- CPT code 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.)

We have previously considered requests to add these codes to the telehealth list. As we stated in the CY 2011 PFS final rule with comment period (75 FR 73315), while initial inpatient consultation services are currently on the list of approved telehealth services, there are no services on the current list of telehealth services that resemble initial hospital care for an acutely ill patient by the admitting practitioner who has ongoing responsibility for the patient's treatment during the course of the hospital stay. Therefore, consistent with prior rulemaking, we did not propose that initial hospital care services be added to the Medicare telehealth services list on a category 1 basis.

The initial hospital care codes describe the first visit of the hospitalized patient by the admitting practitioner who may or may not have seen the patient in the decision-making phase regarding hospitalization. Based on the description of the services for these codes, we believed it is critical that the initial hospital visit by the admitting practitioner be conducted in person to ensure that the practitioner with ongoing treatment responsibility comprehensively assesses the patient's condition upon admission to the hospital through a thorough in-person examination. Additionally, the requester submitted no additional research or evidence that the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the

patient; therefore, we also did not propose adding initial hospital care services to the Medicare telehealth services list on a Category 2 basis.

We noted that Medicare beneficiaries who are being treated in the hospital setting can receive reasonable and necessary E/M services using other HCPCS codes that are currently on the Medicare telehealth list, including those for subsequent hospital care, initial and follow-up telehealth inpatient and emergency department consultations, as well as initial and follow-up critical care telehealth consultations.

Therefore, we did not propose to add the initial hospital care services to the list of Medicare telehealth services for CY 2019.

(4) Subsequent Hospital Care Services (CPT Codes 99231-99233)

- CPT code 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 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

data costs are administrative costs that are not unique to individual procedures, in the same fashion that we do not assign separate direct PE for higher electricity costs to diagnostic imaging procedures as compared to cognitive evaluation procedures. We continue to believe that these data costs are appropriately captured via the indirect PE methodology as opposed to being included as a separate direct PE input. We also note that other services that require around-the-clock monitoring, such as the home PT/INR monitoring described in HCPCS code G0249 (Provision of test materials and equipment for home inr monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests), do not include additional direct PE inputs for data costs, and we do not believe it would be appropriate to include them for CPT code 99454.

Comment: One commenter stated that CMS should add the cost of equipment sanitation and reprocessing as a one-time cost that is directly attributable to a patient. The commenter stated that FDA device guidelines require that a reusable medical device be reprocessed, which includes sanitation or sterilization and ensuring that all personal data is 'wiped' or removed from the device. The commenter stated that this cost was not considered by the RUC, however, it is routinely part of the 'set up' costs that are onetime costs directly attributable to a patient.

Response: We disagree with the commenter that these expenses would constitute a separate form of direct PE. We agree with the RUC, which discussed the specialty society's recommended supply items, shipping costs and a device reprocessing fee, and determined that these expenses are not specifically allocable to the patient for this service, and would be considered indirect practice expenses.

Comment: One commenter stated that there was direct time spent by pharmacists for each patient, and the commenter requested that CMS factor pharmacist time into the PE valuation for CPT codes 99453, 99454, 99091, and 99457.

Response: We typically do not consider time spent by a pharmacist to be a part of the clinical labor time for purposes of direct PE. For additional information, we direct readers to the Practice Expense portion of this final rule (section II.B. of this final rule).

Comment: Many commenters pointed out that beneficiary cost sharing is a significant barrier to the use of non-face-to-face services, like remote patient monitoring. Commenters requested that CMS waive the cost sharing requirements for these codes.

Response: We do not have the authority to make changes to the applicable beneficiary cost sharing for most physicians' services, including these.

Comment: Many commenters requested that CMS clarify the kinds of technology covered under CPT codes 99453, 99454, and 99457. Commenters provided examples of the kinds of technology these codes should cover including software applications that could be integrated into a beneficiary's smart phone, Holter-Monitors, Fit-Bits, or artificial intelligence messaging. One commenter suggested that behavioral health data and data from wellness applications be included as well. Another commenter stated that the descriptor should include results of patients' self-care tasks. Many commenters stated that CMS should clarify certain elements in the scope of service and code descriptors and issue appropriate sub-regulatory guidance. Commenters inquired as to whether CPT code 99453 can be furnished via telecommunication technology, if it can be billed again if the number of parameters changed in the future. Commenters requested that CMS clarify the meaning of "programmed alerts transmission" in the descriptor for CPT code 99454, and whether it included transmissions that

occurred other than daily. Commenters also encouraged CMS to allow flexibility in the time frame covered by these services.

Response: We plan to issue guidance to help inform practitioners and stakeholders on these issues.

Comment: Commenters requested that CMS clarify whether CPT code 99457 can be billed incident to a practitioner's professional services and asked that CMS make an exception to the direct supervision requirements, stating that general supervision is sufficient for these services.

