healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Telemedicine Reimbursement Policy		
Policy Number:	PO-RE-078v6		
Effective Date:	01/01/2025	**Last Approval Date:**	9/04/2025

*Medicare telehealth waivers implemented during the COVID-19 Public Health Emergency are expected to expire at the end of **September 2025**. **However**, Healthfirst will continue to reimburse **telehealth services provided to members in their homes through Calendar Year (CY) 2026**. This ensures continued access and flexibility for members receiving care via telehealth beyond the federal expiration.*

***Effective 1/1/2025:** Healthfirst has aligned with CMS and will not recognize new CPT Codes 98000-98015, for all lines of business, to ensure payment parity. Instead, CMS has assigned these codes a procedure status indicator of "I", which means there is a more specific code (i.e., existing office/outpatient E/M codes 99202-99215) to be used for all lines of business.*

I. Policy Description

This policy outlines the guidelines for telemedicine and telehealth services eligible for reimbursement by Healthfirst. It aims to ensure that these services meet the same standard of care as in-person consultations while complying with the HIPAA Privacy Rule.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage*
- Medicare PPO*
- Personal Wellness Plan (PWP)/Health & Recovery (HARP)
- Essential Plan (EP)
- Managed Long-Term Care (MLTCP – Senior Health Partners)*
- Medicaid Advantage Plus/MAP (CompleteCare)*
- Qualified Health Plan (QHP)

Definitions:

- Audio-only is the use of the telephone for visits without video:
  - Behavioral Health Services rendered through Audio-Only Telehealth:
    - Under the Telemedicine and Telehealth Parity Law, A behavioral health service that was provided through real-time, two-way audio without a video component, whether

utilized in combination with asynchronous store-and-forward technology, including audio-only telephone conversation shall be reimbursed at a rate that equals the provider reimbursement rate for the service when provided in person.

- Physical Health Services rendered through Audio-Only Telehealth:
  - This exception applies to a physical health care service that was provided through real-time, two-way audio without a video component, whether utilized in combination with asynchronous store-and-forward technology, including through audio-only telephone conversation.

- Asynchronous: Also known as “store and forward” or “non-interactive telecommunication” means the acquisition and transmission of images, diagnostics, data, and medical information either to, or from, and originating site or to, or from, the healthcare provider at a distant site which allows for the patient to be evaluated without being physically present.

- Distant Site: Means a site which a health care provider, acting within the scope of a valid license or certification, is located while providing health care services by means of HIPAA compliant telemedicine.

- Originating Site: Means a site at which a patient is located at the time that health care services are provided to the patient by means of telemedicine.

- Synchronous: Means live, two-way interaction between a person and a provider using audiovisual telecommunications technology.

- Telehealth: Means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, provider consultation, patient and professional health-related education, public health, health administration, and other services.

- Telemedicine: Means the delivery of healthcare services using HIPAA compliant and secure electronic communications, information technology, or other electronic or technological means to bridge the gap between a health care provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening health care provider for the purpose of diagnosis, consultation, and/or treatment of a patient. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

Reimbursement Guidelines

This policy applies to all telemedicine and telehealth services provided by healthcare providers. It encompasses services delivered through interactive, real-time, two-way audio and video technologies, as well as approved audio-only consultations. The policy is applicable to telemedicine

services rendered by individual practitioners and facilities, ensuring that all parties comply with the outlined requirements for reimbursement.

Healthfirst will reimburse participating providers for covered telehealth services (as noted below) in accordance with the fee schedule applicable to the providers' contract. Healthfirst will consider reimbursement for covered Telehealth services (as noted below) when claims are billed with a place of service (POS) 02 or 10 on a CMS 1500 claim form. When billing telehealth services, providers must bill with place of service code (POS) 02 and 10 in conjunction with modifier FQ, GT, 93 or 95 to be considered for reimbursement.

Place of Service (POS) Code	
02	Telehealth is provided other than in the home of the patient.
10 - Effective (1/1/2022)	Telehealth is provided in the home of the patient (which is a location other than a hospital or other facility where the patient receives care in a private residence.

