Partnership to Advance Virtual Care

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October 5, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1734-P
P.O. Box 8013
Baltimore, MD 21244-1850

Re: [CMS-1734-P] Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy

Dear Administrator Verma:

On behalf of the Partnership to Advance Virtual Care (the "Partnership"), we thank you and the Centers for Medicare and Medicaid Services (CMS) for the work you are doing to ensure providers and patients continue to have access to necessary care during the pandemic and beyond through the numerous waivers and flexibilities related to telehealth. The Partnership is composed of health systems, health IT vendors, innovators, chronic care specialists, and primary care stakeholders who are committed to ensuring patients, who receive care via telehealth, have access to the highest quality of care. As a coalition representing leaders across the telehealth space, we appreciate the opportunity to comment on the numerous telehealth proposals in the CY 2021 Medicare Physician Fee Schedule (PFS) proposed rule.

We applaud the broad and swift action taken by CMS in response to the pandemic to make certain Medicare beneficiaries continue to have access to necessary care. In the proposed rule, the agency presents a thoughtful approach to ensuring that care now being delivered via telehealth is not abruptly and negatively impacted when the current public health emergency (PHE) ends. The Partnership appreciates CMS's foresight and action. Additionally, we recognize that outside of the current PHE that CMS's authority to eliminate or waive certain telehealth requirements, such as originating and distant site requirements is limited by current statute. To fully realize the value and benefit of telehealth, the Partnership continues to recommend that Congress remove all telehealth site of service limitations and to allow Medicare beneficiaries to access telehealth services from all hospitals, healthcare facilities, and patients' homes or other locations deemed appropriate by a clinician. Absent such changes, the uptake and utility of telehealth services will be limited even as CMS acts to add services to the Medicare telehealth services list.

The Partnership's comments on the CY 2021 Medicare PFS proposed rule focus on the following proposals:

1) Medicare Telehealth Services List
    - Addition of Services on a Category 1 Basis
    - Proposed Temporary Addition of Category 3 Basis
    - Services Not Proposed for Addition on a Category 3 Basis

2) Telehealth Frequency Limitations: Nursing and Inpatient Facilities

3) Amendments to Current Telehealth Regulations: Permissible Modalities

4) Communication-Based Services (CTBS)
    - New CTBS Services
    - Obtaining Patient Consent
    - Established Patients
    - New Patients

5) Non-Telehealth Services
    - Creating Audio-Only and Text-Based Services
    - Defining Inherently Non-Face-to-Face Services

6) Supervision Requirements: Expanding Permissible Modalities

7) Remote Patient Monitoring Data Collection Requirements

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1) Medicare Telehealth Services List

Several conditions must be met for Medicare to make payments for telehealth services under the PFS. One condition is that the service must be on the list of Medicare telehealth services. In CY 2003, CMS established a process for adding to and deleting from the list of Medicare telehealth services. Such maintenance of the telehealth services list is critical to ensuring that Medicare beneficiaries have access to a broad range services that may be furnished safely and effectively via telehealth. Historically, CMS has limited the number of services on the list of Medicare telehealth services. The COVID-19 PHE, however, limited the availability of in-person care and created demand for greater access to telehealth services and virtual care. The result has been an unprecedented increase in both access to and utilization of telehealth services by Medicare beneficiaries, driven in part by large expansion of the Medicare telehealth services list. **The Partnership applauds CMS for its response to the PHE and the agency's efforts to ensure Medicare beneficiary access to a broad range of services furnished via telehealth during this critical time. CMS's swift action allowed our members to ensure Medicare beneficiaries maintained access to safe, high quality care.**

In the rule, CMS proposes changes to the Medicare telehealth services list. Proposed changes reflect established processes, but also the Agency's experience during the PHE. **The Partnership recognizes and supports CMS's desire to balance expanding access to telehealth services, ensuring maintenance of high quality care and safeguarding Medicare beneficiaries. We urge CMS to thoughtfully consider stakeholder comments**

describing provider and beneficiary experiences leveraging innovative technologies to furnish safe, high quality care via telehealth and other virtual platforms.

