage of an item or services, including face-to-face evaluations and re-evaluations for continued coverage. On an interim basis, CMS is waiving the requirements for these face-to-face and in-person encounters included in NCDs and LCDs for continued coverage. *This does not change any of the clinical indications for coverage in a NCD or LCD unless specifically addressed in this rule and outlined below. At the conclusion of the PHE, CMS will return to enforcement of these clinical indications.*

- Certain Respiratory, Home Anticoagulation Management and Infusion Pump Policies: CMS will not enforce the clinical indications for coverage across respiratory, home anticoagulation management and infusion pump NCDs and LCDs. This includes, but is not limited to home oxygen (NCD 240.2), continued positive airway pressure for obstructive sleep apnea (NCD 240.4), respiratory assist devices (LCD L33800), intrapulmonary percussive ventilator (NCD 240.5), oxygen and oxygen equipment (LCD L33797), home prothrombin time/international normalized ratio monitoring for anticoagulation management (NCD 190.11), infusion pumps (NCD 280.14), and external infusion pumps (LCD L33794).

Also, the chief medical officer of a facility can authorize that supervisions requirements in NCDs and LCDs do not apply during the PHE.

Level Selection for Office/Outpatient E/M Visits When Furnished Via Medicare Telehealth (pg. 135)

For office/outpatient visits delivered via telehealth during the PHE, CMS is revising its policy to allow providers to select the level of a visit based on MDM or time with time defined as all of the time associated with the E/M on the day of encounter. Providers will also not be required to document history and/or physical exam in the medical record. This policy is similar to the E/M documentation policy scheduled to be implemented on January 1, 2021. Despite the similarity, the agency is maintaining the current definition of MDM and using the times available in the [public use file](#).

TRAINING PROVISIONS

Application of Teaching Physician and Moonlighting Regulations during the PHE for the COVID-19 pandemic During the PHE for COVID-19 (pg. 101)

Revisions to Teaching Physician Regulations during a PHE for the COVID-19 Pandemic

Current policy requires PFS payment made only if the teaching physician is present during the key portion of any service or procedure for which payment is sought if a resident participates in a service furnished in a teaching setting. In response to stakeholders' concern and for the duration of the COVID-19 emergency, CMS is amending the teaching physician regulations to allow the teaching physician to provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of the service. CMS recognizes that if the teaching physician or resident is under quarantine or at home, it could limit the number of practitioners available to provide health care services to Medicare patients.

Currently, under the primary care exception (PCE) certain lower and mid-level office/outpatient E/M services provided in certain primary care centers are exempt from the physical presence requirement. The teaching physician must provide direct supervision. Therefore, CMS is finalizing policy, on an interim basis, to allow that all levels of an office/outpatient E/M service provided in primary care centers may be provided under direct supervision of the teaching physician by interactive telecommunications technology. Furthermore, CMS will allow PFS payment to be made for the interpretation of diagnostic radiology and other diagnostic tests when the interpretation is performed by a resident under direct supervision of the teaching physician by interactive telecommunications technology. The teaching physician must still review the resident's interpretation. **CMS seeks comment on their belief that direct supervision by interactive telecommunications technology is appropriate during the COVID-19 emergency.**

CMS lists exceptions to this policy. For example, the teaching physician must be present in the case of surgical, high-risk, or other complex procedures, including procedures performed through an endoscope. The teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. **CMS seeks comment on other possible procedures that should be exempt from this policy.**

Application of the Expansion of Telehealth Services to Teaching Physician Services

On March 17, 2020, CMS announced the expansion of telehealth services on a temporary and emergency basis pursuant to waiver authority added under section 1135(b)(8) by the Coronavirus Preparedness and Response Supplemental Appropriations Act. This expansion allows Medicare to pay for telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients located anywhere across the country including in a patient's place of residence.

CMS believes that "allowing Medicare payment for services billed by the teaching physician when the resident is furnishing services, including office/outpatient E/M services provided in primary care centers, via telehealth under direct supervision by interactive telecommunications technology would allow residents to furnish services remotely to patients who may need to be isolated for purposes of exposure risk based on presumed or confirmed COVID-19 infection, and as a result, would increase access to services for patients." Therefore, for the duration of the COVID-19 PHE, the agency will allow Medicare payment under the PFS for teaching physician services when a resident furnishes telehealth services to beneficiaries under direct supervision of the teaching physician by interactive telecommunications technology. Additionally, Medicare may make payment under the PFS for services billed under the PCE by the teaching physician when a resident furnishes telehealth services to beneficiaries under the direct supervision of the teaching physician by interactive telecommunications technology. **CMS seeks comment on their belief that direct supervision by interactive telecommunications technology is appropriate during the COVID-19 emergency.**

Payment under the PFS for Teaching Physician Services when Resident under Quarantine

CMS recognizes that there may be circumstances in which a resident may need to furnish services while under quarantine. Therefore, CMS is also finalizing for the duration of the COVID-19 emergency that Medicare may also make payment under the PFS for teaching physician services when the resident is furnishing these services while in quarantine under direct supervision of the teaching physician by interactive telecommunications technology. CMS believes this revised policy will limit exposure risks of COVID-19 while also preventing limited access to physician services.