Modifier	**Description**
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.
95	Synchronous telemedicine service rendered via real-time interactive audio and video telecommunication system
FQ	A telehealth service furnished using real-time audio-only communication technology (**Behavioral Health Only**)
GT	Via interactive audio and video telecommunication systems

Healthfirst recognizes the CMS-designated originating sites considered eligible for furnishing telehealth services to a patient in an originating site.

Examples of originating sites include but are not limited to:

- The office of a physician or practitioner
- Hospital (inpatient or outpatient)
- Federally qualified health center (FQHC)
- Skilled nursing facility (SNF)
- Community mental health center

Eligibility for Reimbursement

Healthfirst will consider telemedicine services for reimbursement when the following criteria are met:

1. Real-Time Interaction: Telemedicine services must meet all requirements equivalent to a face-to-face consultation between a healthcare provider and patient.
2. Audio-Only Services: Audio-only consultations are eligible for reimbursement only for specific services listed in the attached eligible audio-only services document.
3. Billing for Distant Site Providers: Reimbursement will only be granted to distant site providers rendering telemedicine services. Any originating site provider delivering in-person services should use the appropriate code for those services.
4. Deductibles and Copayments: Telemedicine services will be subject to the same deductible and copayment requirements as in-person visits, in accordance with the members' benefit plan.
5. Coding Guidelines: Use the designated CPT and HCPCS codes for reporting telemedicine services. Specific codes and modifiers must be appended as outlined in the coding section of this policy.

Privileging Requirement

Providers who wish to render Telehealth services must first submit a Telehealth Application and Assessment Tool. This application will help Healthfirst capture essential information related to the Provider and their Telehealth capabilities regarding performing Telehealth services. Once submitted, the application and assessment tool will be reviewed, and a response will be provided on the Provider's Telehealth privileging status.

Providers who practice in a virtual-only capacity must have a written agreement with Healthfirst prior to joining the network. The agreement must indicate how patients would be treated in person should a medical need arise. Virtual-only Providers are defined as Providers who offer Telehealth with the absence of a physical office. Virtual-only Providers must meet Healthfirst credentialing requirements as outlined in the Provider Manual including maintaining a valid NYS license and an active MMIS number.

Billing and Claims Submission Requirements

1. Healthfirst requires that claims for telemedicine services are submitted with the following:
    a. Modifier -95 or -GT is appended to eligible real-time audio and video CPT or HCPCS codes.
        - By coding and billing modifier -95 or -GT with a covered procedure code, the provider is certifying that the patient was present at an originating site when the provider furnished the telemedicine service.
    b. Modifier -93 or -FQ is appended to eligible audio-only CPT or HCPCS codes.
    c. Place of service 10 is appended for services provided to a member who is physically in their home.
    d. Place of service 02 is appended for services provided to a member who is physically in an office or facility at the time of the telemedicine consultation.

2. The following services are not eligible for reimbursement under this policy:
    a. Non-direct patient services (e.g. coordination of care rendered before or after patient interaction) shall not be considered for reimbursement.
    b. Any service that is not eligible for separate reimbursement when rendered to the patient in-person.
    c. ***Synchronous audio-video visit codes 98000-98015. Instead, services should be billed using E&M codes 99202-99215 with modifier 93, 95, FQ, or GT.***

Application of Specific Telehealth Billing Rules

When both the originating site and the distant site are part of the same provider billing entity, there will only be one payment. In these cases, only the originating site should bill for the telemedicine encounter.

Fee-for-Service Billing for Telemedicine by Site and Location

If services are provided through telemedicine to a member located in one of the following originating sites, the provider should bill for the telemedicine encounter as if the provider saw the member face to face in the office or Article 28 clinic setting using the appropriate billing rules.

Article 28 Clinic Originating Sites Billing Under Ambulatory Patient Groups (APG)

1. Institutional Component (Originating Site)

    a. When services are provided via telemedicine to a member located at an Article 28 originating site (outpatient department/clinic, emergency room), the originating site may bill only CPT code Q3014 (telehealth originating-site facility fee) through APGs to recoup administrative expenses associated with the telemedicine encounter.

    b. When a separate and distinct medical service, unrelated to the telemedicine encounter, is provided by a qualified practitioner at the originating site, the originating site may bill for the medical service provided in addition to Q3014. The CPT code billed for the separate and distinct service must be appended with modifier 25.