Addition of Services on a Category 1 Basis

Consistent with established processes, for CY 2021 CMS proposes to add nine services to the telehealth service list. All nine services are proposed on a Category 1 basis. Services considered under a Category 1 basis are those that CMS identifies as similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. CMS evaluates services proposed for addition to services currently on the list with respect to the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site. **The Partnership agrees that the nine services proposed for addition to the list of telehealth services are similar to services currently on the list and we support the addition of these services on a Category 1 basis.**

Proposed Temporary Addition of Category 3 Basis

During the COVID-19 PHE, CMS issued numerous flexibilities and waivers to protect Medicare beneficiaries and providers and to maintain access to care. One major change was the significant expansion of the list of telehealth services. Beneficiaries and providers responded by readily adopting this new mode of care delivery. In the CY 2021 proposed rule, CMS acknowledges the significant expansion of telehealth services under the PHE. CMS also recognizes the role that telehealth is currently serving in maintaining access to care for Medicare beneficiaries and raises concerns that in the absence of action, access to a wide-range of telehealth services will end abruptly at the termination of the PHE. To address concerns, CMS proposes to temporarily add a new basis for evaluating services for addition to the telehealth services list. CMS indicates that the new, temporary Category 3 is a means for providing continued, access to certain services added to the telehealth services list during the PHE, allowing additional time to develop evidence sufficient to support permanent addition to the list of telehealth services. Services recommended for addition on a Category 3 basis are those that CMS has identified as being clinically beneficial, but for which CMS is unable to add on a Category 1 or Category 2 basis**. The Partnership shares CMS's concern that abrupt elimination of services from the telehealth services list may limit access to care for Medicare beneficiaries and create additional stress on providers and the healthcare system. As such, we support the temporary addition of Category 3 as a basis for adding services to the telehealth services list and as a pathway that allows additional data and evidence to be gathered to demonstrate the appropriateness of furnishing these services via telehealth permanently.**

For services added on a Category 3 basis, CMS proposes that services remain on the list of Medicare telehealth services until the end of the calendar year in which the PHE expires. Currently, the PHE is set to expire on January 21, 2021. If this policy is finalized and the PHE expires in January, services added on a Category 3 basis would remain on the list of Medicare telehealth services until December 31, 2020. Such an outcome provides an eleven month temporary transition period. However, if the PHE expires on July 1, 2020, services added on a Category 3 basis would be provided only a six month temporary transition period as these services would also remain on the list of Medicare telehealth services until December 31, 2020. Such an outcome would not achieve CMS's objective of providing a temporary transition period that allows for additional evidence to be collected to support permanent addition to the telehealth services list. **The Partnership urges CMS to revise its proposal and to finalize a policy where services added to the Medicare telehealth services list on a Category 3 basis expire at the end of the calendar year that follows the year in which the PHE expires.** Under such a policy, if

the PHE were to expire on January 21, 2021, services added to the list of telehealth services on a Category 3 basis would expire on December 31, 2022. Were the PHE to end on July 1, 2021, services added to the telehealth service list on a Category 3 basis would also expire on December 31, 2022. The Partnership believes that such a revision ensures that stakeholders have sufficient time to obtain the necessary evidence to demonstrate that such services may be furnished fully, effectively and safely via telehealth and therefore should be added permanently to the list of telehealth services. The proposed revision also provides necessary certainty for Medicare beneficiaries and providers furnishing care.

CMS proposes to add on a Category 3 basis 13 services to the list of Medicare telehealth services. The services proposed for temporary addition to the telehealth services list include services related to domiciliary or rest home care, home visits, emergency department visits, nursing facility discharge day management and psychological and neuropsychological testing. **The Partnership supports CMS's proposal to add services to the list of telehealth services on a Category 3 basis. However, we urge CMS to add all services added to the telehealth services list during the PHE to the Medicare telehealth services list on a Category 3 basis.**

