E. Care Management Services and Remote Physiologic Monitoring Services

1. Background

In recent years, we have updated PFS policies to improve payment for care management and coordination. Working with the CPT Editorial Panel and other clinicians, we have expanded the suite of codes describing these services. New CPT codes were created that describe services that involve direct patient contact (for some services, in-person) or do not involve direct patient contact; represent a single encounter, monthly service, or both; are timed services; address specific conditions; and represent the work of the billing practitioner, auxiliary personnel (specifically, clinical staff), or both (*see* Table 17). In this final rule for CY 2021, we continue our work to improve payment for care management services through code refinements related to remote physiologic monitoring (RPM), transitional care management (TCM), and psychiatric collaborative care model (CoCM) services.

**TABLE 17: Summary of Care Management Codes**

| Service | Summary |
|---|---|
| Care Plan Oversight (CPO) (also referred to as Home Health Supervision, Hospice Supervision) (HCPCS codes G0181, G0182) | Supervision of home health, hospice, per month |
| ESRD Monthly Services (CPT codes 90951-70) | ESRD management, with and without face-to-face visits, by age, per month |
| Transitional Care Management (TCM) (adopted in 2013) (CPT codes 99495, 99496) | Management of transition from acute care or certain outpatient stays to a community setting, with face-to-face visit, once per patient within 30 days post-discharge |
| Chronic Care Management (CCM) (adopted in 2015, 2017, 2019, 2020, 2021) (CPT codes 99487, 99489, 99490, 99491, HCPCS code G2058 to be replaced by CPT code 99439, in CY 2021 ) | Management of all care for patients with two or more serious chronic conditions, timed, per month |
| Advance Care Planning (ACP) (adopted in 2016) (CPT codes 99497, 99498) | Counseling/discussing advance directives, face-to-face, timed |
| Behavioral Health Integration (BHI) (adopted in 2017) (CPT codes 99484, 99492, 99493, 99494, HCPCS code G2214) | Management of behavioral health conditions(s), timed, per month |
| Cognitive Impairment Assessment and Care Planning (adopted in 2017) (CPT code 99483) | Assessment and care planning of cognitive impairment, face-to-face visit |
| Prolonged Evaluation & Management (E/M) Without Direct Patient Contact (adopted in 2017) (CPT codes 99358, 99359) | Prolonged non-face-to-face E/M work related to a face-to-face visit (other than office/outpatient visits beginning in 2021), timed |
| Prolonged Office/Outpatient E/M Visit (adopted for 2021) (HCPCS code G2212) | Prolonged face-to-face and/or non-face to face E/M work related to an office/outpatient E/M visit, timed |
| Remote Physiologic Monitoring Treatment Management Services (RPM) (adopted in 2020) (CPT codes 99457, 99458) | Development and management of a plan of treatment based upon patient physiologic data |
| Interprofessional Consultation (adopted in 2019) (CPT codes 99446, 99447, 99448, 99449, 99451, 99452) | Inter-practitioner consultation |
| Principal Care Management (adopted in 2020) (HCPCS codes G2064, G2065) | Management of a single, high risk disease |

2. Digitally Stored Data Services/Remote Physiologic Monitoring/Treatment Management Services (RPM)

RPM involves the collection and analysis of patient physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. In recent years, we have finalized payment for seven CPT codes in the RPM code family. Five of the seven codes have been the focus of frequent questions from stakeholders.

In response to proposals in the CY 2019 PFS proposed rule (83 FR 35771) and the CY 2020 PFS proposed rule (84 FR 40555 through 40556), stakeholders requested that we clarify

how we interpret aspects of the RPM code descriptors for CPT codes 99453, 99454, 99091, and 99457. Commenters asked us, for example, to identify who can furnish RPM services, what kinds of devices can be used to collect data, how data should be collected, and how "interactive communication" is defined. We stated in the CY 2020 PFS final rule (84 FR 62697) that we would provide guidance in the future about the codes. For CY 2021, we are clarifying how we read CPT code descriptors and instructions associated with CPT codes 99453, 99454, 99091, and 99457 (and the add-on code, CPT code 99458) and their use for remote monitoring of physiologic parameters of a patient's health.

The RPM process begins with two PE only codes, CPT codes 99453 and 99454, finalized in the CY 2019 PFS final rule (83 FR 59574 through 59576). As PE only codes, they are valued to include clinical staff time, supplies, and equipment, including the medical device for the typical case of remote monitoring. CPT code 99453 (*Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment*) is valued to reflect clinical staff time that includes instructing a patient and/or caregiver about using one or more medical devices. CPT code 99454 (*Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days*) is valued to include the medical device or devices supplied to the patient and the programming of the medical device for repeated monitoring. We reviewed the PE inputs for CPT code 99454 in the proposed rule and clarified that the medical devices that are supplied to the patient and used to collect physiologic data are considered equipment and, as such, are direct PE inputs for the code.