Office Setting or Other Secure Location – Billing by Originating and/or Distant-Site Practitioner

1. Practitioner (Professional) Component (Originating Site)

    a. When a telemedicine service is being provided by a distant-site practitioner to a member located in a private practitioner's office (originating site), the originating-site practitioner may bill CPT code Q3014 to recoup administrative expenses associated with the telemedicine encounter.

b. When a telemedicine service is being provided by a distant-site practitioner to a member located in a private practitioner's office (originating site) and the originating-site practitioner provides a separate and distinct medical service unrelated to the telemedicine encounter, the originating-site practitioner may bill for the medical service provided in addition to Q3014. The CPT code billed for the separate and distinct medical service must be appended with modifier 25.

2. Practitioner (Professional) Component (Distant Site) a. If the distant-site practitioner is providing services via telemedicine from his/her private office or other secure location, the practitioner should bill the appropriate CPT code for the service provided. The CPT code should be appended with the applicable modifier (95).

Hospital Inpatient

When a telemedicine consultation is being provided by a distant-site physician to a member who is an inpatient in the hospital, payment for the telemedicine encounter may be billed by the distant-site physician. Other than physician services, all other practitioner services are included in the All Patients Refined Diagnosis Related Group (APR-DRG) payment to the facility.

Skilled Nursing Facility (SNF)

When the telehealth practitioner's services are included in the nursing home's rate, the telehealth practitioner must bill the nursing home. If the telehealth practitioner's services are not included in the nursing home's rate, the telehealth practitioner should bill Medicaid as if he/she saw the member face to face. The CPT code billed should be appended with the applicable modifier (95). Practitioners providing services via telehealth should confirm with the nursing facility whether their services are in the nursing home rate.

Federally Qualified Health Centers (FQHC)

1. FQHCs That Have "Opted Into" APGs: FQHCs that have "opted into" APGs should follow the billing guidance outlined above for sites billing under APGs.

2. FQHCs That Have Not "Opted Into" APGs - FQHC Originating Sites:

a. When services are provided via telemedicine to a patient located at an FQHC originating site, the originating site may bill only the FQHC offsite services rate code (4012) to recoup administrative expenses associated with the telemedicine encounter.

b. When a separate and distinct medical service, unrelated to the telemedicine encounter, is provided by a qualified practitioner at the FQHC originating site, the originating site may bill the Prospective Payment System (PPS) rate in addition to the FQHC offsite services rate code (4012).

c. If a provider who is onsite at an FQHC is providing services via telemedicine to a member who is in their place of residence or other temporary location, the FQHC should bill the FQHC offsite services rate code (4012) and report the applicable modifier (95) on the procedure code line.

d. If the FQHC provides services as a distant-site provider, the FQHC may bill their PPS rate.

e-Visits (online digital evaluation and management (E&M) services)

1. eVisits are billed using time-based CPT codes (99421, 99422, 99423, 98970, 98971, 98972), based on cumulative service time over a seven-day period. The billing period begins when the provider reviews the initial patient communication, which must occur within three business days of the patient's inquiry. For instance, if a patient starts an eVisits on a Monday, the review should begin by Thursday.

2. Providers who can bill Evaluation and Management (E&M) codes independently such as physicians, nurse practitioners, and midwives can bill CPT codes 99421, 99422, and 99423.

3. Providers who may not bill Evaluation and Management (E&M) codes independently such as licensed social workers, clinical psychologists, speech language pathologists, physical therapists, and occupational therapists may bill CPT codes 98970, 98971, and 98972.

4. Service time may include evaluating patient records, discussing the issue with clinical staff, and follow-up communications, provided these are not billed separately. eVisits can only be billed once per seven-day period, using the last date of communication within that timeframe as the service date. They cannot be billed if the patient’s inquiry relates to a visit within the previous seven days.