Services Not Proposed for Addition on a Category 3 Basis

In addition to proposing additions to the list of telehealth services on a Category 3 basis, CMS seeks comments on whether other services added to the Medicare telehealth services list for the duration of the PHE should be added on a Category 3 basis. The Partnership supports a structured approach to determining which services are added the list of Medicare telehealth services. Additionally, the Partnership recognizes the need to temporarily, rather than permanently, include certain services on the telehealth service list as the agency evaluates which services may be added on a Category 1 or Category 2 basis in the future. For the duration of the PHE, CMS temporarily added on a Category 2 basis, 135 services to the Medicare telehealth services list. **While the Partnership appreciates that the unique circumstances of the PHE influenced CMS's assessment of these services and their addition to the telehealth services list, these services are now being delivered safely and effectively via telehealth. Narrowly limiting services added on a Category 3 basis will result in an abrupt termination of coverage for the majority of services added during the PHE.** Such an abrupt end to coverage is problematic for both beneficiaries and providers. **CMS should add all services on a Category 3 basis.** Doing so will give Medicare beneficiaries and clinicians furnishing care greater certainty with respect to ongoing coverage for these services. As described above, providing an opportunity for clinicians to perform these telehealth services outside the context of the PHE will also ensure sufficient time to collect evidence to evaluate these services for permanent addition to the telehealth services list.

If the agency is unwilling to add all services to the telehealth service list on a Category 3 basis, the Partnership urges CMS to add higher level emergency visits (99284-99285), new patient domiciliary services (99324-99327), new patient home visits (99341-99344), hospital, ICU, emergency care, and observation stays (99217-99226), inpatient neonatal and pediatric critical care, initial (99468-99472) and continuing intensive care (99477-99480) and other critical care services (99291-99292) under this category (Table 1, Appendix A).

The agency proposes to temporarily include lower level emergency department visits (99281-99283) on the telehealth services list. The Partnership believes that including the higher level emergency department visits is also appropriate on a Category 3 basis. CPT code 99284 and 99285 are closely related to the lower level emergency department evaluation codes and should be included under the proposed Category 3. These services (99284-99285) differing from lower level codes, only in complexity of medical decision making required to

evaluate a patient's history and medical examination. Temporarily including codes 99284 and 99285 on the telehealth service list is consistent with the current proposed code set for inclusion on a Category 3 basis.

The agency also proposes to include on the telehealth services list on either a Category 1 or Category 3 basis all established patient domiciliary services (99334-99337) and established patient home visits (99347-99350) on a Category 3 basis. The Partnership believes that including new patient domiciliary services (99324-99327) and new patient home visits (99341-99344) is also appropriate on a Category 3 basis. These sets of services are similar both in setting and in intensity of procedure. The only distinguishing factor is the relationship with the patient. As such, the Partnership urges CMS to expand the telehealth service list under Category 3 to include new patient domiciliary services (99324-99328) and new patient home visits (99341-99344). Including these services under the telehealth list provides consistency for providers in the types of services included on the telehealth service list and ensure patients can continue to receive appropriate care via telehealth.

Additionally, hospital, ICU, emergency care, and observation stays (99217-99226), inpatient neonatal and pediatric critical care, initial (99468-99472) and continuing intensive care (99477-99480) and other critical care services (99291-99292) are also similar in type of care, intensity and complexity of other services proposed under Category 3. Further, there are improvements in technology that enable providers to appropriately provide all the services described by these codes. As such, during the PHE these services demonstrated clinical benefits to patients, and as they can appropriately be furnished via telehealth, CMS should temporarily include these codes on the telehealth service list in order to collect data on the clinical impacts outside the context of the PHE. The inclusion of these codes under Category 3 do not raise concerns over clinical appropriateness or patient safety.