Revisions to Moonlighting Regulations during a PHE for the COVID-19 Pandemic

"A licensed resident physician is considered to be "moonlighting" when they furnish physicians' services to outpatients outside the scope of an approved graduate medical education (GME) program."

In response to the current COVID-19 emergency, stakeholders have requested that CMS allow residents to furnish physicians' services to patients in the inpatient setting outside of the scope of their approved GME programs in the hospital where they have their training. Currently, there is a greater demand for physicians to respond to patient needs, such as furnishing services to patients in inpatient settings who have either a presumed or confirmed COVID-19 infection. Consequently, CMS is amending CFR 42 § 415.208 and finalizing for the duration of the COVID-19 emergency that the services that are not related to residents' approved GME programs and are performed in the inpatient setting of a hospital in which they have their training program are in fact separately billable physicians' services and Medicare payment can be made under the PFS.

Counting of Resident Time During the PHE for the COVID-19 Pandemic (pg. 137)

Hospitals may claim residents for IME and DGME purposes for the time the resident is providing care to hospital patients at home or in the home of a patient as long as they are performing care duties within the scope of the approved residency requirements and meets the physician supervision requirements outlined earlier in the rule.

QUALITY PROGRAM PROVISIONS

Innovation Center Models (pg.114)

Medicare Diabetes Prevention Program (MDPP) expanded model Emergency Policy

In response to the COVID-19 emergency, this rule amends the MDPP to allow certain beneficiaries to obtain the set of MDPP services more than once per lifetime, increase the number of virtual make-up sessions, and allow certain MDPP suppliers to deliver virtual MDPP sessions on a temporary basis. The COVID-19 emergency interrupted the expanded model services delivered by MDPP suppliers and has therefore prevented MDPP beneficiaries from attending live in-person sessions. Changes in this rule are only applicable to MDPP suppliers that are enrolled in MDPP as of March 1, 2020, and MDPP beneficiaries who were receiving MDPP services as of March 1, 2020.

Through this interim rule, CMS plans to implement provisions that allow for temporary flexibilities for the continuation of services for MDPP suppliers and MDPP beneficiaries. First, the requirement for beneficiaries to attend the first core-session in-person remains in effect. If beneficiaries are prohibited from attending the first core session in person, suppliers will be unable to start any new cohorts with MDPP beneficiaries until the conclusion of the COVID-19 PHE.

The Centers for Disease Control and Prevention (CDC) issued guidance to all MDPP suppliers providing alternative delivery options during the COVID-19 national emergency. CMS plans to conform with CDC guidance to minimize disruption of services for MDPP suppliers and MDPP beneficiaries and is amending the MDPP regulations to allow MDPP suppliers to either deliver MDPP services virtually or suspend in-person services and resume services at a later date. Furthermore, the limit to the number of virtual make-up sessions is waived for MDPP suppliers with existing capabilities to provide services virtually. MDPP suppliers may only furnish to the MDPP beneficiary a maximum of one session on the same day as a regularly scheduled session and a maximum of one virtual make-up session per week. Virtual make-up sessions may only be furnished to achieve attendance goals and may not be furnished to achieve weight-loss goals.

Under these changes, CMS also permits beneficiaries to obtain a set of MDPP services more than once per lifetime so that MDPP beneficiaries can maintain eligibility for MDPP services “despite a break in service, attendance, or weight loss achievement.”

Alternative Payment Model (APM) Treatment under the Quality Payment Program

CMS recognizes that current regulations may be insufficient preventing in preventing burden or negative consequences among APM participants in the Quality Payment Program (QPP). CMS believes flexibilities may be necessary for APMs, including applicable model tests conducted by the Center for Medicare and Medicaid Innovation (Innovation Center), as well as the Medicare Shared Savings Program. CMS is considering additional rulemaking, possibly another interim final rule, to amend or suspend certain APM QPP policies to ensure accurate and appropriate application of QPP policies subsequent to the COVID-19 emergency.

Changes to Medicare Shared Savings Program Extreme and Uncontrollable Circumstances Policy (pg. 129)

Under current policy, the Shared Savings Program extreme and uncontrollable policy does not apply for a performance year if an extreme and uncontrollable circumstance occurs during the quality reporting period for that reporting period and the quality reporting period is extended. The extension of the MIPS reporting period also applies to ACOs in the Medicare Shared Savings program. However, CMS is modifying this policy to provide relief for all ACOs participating in the 2019 Shared Savings Program despite the extension of the reporting period.