5. If an eVisit transitions into an Evaluation and Management (E&M) visit, the eVisit should not be billed separately; however, the time spent can be included in the E&M billing.

6. Providers must adhere to all relevant guidelines from the American Medical Association concerning billing frequency and restrictions, particularly when an eVisit leads to an in-person visit.

7. For Article 28 clinics via APGs, eVisits codes will only be payable to the clinic only, and providers cannot bill a professional component.

8. Federally Qualified Health Centers (FQHCs) are currently not permitted to bill for eVisits.

9. Documentation Requirements:
    a. The following information **must be** documented in the medical record by the provider:
        i. the written or verbal consent made by the patient for the Telehealth visit.

Exclusions and limitations

G2010 and G2252 are not Healthfirst covered telehealth services.

In addition, administrative services such as the following are excluded from reimbursement for Telehealth:

- Services rendered by email, fax, or text.
- Telehealth encounters for patients billed with the same date of service as a in person face to face visit.
- Administrative functions, including but not limited to, telehealth appointment scheduling and registration, reminders, requests for referrals or prescriptions, and ordering of diagnostic studies.

Adjudication and Appeal Process

1. Reimbursement for Telehealth Services will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.

2. Claims submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.

3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

NOTES:
Note 1: Available service codes will vary depending on the specific line of business. Specific services may also require pre-authorization, please refer to Section 13 of the Provider Manual. Coverage for provisional service codes may end based on Center for Medicare and Medicaid Service (CMS) guidelines.

Note 2: Not all telehealth services are covered under Senior Health Partners Plan (SHP). Please verify individual member's coverage.

Note 3: Medicare Line of Business (LOB), Remote Patient Monitoring (RPM) services are not billable when rendered in POS 02 or 10.

For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization

II. Applicable Codes

CPT Code	Description	Audio only allowed	Comment
77427	Radiation treatment management, five treatments.		
90785	Interactive complexity (list separately in addition to the code for primary procedure).	Yes	
90791	Psychiatric diagnostic evaluation.	Yes	
90792	Psychiatric diagnostic evaluation with medical services.	Yes	
90832	Psychotherapy, 30 minutes with patient.	Yes	
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure).	Yes	
90834	Psychotherapy, 45 minutes with patient.	Yes	
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure).	Yes	
90837	Psychotherapy, 60 minutes with patient.	Yes	
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure).	Yes	
90839	Psychotherapy for crisis; first 60 minutes.	Yes	
90840	Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service).	Yes	
90845	Psychoanalysis.	Yes	
90846	Family psychotherapy (without the patient present), 50 minutes.	Yes	
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes.	Yes	
90849	Multiple-family group psychotherapy.		
90853	Group psychotherapy (other than of a multiple-family group).	Yes	

CPT Code	Description	Audio only allowed	Comment
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes		
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions		
90901	Biofeedback training by any modality		
90951	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.		
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.		
90953	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.		
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.		
90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.		
90956	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.		
90957	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.		

CPT Code	Description	Audio only allowed	Comment
90958	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.		
90959	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual.		
90960	End-Stage Renal Disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month.		
90961	End-Stage Renal Disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month.		
90962	Evaluation of speech fluency (e.g., stuttering, cluttering).		
90963	End-Stage Renal Disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth an develop.		
90964	End-stage renal disease (ESRD) for home dialysis per full month for patients 2-11 years of age, including monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.		
90965	End-Stage Renal Disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents.		
90966	End-Stage Renal Disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older.		
90967	End-Stage Renal Disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age.		
90968	End-Stage Renal Disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age.		
90969	End-Stage Renal Disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age.		