2) Telehealth Frequency Limitations: Nursing and Inpatient Facilities

Across certain care settings and services, CMS limits the frequency with which patients may receive care via telehealth. In the proposed rule, CMS seeks comments from stakeholders on whether frequency limitations are burdensome and limit access to necessary care, and how best to ensure that patients are receiving necessary in-person care. While we acknowledge that certain patient acuity and complexity of illness may require more frequent in-person care, clinicians should maintain authority over clinical decision-making, and CMS shouldn't interfere in the provider-patient relationship. Further, telehealth frequency limitations may restrict patients from receiving care from specialists or other practitioners when in-person care is not an option. Access to specialty care in rural geographical settings is increasingly becoming more limited. Removing frequency limitations and considering potential unintended consequences could help improve beneficiary access to care and improve clinical outcomes. **The Partnership urges CMS to reevaluate current frequency limitations for telehealth services across all care settings and services.**

In the rule, CMS does propose to revise the frequency limitation for nursing facilities and to permit subsequent nursing facility visits to be furnished via telehealth once every 3 days eliminating the current 30 day frequency limitation. Stakeholders weighing in on frequency limitations related to subsequent nursing facility visits expressed points similar to those above indicating that the use of Medicare telehealth is crucial to maintaining a continuum of care in this setting and that CMS should leave it up to clinicians to decide how frequently a visit may be furnished as a Medicare telehealth service rather than in person depending on the needs of specific patients. Not every clinical visit requires in-person care. Providers can ensure patients are receiving necessary and timely care via telehealth, and by leveraging technology, providers across the care team can continue to

collaborate and ensure care coordination. **The Partnership applauds CMS for continuing to prioritize patient access by eliminating the 30 day frequency limitation for telehealth visits in nursing facilities.**

3) Amendments to Current Telehealth Regulations: Permissible Modalities

Current regulations at 42 CFR § 410.78(a)(3) define an interactive telecommunications system for the purposes of furnishing Medicare telehealth services as 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 definition also explicitly prohibits the use of telephones, facsimile machines, and electronic mail systems for purposes of furnishing Medicare telehealth services. CMS proposes to revise the current definition by removing the sentence of the regulation at § 410.78(a)(3) which specifies that ‘‘[t]elephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.” **The Partnership supports this update to the agency’s definition of an “interactive telecommunications system.”**

The Partnership recognizes the limits CMS has in expanding telehealth services. However, as the definition of an interactive telecommunications system is within the purview of the agency, the Partnership applauds CMS in making this change. While this change to the definition does not immediately expand the list of appropriate technologies with which telehealth services may be furnished, by revising the definition CMS is removing potential barriers to telehealth expansion as technology evolves. New technologies are constantly created and improved across sectors, but technology within the healthcare system is especially expedient. By removing this sentence, CMS is ensuring that as technology improves Medicare beneficiaries will continue to have access to the best and most clinically appropriate care.

Additionally, we urge CMS to consider audio-only and HIPAA-compliant text-based communications within the definition of an "interactive telecommunications systems." We recognize that not every service on the telehealth services list may be delivered safely and effectively via audio-only or text-based communication, but certain services may. For the duration of the PHE, CMS identified 89 services for which audio-only interaction meets requirements for a telehealth service. The Partnership urges CMS to maintain a list of services for which audio-only interaction is sufficient and add a list of services for which text-based services is sufficient. Allowing audio-only and text-based services that may be delivered safely and effectively would help providers to treat vulnerable, including Medicare beneficiaries in rural or underserved communities, who may have limited access to broadband internet or two-way video/audio capabilities to have access to care rather than delaying or foregoing care. Additionally, recognizing audio-only and text-based communication within the definition of an “interactive telecommunications system” would allow for rapid pivots in care delivery in times of emergency or travel-limiting events, such as snowstorms, hurricanes or local flooding, that limit in-person and/or audio/visual access to care.

4) Communication Technology-Based Services (CTBS)

As part of the CY 2021 proposed rule, CMS proposes to add new CTBS services and seeks to clarify certain aspects of these services.