Merit-based Incentive Payment System (MIPS) Updates (pg. 163)

MIPS Improvement Activities Inventory Update

CMS is adding an improvement activity that promotes clinician participation on a COVID-19 clinical trial utilizing a drug or biological to treat a patient with the virus for the CY 2020 performance period in response to the PHE. To receive credit, a clinician must report findings through an open source clinical data repository or clinical data registry.

MIPS Applications for Reweighting Based on Extreme and Uncontrollable Circumstances

CMS is applying the MIPS automatic and extreme and uncontrollable circumstances policy to MIPS eligible clinicians for the 2019 MIPS performance period/2021 MIPS payment year. This policy defines these circumstances as “rare events entirely outside of your control and the control of the facility in which you practice.” They cause a clinician to be unable to collect or submit the information used to score a performance category for an extended period of time.

The automatic policy does not apply to groups and virtual groups. To provide relief for clinicians in these arrangements, CMS is extending the deadline to submit an application for reweighting the quality, cost, and improvement activities performance categories to April 30, 2020. Applicants must demonstrate that the clinician has been adversely affected by the PHE.

CMS is also creating a similar exception for the promoting interoperability category.

HOSPITAL CAPACITY PROVISIONS

Frequency Limitations on Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations and Required “Hands-on” Visits for ESRD Monthly Capitation Payments (pg. 41)

CMS is removing, on an interim basis, the frequency restrictions for the following codes for subsequent inpatient visits and nursing facility visits that are furnished by telehealth.

- CPT codes for subsequent inpatient visits (99231, 99232, 99233)
- CPT codes for subsequent nursing facility visits (99307, 99308, 99309, 99310)

The agency is also removing the restriction that critical care consultation codes may only be furnished to a Medicare beneficiary once per day. This applies to HCPCS codes G0508 and G0509.

The agency requested comment on how these services are furnished through telecommunications technology to ensure that patients are safe and receiving adequate care.

Required “Hands-on” Visits for ESRD Monthly Capitation Payments

For Medicare patients with End Stage Renal Disease (ESRD), clinicians no longer must have one “hands on” visit per month for the current required clinical examination of the vascular access site.

CMS is exercising enforcement discretion on the requirement that individuals receiving home dialysis must receive a face-to-face visit without the use of telehealth at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months. This means that clinicians will be able to provide this service via telehealth for patients with ESRD for the interim of the PHE.

The following CPT codes are impacted by these policies: 90951, 90952, 90953, 90954, 90955, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, and 90970.

Medicare Clinical Laboratory Fee Schedule: Payment for Specimen Collection for Purposes of COVID-19 Testing (pg. 92)

In response to the PHE and in an effort to be as expansive as possible within the current authorities to have testing available to Medicare beneficiaries who need it, the agency is changing Medicare payment policies to provide payment to independent laboratories for specimen collection for COVID-19 testing under certain circumstances.

The IFC establishes the following changes to the specimen collection fee policy for the duration of the PHE. CMS will provide payment of a nominal specimen collection fee and associated travel allowance to independent laboratories for collection of specimens related to COVID-19 clinical diagnostic laboratory testing for homebound and non-hospital inpatients.

Under this policy, the nominal specimen collection fee for COVID-19 testing for homebound and non-hospital inpatients generally will be \$23.46 and for individuals in a SNF or individuals whose samples will be collected by laboratory on behalf of a Home Health Agency will be \$25.46. Medicare-enrolled independent laboratories can bill Medicare for the specimen collection fee using one of two new HCPCS

codes shown below for specimen collection for COVID-19 testing and bill for the travel allowance with the current HCPCS codes set forth in section 60.2 of the Medicare Claims Processing Manual (P9603 and P9604).

Level II HCPCS codes, effective with line item date of service on or after March 1, 2020:

- G2023 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source
- G2024 - Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source

Physician Supervision Flexibility for Outpatient Hospitals – Outpatient Hospital Therapeutic Services Assigned to the Non-Surgical Extended Duration Therapeutic Services (NSEDTS) Level of Supervision (pg.126)

CMS describes non-surgical extended duration therapeutic services (NSEDTS) as “services that have a significant monitoring component that can extend for a sizable period of time, that are not surgical, and that typically have a low risk of complications after the assessment at the beginning of the service.”