CPT Code	Description	Audio only allowed	Comment
90970	End-Stage Renal Disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older.		
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient		
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits		
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient		
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits		
92227	Remote Imaging for Detection of Retinal Disease (E.g., Retinopathy In A Patient with Diabetes) With Analysis and Report Under Physician Supervision, Unilateral or Bilateral		
92228	Remote Imaging for Monitoring and Management of Active Retinal Disease (E.g., Diabetic Retinopathy) With Physician Review, Interpretation and Report, Unilateral or Bilateral		
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual.	Yes	
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	Yes	
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	Yes	
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).	Yes	
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive, and expressive language).	Yes	
92524	Behavioral and qualitative analysis of voice and resonance	Yes	
92526	Treatment of swallowing dysfunction and/or oral function for feeding		
92550	Tympanometry and reflex threshold measurements		
92552	Pure tone audiometry (threshold); air only		

CPT Code	Description	Audio only allowed	Comment
92553	Pure tone audiometry (threshold); air and bone		
92555	Speech audiometry threshold;		
92556	Speech audiometry threshold; with speech recognition		
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)		
92563	Tone decay test		
92565	Stenger test, pure tone		
92567	Tympanometry (impedance testing)		
92568	Acoustic reflex testing, threshold		
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing		
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report		
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report		
92601	Diagnostic analysis of cochlear implant, patients younger than 7 years of age; with programming.		
92602	Diagnostic analysis of cochlear implant, patients younger than 7 years of age; subsequent reprogramming		
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming.		
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming.		
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour		
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)		
92609	Therapeutic services for the use of speech-generating devices, including programming and modification.		
92610	Evaluation of oral and pharyngeal swallowing function		

CPT Code	Description	Audio only allowed	Comment
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)		
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour.		
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (list separately in addition to code for primary procedure).		
93228	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query).		
93229	External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query).		
93268	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional.		
93270	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection).		
93271	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection).		
93272	External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional.		

CPT Code	Description	Audio only allowed	Comment
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional.		
93750	Interrogation of ventricular assist device (VAD), in person, with physician or other qualified health care professional analysis of device parameters (e.g., drivelines, alarms, power surges), review of device function (e.g., flow and volume status, septum status, recovery), with programming, if performed, and report.		
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)		
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)		
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day		
94003	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day		
94004	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day		
94005	Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more		
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)		
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)		

CPT Code	Description	Audio only allowed	Comment
94664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device		
95970	Alys npgt w/o prgrmg		
95971	Alys smpl sp/pn npgt w/prgrm		
95972	Alys cplx sp/pn npgt w/prgrm		
95983	Alys brn npgt prgrmg 15 min		
95984	Alys brn npgt prgrmg addl 15		
96041	Medical genetics and genetic counseling services, each 30 minutes		
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by Boston Diagnostic Aphasia Examination) with interpretation and report, per hour		
96110	Developmental screening (e.g., developmental milestone survey, speech, and language delay screen), with scoring and documentation, per standardized instrument.		
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour.		
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (list separately in addition to code for primary procedure).		
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgment, [e.g., acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour.	Yes	

CPT Code	Description	Audio only allowed	Comment
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (list separately in addition to code for primary procedure).	Yes	
96125	Standardized cognitive performance testing (e.g., ross information processing assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.		
96127	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument.	Yes	
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.	Yes	
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).	Yes	
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.	Yes	

CPT Code	Description	Audio only allowed	Comment
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).	Yes	
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.	Yes	
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).	Yes	
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	Yes	
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).	Yes	
96156	Health behavior intervention, individual, face-to-face; each additional 15 minutes (list separately in addition to code for primary service).	Yes	
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes.	Yes	
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (list separately in addition to code for primary service)	Yes	
96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument.	Yes	
96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.	Yes	
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes.	Yes	

CPT Code	Description	Audio only allowed	Comment
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (list separately in addition to code for primary service).	Yes	
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes.	Yes	
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service).	Yes	
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes.		
96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service).		
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)		
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes		
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)		
97150	Therapeutic procedure(s), group (2 or more individuals)		

CPT Code	Description	Audio only allowed	Comment
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan		
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes		
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes		
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes		
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes		
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes		
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes		
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes		

CPT Code	Description	Audio only allowed	Comment
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.		

CPT Code	Description	Audio only allowed	Comment
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 (i.e., 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 (e.g., 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.		