New CTBS Services

For CY 2021, CMS proposes to create two additional HCPCS G codes to allow billing of CTBS by certain non-physician practitioners, consistent with the scope of practice for these providers. **The Partnership supports the addition of new G codes that allow non-physician practitioners who cannot independently bill for E/M services to bill for CTBS.**

Obtaining Patient Consent

In the proposed rule, CMS clarifies that there is flexibility in the manner and timing of receiving beneficiary consent for CTBS services. Specifically, CMS indicates that the consent from the patient to receive these services can be documented by auxiliary staff under general supervision, as well as by the billing practitioner. **The Partnership appreciates CMS for providing this clarification. We also urge CMS to confirm that consent documented by auxiliary staff under general supervision or a single billing practitioner in a group practice extends to all clinicians in the group practice.**

Established Patients

In the proposed rule, CMS clarifies that a CTBS service is separately billable only when such service does not originate from a related E/M visit, including an E/M service furnished as a telehealth service. What remains unclear to the Partnership is whether an E/M service furnished via telehealth is sufficient to establish a relationship with a patient, such that a physician furnishing a new patient E/M office visit (e.g., 99203) via telehealth may subsequently bill a CTBS service for the same patient. **The Partnership urges CMS to clarify that a physician may establish a relationship with a patient through services furnished via telehealth and that services that require an established relationship, such as CTBS services, may subsequently be provided to these patients.**

New Patients

Additionally, **if current coding for current CTBS services are limited to established patients, we urge CMS to implement coding that is specific to new patients.** Data show that patients from underserved communities have less access to care and are less likely to have a primary care physician. These factors as well as others contribute to significant disparities in health outcomes. Establishing CTBS codes for new patients, while not a panacea, will minimize certain barriers to care by allowing patients to access care they may not otherwise seek.

5) Non-Telehealth Services

Creating Audio-Only and Text-Based Services

For the duration of the PHE, CMS expanded access to care by permitting certain services to be furnished via audio-only technology. In addition to covering certain services when delivered via audio-only, CMS also

provided coverage and payment for telephone evaluation and management (E/M) services, establishing payment at rates, comparable to office or outpatient visits for established patients. Specifically, CPT codes 99441, 99442, and 99443, which were previously non-covered, were crosswalked to CPT codes 99212, 99213, 99214, respectively. This resulted in payment for audio-only E/M services consistent with services furnished in-person or via telehealth during the PHE. CMS is not proposing to maintain coverage and payment for telephone E/M services after the termination of the current PHE. CMS is, however, seeking comments on the potential development of audio-only services similar to current virtual check-ins, but with longer duration and, subsequently, a higher value.

Audio-only visits have been essential to ensuring continuity of care for Medicare beneficiaries and to promoting equity in access during the PHE. Many beneficiaries do not have access to a smart device capable of audio-visual technologies, do not understand the technology and/or are unable to navigate the application, or don't have access to broadband internet to support audio-visual technology. In these circumstances, telephone visits were able to supplement care provided. Similarly, text-based care provides the opportunity to further augment care availability to beneficiaries without broadband or those that cannot engage in audio visits due to caregiving or work responsibilities. **As such, the Partnership appreciates CMS's recognition of the role audio-only E/M services have played during the PHE as well as the Agency's openness to maintaining payment for such services. We urge CMS to create new codes to describe audio-only E/M and text-based E/M services and to work with stakeholders to ensure appropriate valuation of these codes. Moreover, until new audio-only and text-based codes are established and valued, we recommend CMS continue to cover current audio-only E/M services on a Category 3 basis.** However, we would note, as CMS describes in the proposed rule, services that are inherently non-face-to-face are not required to be on the Medicare telehealth services list in order to be covered. **Like with other telehealth services, the Partnership urges CMS to prevent an abrupt end to coverage for audio-only E/M services by allowing coverage and payment until the end of the CY that follows the year in which the PHE expires.** Under such a timeline, if the PHE were to expire on April 25, 2021, coverage and payment for audio-only E/M services would expire on December 31, 2022. This would ensure that there are limited disruptions for providers and consistency in coding for an appropriate period after the termination of the PHE.