Response: We note that CPT code 99457 describes professional time and therefore cannot be furnished by auxiliary personnel incident to a practitioner's professional services.

Comment: A few commenters suggested that additional medical professionals, including pharmacists, paramedics, chiropractors, physical therapists, occupational therapists and dentists should be allowed to bill Medicare for these services. Other commenters requested that CMS clarify the practitioners referred to as "other qualified healthcare professionals" in the code descriptor.

Response: We note that all practitioners must practice in accordance with applicable state law and scope of practice laws, and that some of the practitioners identified by the commenters are not authorized to bill Medicare independently for their services. We note that the term, "other qualified healthcare professionals," used in the code descriptor is a defined by CPT, and that definition can be found in the CPT Codebook.

Comment: A few commenters provided specific suggestions for revising the code descriptors, including the addition of secure messaging platforms, revision of the time thresholds, specifying that the follow-up should be written in all instances, including "for

medical consultative discussion and review" in the descriptor for CPT codes 99446 through 99449, and striking "referral services" and rather, including language similar to the other codes regarding "assessment and management" services. Other commenters requested CMS clarify the definition of "health record assessment" in the descriptors for CPT codes 99451 and 99452. One commenter suggested that CMS add language about use of EHR to the existing CPT codes, rather than finalize separate payment for CPT codes 99451 and 99452.

Response: While we appreciate all of the specific suggestions regarding the code descriptions, we defer to the CPT to maintain code descriptors for CPT codes. Where additional clarification is needed, we may provide guidance in the future.

Comment: A few commenters urged CMS not to be prescriptive regarding the technology that could be used to perform consultations, including real-time video, a store-and-forward visit, or simply a patient-provider message via a patient portal.

Response: While we are sympathetic to the commenters' desire not to be overly prescriptive about the technology used to furnish these services, especially given the speed at which technology evolves, we note that we refer to the CPT code descriptors and guidance to ascertain the scope of technology that is used to furnish these services.

Comment: One commenter asked whether there were geographic restrictions on these services.

Response: There are no geographic restrictions, as these services are not Medicare telehealth services.

After considering the public comments, we are finalizing the RUC-recommended work RVU of 0.61 for CPT code 99457 and the direct PE inputs for all three codes as proposed.

(59) Interprofessional Internet Consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449)

In September 2017, the CPT Editorial Panel revised four codes and created two codes to describe interprofessional telephone/internet/electronic medical record consultation services. CPT codes 99446 (Interprofessional telephone/Internet 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), 99447 (Interprofessional telephone/Internet 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), 99448 (Interprofessional telephone/Internet 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), and 99449 (Interprofessional telephone/Internet 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) describe assessment and management services in which a patient’s treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a physician with specific specialty expertise to assist with the diagnosis and/or management of the patient’s problem without the need for the face-to-face interaction between the patient and the consultant. These CPT codes are currently assigned a procedure status of B (bundled) and are not separately payable under Medicare. The CPT Editorial Panel revised these

codes to include electronic health record consultations, and the RUC reaffirmed the work RVUs it had previously submitted for these codes. We reevaluated the submitted recommendations and, in light of changes in medical practice and technology, we proposed to change the procedure status for CPT codes 99446, 99447, 99448, and 99449 from B (bundled) to A (active). We also proposed the RUC re-affirmed work RVUs of 0.35 for CPT code 99446, 0.70 for CPT code 99447, 1.05 for CPT code 99448, and 1.40 for CPT code 99449.

The CPT Editorial Panel also created two new codes, CPT code 99452 (Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes) and CPT code 99451 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time). The RUC-recommended work RVUs are 0.50 for CPT code 99452 and 0.70 for 99451. Since the CPT code for the treating/requesting physician or qualified healthcare professional and the CPT code for the consultative physician have similar intraservice times, we believe that these CPT codes should have equal values for work. Therefore, we proposed a work RVU of 0.50 for both CPT codes 99452 and 99451.

We welcomed comments on this proposal. We also direct readers to section II.D. of this final rule, Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services, which includes additional detail regarding our policies for modernizing Medicare physician payment by recognizing communication technology-based services.

There are no recommended direct PE inputs for the codes in this family.

The following is a summary of the public comments we received on our proposals involving the Interprofessional Internet Consultation family of codes.

Comment: Almost all commenters were supportive of CMS' proposal to unbundle CPT codes 99446 through 99449 and make separate payment for CPT codes 99452 and 99451. Almost all commenters did not support lowering the RVU of CPT code 99451 to 0.50 as the work of the consulting physician in CPT code 99451 is more intense than the work of the treating physician in CPT code 99452. Commenters stated that the consulting practitioner exercises greater effort, both in judgment and technical skill to make a recommendation for the treatment of a previously unknown patient than the treating physician does in conveying the relevant information. A few commenters expressed concern that the proposed work RVU for CPT code 99452 is too low, and does not accurately reflect the resources associated with the work of the treating physician.