CPT Code	Description	Audio only allowed	Comment
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 (i.e., 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. Patients may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., 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 (i.e., 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 (e.g., 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.		

CPT Code	Description	Audio only allowed	Comment
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.		
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes		
97535	Self-care/home management training (e.g., 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	Yes	
97537	Community/work reintegration.		
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes		
97750	Physical performance test or measurement (e.g., 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		
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes		
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.	Yes	

CPT Code	Description	Audio only allowed	Comment
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.	Yes	
97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes.	Yes	
98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.		Not Accepted Please use 99202
98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.		Not Accepted Please use 99203
98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.		Not Accepted Please use 99204
98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.		Not Accepted Please use 99205
98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.		Not Accepted Please use 99212

CPT Code	Description	Audio only allowed	Comment
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.		Not Accepted Please use 99213
98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.		Not Accepted Please use 99214
98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.		Not Accepted Please use 99215
98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.		Not Accepted Please use 99202
98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.		Not Accepted Please use 99203
98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.		Not Accepted Please use 99204

CPT Code	Description	Audio only allowed	Comment
98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.		Not Accepted Please use 99205
98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.		Not Accepted Please use 99212
98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.		Not Accepted Please use 99213
98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.		Not Accepted Please use 99214
98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.		Not Accepted Please use 99215
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient.		

CPT Code	Description	Audio only allowed	Comment
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients.		
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients.		
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	Yes	
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	Yes	
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 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	Yes	
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes		
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes		

CPT Code	Description	Audio only allowed	Comment
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes		
99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days		
99202	Office or other outpatient visits for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. when using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.		
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.		
99204	Office or other outpatient visits for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.		
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.		
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.		

CPT Code	Description	Audio only allowed	Comment
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.		
99213	Office or other outpatient visits for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.		
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. when using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.		
99215	Office or other outpatient visits for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.		
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.		

CPT Code	Description	Audio only allowed	Comment
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.		
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A 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.		

CPT Code	Description	Audio only allowed	Comment
99232	Subsequent hospital 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.		
99233	Subsequent hospital 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.		

CPT Code	Description	Audio only allowed	Comment
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.		
99238	Hospital discharge day management; 30 minutes or less		
99239	Hospital discharge day management; more than 30 minutes		
99242	Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded 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, 30 minutes are spent face-to-face with the patient and/or family.		

CPT Code	Description	Audio only allowed	Comment
99243	Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed 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, 40 minutes are spent face-to-face with the patient and/or family.		
99244	Office consultation for a new or established 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 moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.		
99245	Office consultation for a new or established 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 presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.		
99252	Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded 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, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.		

CPT Code	Description	Audio only allowed	Comment
99253	Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed 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, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.		
99254	Inpatient consultation for a new or established 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 moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.		
99255	Inpatient consultation for a new or established 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 presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.		
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.		

CPT Code	Description	Audio only allowed	Comment
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.		

CPT Code	Description	Audio only allowed	Comment
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.		
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)		
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, 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.		

CPT Code	Description	Audio only allowed	Comment
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.		
99307	Subsequent nursing facility care, per day, for the evaluation and management of a 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 patient is stable, recovering, or improving. typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.		
99308	Subsequent nursing facility 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 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 responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.		

CPT Code	Description	Audio only allowed	Comment
99309	Subsequent nursing facility 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 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 has developed a significant complication or a significant new problem. typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.		
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a comprehensive interval history; a comprehensive 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. the patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 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	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family.		
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.		

CPT Code	Description	Audio only allowed	Comment
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.		
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.		

CPT Code	Description	Audio only allowed	Comment
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.		