Defining Inherently Non-Face-to-Face Services

In response to comments from stakeholder requests for new additions to the telehealth service list, in the proposed rule the agency clarifies its standing policy that services that are inherently non-face-to-face are not required to be on the Medicare telehealth service list in order to be covered when provided using telecommunications technology rather than in person with the patient present. **The Partnership appreciates this clarification and recommends CMS work with the AMA to develop a comprehensive list of services that are inherently non-face-to-face and that may therefore be provided via telecommunications technology.** Creating such a list will ensure clinicians can focus on providing essential care without the additional burdens of determining if services are inherently non-face-to-face. As more providers are furnishing services using telecommunications technology and a greater number of patients are requesting such services, CMS should ensure Medicare beneficiaries are receiving appropriate care by creating a list of non-face-to-face services.

6) Supervision Requirements: Expanding Permissible Modalities

CMS adopted a policy revising the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology for the duration of the PHE. CMS is proposing to extend this flexibility until the end of the PHE or December 31, 2021, whichever is later. **We support CMS's efforts to continue providing flexibilities for providers to leverage appropriate technology where appropriate.** Supervising physicians and practitioners can appropriately provide supervision and assist clinicians when needed through audio-visual communications. Moreover, the Partnership supports telehealth policies in which the agency considers how, through existing authorities, to appropriately expand access to care and leverage technologies that improve healthcare delivery.

7) Remote Data Collection Requirements

During the COVID-19 PHE, CMS waived requirements that 16 days of data be collected within 30 days to meet requirements to bill CPT codes 99453 and 99454. In the proposed rule, CMS indicates that when the PHE ends, the agency will once again require that 16 days of data be collected within 30 days to meet the requirements to bill CPT codes 99453 and 99454. CMS indicates that such a policy is consistent with the CPT prefatory language for the CPT codes describing these services. Although CMS is not proposing to extend this flexibility, the agency is seeking comments on whether current RPM coding accurately and adequately describes the full range of clinical scenarios where RPM services may be of benefit to patients and whether additional RPM codes might be necessary. Specifically, CMS seeks comments on whether some patients may require remote monitoring for fewer than 16 days in a 30-day period. **The Partnership finds current RPM coding is insufficient to describe the full range of clinical scenarios where RPM services are furnished to Medicare beneficiaries.**

RPM services are frequently used for shorter durations to manage Medicare beneficiaries during acute illnesses. For example, a 75 year old Medicare beneficiary with a history of asthma and chronic obstructive pulmonary disease diagnosed with the flu during an office visit may have their vitals and oxygen saturation levels monitored remotely. Such remote monitoring has detected declining oxygen levels allowing the patient to be placed on home oxygen via a nasal cannula and avoiding a potential hospital admission as the patient further decompensated. Shorter duration of RPM services has also been used in the context of managing patients diagnosed with COVID-19. Patients with heart failure have been managed through COVID-19 infections through remote monitoring of blood pressure and heart rate, which has allowed for real-time tracking of heart and respiratory rates. Via remote monitoring of these patients, real-time medication adjustments were made to avoid a heart failure related admission. The duration of RPM services in these clinical situations is typically less than seven days. RPM services are also being used increasingly to support early patient discharge. In early patient discharge programs, patients are discharged home with four days of remote monitoring as a minimum requirement. Early discharge assists hospitals capacity levels and the ability to care for additional and more acutely ill patients in need that might otherwise overflow into the Emergency Department. These examples highlight certain clinical scenarios where shorter durations of RPM services are warranted, but there are more. **As such, the Partnership urges CMS to create new RPM codes that describe additional clinical scenarios where RPM services are clinically beneficial but require remote monitoring for fewer than 16 days.**

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Thank you for your consideration of these comments. Please contact Mara McDermott at (202) 487-1393 or mmcdermott@mcdermottplus.com if you have any questions.

Sincerely,

The Partnership to Advance Virtual Care

98point6
AdvancedMD
Amita Health
Ascension
Better Medicare Alliance
Doctor on Demand
Fresenius
InSight + Regroup
LifePoint Health
Sentara Healthcare
University Hospitals

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Appendix A

Table 1. Alternate List of Services Recommended for Addition on a Category 3 basis

HCPCS	Long Descriptor
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.
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

HCPCS	Long Descriptor
	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.
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.
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,

HCPCS	Long Descriptor
	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
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.
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.
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 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.
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

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	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.
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
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)
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)