Response: We agree with commenters that the work of the consulting physician is significant, and we are persuaded by the additional descriptions of that work provided by commenters. We also agree with the commenters who suggested that the proposed work RVU of 0.50 for CPT code 99452 undervalues the work associated with aggregating patient information, communicating with the consulting practitioner, and implementing the results of the consultation. We continue, however, to have concerns regarding the valuation of these services. We note that there are instances where the patient would not be new to the consulting practitioner, and therefore the intensity of the work would be reduced. We are also concerned that, given the similarity of intraservice times, CPT code 99452 is undervalued relative to CPT code 99451, especially since the code descriptor for CPT code 99452 specifies that the consulting practitioner can spend a minimum of 5 minutes providing the consultation. We

believe that a work RVU of 0.50 more accurately describes the work associated with both services. Given the similarity of intraservice times and the information indicating that both codes may be undervalued at 0.50 RVUs, we are finalizing a work RVU of 0.70 for CPT codes 99451 and 99452.

Comment: A few commenters expressed concern that these codes were only payable in the facility setting.

Response: These codes are payable in both facility and non-facility settings.

Comment: One commenter requested that CMS include pharmacists as clinical staff in the direct PE.

Response: We direct readers to the discussion of this issue in the PE section of the rule (Section II.B. of this final rule). We also note that these codes do not have direct PE inputs.

(60) Chronic Care Management Services (CPT code 99491)

In February 2017, the CPT Editorial Panel created a new code to describe at least 30 minutes of chronic care management services performed personally by the physician or qualified health care professional over one calendar month. CMS began making separate payment for CPT code 99490 (Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored) in CY 2015 (79 FR 67715). CPT code 99490 describes 20 minutes of clinical staff time spent on care management services for patients with 2 or more chronic conditions. CPT code 99490 also includes 15 minutes of physician time for

supervision of clinical staff. For CY 2019, the CPT Editorial Panel created CPT code 99491 (Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored) to describe situations when the billing practitioner is doing the care coordination work that is attributed to clinical staff in CPT code 99490. For CPT code 99491, the RUC recommended a work RVU of 1.45 for 30 minutes of physician time.

We believe this work RVU overvalues the resource costs associated with the physician performing the same care coordination activities that are performed by clinical staff in the service described by CPT code 99490. Additionally, this valuation of the work is higher than that of CPT code 99487 (Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month), which includes 60 minutes of clinical staff time, creating a rank order anomaly within the family of codes if we were to accept the RUC-recommended value.

CPT code 99490 has a work RVU of 0.61 for 15 minutes of physician time. Therefore, as CPT code 99491 describes 30 minutes of physician time, we proposed a work RVU of 1.22, which is double the work RVU of CPT code 99490.

We did not propose any direct PE refinements for this code family.

The following is a summary of the public comments we received on our proposals involving CPT code 99491.

Comment: Almost all commenters recommended that CMS finalize the RUC-recommended work value of 1.45 for 99491. The RUC stated that CPT code 99491 is different from the existing chronic care management (CCM) services codes because those codes are performed by clinical staff under the supervision of a physician, while CPT code 99491 is performed by the physicians themselves. Commenters also stated that the typical patient requiring that the physician personally perform the care management services is of greater acuity than the typical patient for whom CCM may be performed by clinical staff. Additionally, CPT code 99491 cannot be reported with CPT code 99490 or CPT code 99487, and must therefore account for all of the care management work in the month. Commenters also pointed out that there are multiple examples of CMS valuing the work of a physician more highly than clinical staff when they perform the same services, for example CPT codes 96101 (Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report) and 96102 (Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI

and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.)

Response: We agree with commenters that a work RVU of 1.45 accurately captures the resources associated when a physician furnishes CCM. We agree that in most cases, the physician would perform CCM on patients with higher acuity and therefore the care planning and medical decision making would be of greater intensity. We also agree with commenters that the work associated with personally performing CCM as opposed to supervising clinical staff is also of greater intensity. Therefore, we are finalizing that value based on our review of comments received.

Comment: A few commenters requested that CMS clarify that CPT code 99491 can be performed incident to a practitioner's professional services.

Response: CPT code 99491 is specifically for use when the billing practitioner personally performs care management services, so this code cannot be furnished incident to a practitioner's professional services.

(61) Diabetes Management Training (HCPCS codes G0108 and G0109)

HCPCS codes G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) and G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes) were identified on a screen of CMS or Other source codes with Medicare utilization greater than 100,000 services annually. For CY 2019, we proposed the HCPAC-recommended work RVU of 0.90 for HCPCS code G0108 and the HCPAC-recommended work RVU of 0.25 for HCPCS code G0109.

For the direct PE inputs, we noted that there was a significant disparity between the specialty recommendation and the final recommendation submitted by the HCPAC. We were