CPT Code	Description	Audio only allowed	Comment
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.		
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes.		
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes.		
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes.		
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes.		
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.	Yes	
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes.	Yes	
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., audit, dast), and brief intervention (sbi) services; 15 to 30 minutes.		
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., audit, dast), and brief intervention (sbi) services; greater than 30 minutes.		
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes		

CPT Code	Description	Audio only allowed	Comment
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes		
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes		
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes		
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	Yes	
99447	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	Yes	
99448	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	Yes	
99449	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Yes	
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	Description	Audio only allowed	Comment
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		
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		
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 (List separately in addition to code for primary procedure)		
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		
99474	Self-measured blood pressure using a device validated for clinical accuracy; 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		

CPT Code	Description	Audio only allowed	Comment
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		
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)		

CPT Code	Description	Audio only allowed	Comment
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 (e.g., basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (e.g., 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 (e.g., 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 (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 60 minutes of total time is spent on the date of the encounter.		
99495	Transitional Care Management Services with the Following Required Elements: Communication (Direct Contact; Telephone; Electronic) With the Patient And/or Caregiver Within 2 Business Days of Discharge		
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge		

CPT Code	Description	Audio only allowed	Comment
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	Yes	
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)	Yes	
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.		
S9152	Speech therapy, re-evaluation		
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.		
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes.	Yes	
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes.	Yes	
G0270	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes.	Yes	
G0296	Counseling visit to discuss need for lung cancer screening using low dose CT scan (ldct) (service is for eligibility determination and shared decision making).	Yes	

CPT Code	Description	Audio only allowed	Comment
G0316	Prolonged hospital inpatient or observation care		
G0317	Prolonged nursing facility evaluation and management service		
G0318	Prolonged home or residence evaluation and management		
G0396	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes.	Yes	
G0397	Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes.	Yes	
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth.	Yes	
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth.	Yes	
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth.	Yes	
G0410	Group psychotherapy other than of a multiple-family group, in a partial hospitalization setting, 45 to 50 minutes		
G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per 1 hour.	Yes	
G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per 1 hour.	Yes	
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session		
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session		
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth.	Yes	
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth.	Yes	
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth.	Yes	
G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit.	Yes	

CPT Code	Description	Audio only allowed	Comment
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit.	Yes	
G0442	Annual alcohol misuse screening, 15 minutes.	Yes	
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes.	Yes	
G0444	Annual depression screening, 15 minutes.	Yes	
G0445	Semiannual high intensity behavioral counseling to prevent stis, individual, face-to-face, includes education skills training & guidance on how to change sexual behavior.	Yes	
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes.	Yes	
G0447	Face-to-face behavioral counseling for obesity, 15 minutes.	Yes	
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy.	Yes	
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service).	Yes	
G0508	Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth.		
G0509	Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth.		
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)	Yes	
G0514	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)	Yes	
G0560	Safety Planning Interventions (SPI), which are services provided to patients in crisis, including those with suicidal ideation or at risk of overdose.		

CPT Code	Description	Audio only allowed	Comment
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.	Yes	
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.	Yes	
G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure).	Yes	
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)	Yes	
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)	Yes	

CPT Code	Description	Audio only allowed	Comment
G3002	Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care e.g., physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. Requires initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using G3002, 30 minutes must be met or exceeded)		
G3003	Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for G3002. When using G3003, 15 minutes must be met or exceeded)		
G9685	Physician service or other qualified health care professional for the evaluation and management of a beneficiary's acute change in condition in a nursing facility. This service is for a demonstration project		
H0002	Behavioral health screening to determine eligibility for admission to treatment program.		
H0004	Behavioral health counseling and therapy, per 15 minutes.		
H0031	Mental health assessment, by non-physician.		
H0035	Mental health partial hospitalization, treatment, less than 24 hours.		
H0036	Community psychiatric supportive treatment; face-to-face; per 15 minutes.		
H0037	Community psychiatric supportive treatment program, per diem.		
H0038	Self-help/peer services, per 15 minutes.		