CMS believes it is critical to provide hospitals with the most flexibility as possible to provide services to Medicare beneficiaries during the current COVID-19 public health emergency. Therefore, CMS is revising its policy to assign all outpatient hospital therapeutic services to require a minimum level of general supervision rather than general supervision as was finalized in the CY 2020 OPPTS/ASC final rule. General supervision requires that the procedure is furnished under the physician’s overall direction and control, but that the physician’s presence is not required during the performance of the procedure. This provision will give providers additional flexibility to address the burden created by the COVID-19 public health emergency.

Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital During the PHE for the COVID-19 Pandemic (pg. 167)

During the PHE, CMS is changing the under arrangements to allow hospitals broader flexibilities to furnish inpatient services including routine services outside of the hospital. Even with this additional flexibility, hospitals will still need to exercise sufficient control and responsibility over the use of hospital resources in treating patients.

Appendix A

- Emergency Department Visits CPT Codes:
 - 99281 (Emergency department visit for the evaluation and management of a 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 self limited or minor.)
 - 99282 (Emergency department visit for the evaluation and management of a 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 low to moderate severity.)
 - 99283 (Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused 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 severity.)
 - 99284 (Emergency department visit for the evaluation and management of a 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 high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.)
 - 99285 (*Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: 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) are of high severity and pose an immediate significant threat to life or physiologic function.*)
- Initial and Subsequent Observations, and Observation Discharge Day Management CPT Codes:
 - 99217 (Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient

- Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.]
- 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.)
 - 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.)
 - 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.)
 - 99224 (Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; 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 patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.)
 - 99225 (Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; 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 patient is responding inadequately to therapy or has developed a minor complication.

Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.)

- 99226 (Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; 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 complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.)
- 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.)
- 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.)
- 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.)
- Initial Hospital Care and Hospital Discharge Day Management CPT Codes:
 - 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.)
- 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) 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.)
 - 99238 (Hospital discharge day management; 30 minutes or less)
 - 99239 (Hospital discharge day management; more than 30 minutes)
 - Initial Nursing Facility Visits and Nursing Facility Discharge Day Management CPT Codes:
 - 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.)
 - 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.)
 - 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.)

- 99315 (Nursing facility discharge day management; 30 minutes or less)
- 99316 (Nursing facility discharge day management; more than 30 minutes)
- Critical Care Services CPT Codes:
 - 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes)
 - 99292 (Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service))
- Domiciliary, Rest Home, or Custodial Care Services CPT Codes:
 - 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.)
 - 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.)
 - 99334 (Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; 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 self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.)
 - 99335 (Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; 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 low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.)

- 99336 (Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; 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, 40 minutes are spent with the patient and/or family or caregiver.)
- 99337 (Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to 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) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.)
- Home Visits CPT Codes:
 - 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.)
 - 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. 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.)
 - 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.)
- 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.)
 - 99347 (Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; 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 self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.)
 - 99348 (Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; 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 low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.)
 - 99349 (Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; 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 moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.)
 - 99350 (Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to 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) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.)

- Inpatient Neonatal and Pediatric Critical Care CPT Codes:
 - 99468 (Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger)
 - 99469 (Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger)
 - 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)
 - 99472 (Subsequent 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)
 - 99473 (Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration)
 - 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)
 - 99476 (Subsequent 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)
- Initial and Continuing Intensive Care Services CPT Codes:
 - 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)
 - 99478 (Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams))
 - 99479 (Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams))
 - 99480 (Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams))
- Care Planning for Patients with Cognitive Impairment CPT Code:
 - 99483 (Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decisionmaking capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.)

- Group Psychotherapy CPT Code:
 - 90853 (Group psychotherapy (other than of a multiple-family group))
- ESRD Services CPT Codes:
 - 90952 (End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month)
 - 90953 (End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month)
 - 90959 (End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month)
 - 90962 (End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month)
- Psychological and Neuropsychological Testing CPT Codes:
 - 96130 (Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour)
 - 96131 (Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure))
 - 96132 (Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour)
 - 96133 (Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure))
 - 96136 (Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes)

- 96137 (Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure))
- 96138 (Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes)
- 96139 (Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure))
- Therapy Services CPT Codes:
 - 97161 (Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.)
 - 97162 (Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.)
 - 97163 (Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.) 97164 (Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.)
 - 97165 (Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem;

- An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.)
- 97166 (Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.)
 - 97167 (Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.)
 - 97168 (Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.)
 - 97110 (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility) 97112 (Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of

- movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities)
- 97116 (Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing))
- 97535 (Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes)
- 97750 (Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes)
- 97755 (Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes)
- 97760 (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes))
- 97761 (Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes)
- 92521 (Evaluation of speech fluency (eg, stuttering, cluttering))
- 92522 (Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria))
- 92523 (Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language))
- 92524 (Behavioral and qualitative analysis of voice and resonance)
- 92507 (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual)
- Radiation Treatment Management Services CPT Code:
 - CPT Code 77427 (Radiation treatment management, 5 treatments)