CPT Code	Description	Audio only allowed	Comment
H0040	Assertive community treatment program, per diem.		
H0044	Supported housing, per month.		
H0045	Respite care services, not in the home, per diem.		
H0049	Alcohol and/or drug screening.		
H0050	Alcohol and/or drug service, brief intervention, per 15 minutes.		
H2010	Comprehensive medication services, per 15 minutes.		
H2011	Crisis intervention service, per 15 minutes.		
H2012	Behavioral health day treatment, per hour.		
H2014	Skills training and development, per 15 minutes.		
H2017	Psychosocial rehabilitation services, per 15 minutes.		
H2018	Psychosocial rehabilitation services, per diem.		
H2019	Therapeutic behavioral services; per 15 minutes.		
H2023	Supported employment, per 15 minutes.		
H2025	Ongoing support to maintain employment, per 15 minutes.		
Q3014	Telehealth Originating Site Facility Fee		
S9484	Crisis intervention mental health services, per hour.		
S9485	Crisis intervention mental health services, per diem.		
T1014	Telehealth transmission, per minute, professional services bill separately		
T1015	Clinic Visit/Encounter, All-Inclusive		
T2013	Habilitation, Educational, Waiver; Per Hour		
T2015	Habilitation, prevocational, waiver; per hour		
T2017	Habilitation, Residential, Waiver; 15 Minutes		
T2019	Habilitation, Supported Employment, Waiver; Per 15Minutes		
T2024	Service Assessment/Plan of Care Development, Waiver		

III. Definitions

Term	Meaning
APG	Ambulatory Patient Group
BH	Behavioral Health
CPT	Current Procedural Terminology

Distant Site	The distant site is where a rendering Provider is located during a Telehealth encounter and reported with the appropriate POS, either 02 or 10
FQHC	Federally Qualified Health Centers
Medicaid Advantage Plus/MAP (CompleteCare)	CompleteCare integrates benefits from both Medicare Advantage and Medicaid Managed Care. Please refer to the covered benefits for both plans
MMIS	Medicaid Management Information System
Originating Site	The originating site is where the patient is located during the Telehealth encounter. The originating site may submit a claim for services of the facility. If the originating site is the member's home, reimbursement is limited to the professional Telehealth claim
POS	Place of Service
PPS	Prospective Payment System
SNF	Skilled Nursing Facility
Telehealth/Telemedicine	Telehealth services are live, interactive audio and visual transmissions of a physician-patient encounter from one site to another using telecommunications technology. They may include transmissions of real-time telecommunications or those transmitted by store-and-forward technology.

IV. Related Policies

Policy Number	Policy Description
PO-RE-074	Reimbursement-Policy-PO-RE-074-Remote-Patient-Monitoring_FINAL.pdf
PO-RE-124	Reimbursement-Policy-PO-RE-124-Medicare-Health-Equity-Services_FINAL.pdf
PO-RE-111	Reimbursement-Policy-PO-RE-111-Lactation_FINAL.pdf
PO-RE-101	ReimbursementPolicy-PO-RE-101-After-Hours-Care_FINAL.pdf

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Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

NYS Medicaid Coverage of Telehealth
Telehealth | CMS
MLN901705 -Telehealth & Remote Patient Monitoring

VI. Revision History

Revision Date	Summary of Changes
8/26/2025	Medicare telehealth waivers implemented during the COVID-19 Public Health Emergency are expected to expire at the end of September 2025. However, Healthfirst will continue to reimburse telehealth services provided to members in their homes through Calendar Year (CY) 2026. This ensures continued access and flexibility for members receiving care via telehealth beyond the federal expiration. Added Medical genetics and genetic counseling services (96041)
5/8/2025	Added Safety Planning Interventions (SPI) G0560
3/11/2025	• Removed Audio-only deleted codes 99441-99443. • Removed deleted codes G2012 and 96040 • Added definitions section pg. 1 • Eligibility for reimbursement section pg. 3 Added billing and claims submission requirements pg. 4
8/19/2024	• New requirements added for eVisits. • Removed 12 deleted CPT codes.
04/17/2024	• Removed service codes 99451 and 99452 (refer to eConsults reimbursement policy)
03/06/2024	• Removed G2012 from exclusion list, added to acceptable service code list. • Notes added: Note 1: Available service codes will vary depending on the specific line of business. Specific services may also require pre-authorization, please refer to Section 13 of the Provider Manual. Coverage for provisional service codes may end based on Center for Medicare and Medicaid Service (CMS) guidelines.
01/01/2024	• The Telemedicine policy service code list to reimburse an additional 263 service codes

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Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.