Review of CPT prefatory language (CPT® 2021 Professional Codebook (hereafter, CPT Codebook), pp. 52-53) provides additional information about the two PE-only codes. For

example, the CPT prefatory language indicates that monitoring must occur over at least 16 days of a 30-day period in order for CPT codes 99453 and 99454 to be billed. Additionally, these two codes are not to be reported for a patient more than once during a 30-day period. This language suggests that even when multiple medical devices are provided to a patient, the services associated with all the medical devices can be billed only once per patient per 30-day period and only when at least 16 days of data have been collected. We also noted that CPT code 99453 can be billed only once per episode of care where an episode of care is defined as "beginning when the remote physiologic monitoring service is initiated and ends with attainment of targeted treatment goals" (CPT Codebook, p. 52).

Other stakeholder inquiries about CPT codes 99453 and 99454 focused upon the kinds of medical devices that can be used to collect a patient's physiologic data. Prefatory language in the CPT Codebook states that "the device must be a medical device as defined by the FDA." CPT simply specifies that the device must meet the FDA's definition of a medical device as described in section 201(h) of the Federal, Food, Drug and Cosmetic Act (FFDCA). As discussed in the CY 2021 PFS proposed rule (85 FR 50118), we found no language in the CPT Codebook indicating that a medical device must be FDA cleared as some stakeholders suggested, although such clearance may be appropriate. We also noted that we did not find information that suggested a medical device must be prescribed by a physician, although this could be possible depending upon the medical device. Beyond acknowledging the CPT specification that the medical device supplied for CPT code 99454 must meet the FDA definition of a medical device, we clarified in the proposed rule that the medical device should digitally (that is, automatically) upload patient physiologic data (that is, data are not patient self-recorded and/or self-reported). We also noted that use of the medical device or devices that digitally collect and transmit a patient's physiologic data must, as usual for most Medicare covered services, be reasonable and

necessary for the diagnosis or treatment of the patient's illness or injury or to improve the functioning of a malformed body member. Further, we noted that the device must be used to collect and transmit reliable and valid physiologic data that allow understanding of a patient's health status in order to develop and manage a plan of treatment.

The CPT Codebook lists the RPM codes under the main heading Evaluation and Management (E/M). We clarified in the proposed rule that as E/M codes, CPT codes 99453, 99454, 99091, 99457, and 99458, can be ordered and billed only by physicians or NPPs who are eligible to bill Medicare for E/M services.

Although we initially described RPM services in the CY 2019 PFS final rule (83 FR 59574) as services furnished to patients with chronic conditions, we clarified in the CY 2021 PFS proposed rule (85 FR 50118) that practitioners may furnish these services to remotely collect and analyze physiologic data from patients with acute conditions as well as from patients with chronic conditions.

After the data collection period for CPT codes 99453 and 99454, the physiologic data that are collected and transmitted may be analyzed and interpreted as described by CPT code 99091, a code that includes only professional work (that is, there are no direct PE inputs). We finalized payment for CPT code 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*) in the CY 2018 PFS final rule (82 FR 53013 through 53014). The valuation for CPT code 99091 includes a total time of 40 minutes of physician or NPP work, broken down as follows: 5 minutes of preservice work (for example, chart review); 30 minutes of intra-service work (for example, data analysis and interpretation, report based upon the

physiologic data, as well as a possible phone call to the patient); and 5 minutes of post-service work (that is, chart documentation). We noted that stakeholders have expressed confusion about the specification in the code descriptor for CPT code 99091 that the service is furnished by a "physician or other qualified health care professional, qualified by education, training, licensure/regulation." The phrase "physician or other qualified health care professional" is defined by CPT as "an individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff … [which refers to] a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service but does not individually report that professional service."[3] Accordingly, when referring to a particular service described by a CPT code for Medicare purposes, a physician or other qualified health care professional is an individual whose scope of practice and Medicare benefit category includes the service, and who is authorized to independently bill Medicare for the service. See our previous discussion of this in the CY 2016 PFS final rule at 80 FR 70957. Medicare also covers and makes payment for certain services performed by auxiliary personnel (which includes clinical staff) "incident to" the professional services of the billing practitioner. Our regulation at § 410.26(a) defines auxiliary personnel and delineates the conditions for payment for "incident to" services.

After analyzing and interpreting a patient's remotely collected physiologic data, we noted that the next step in the process of RPM is the development of a treatment plan that is informed

[3] CPT Codebook, p. xiv.

by the analysis and interpretation of the patient's data. It is at this point that the physician or NPP develops a treatment plan with the patient and/or caregiver (that is, develops a patient-centered plan of care) and then manages the plan until the targeted goals of the treatment plan are attained, which signals the end of the episode of care. CPT code 99457 (*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes*) and its add-on code, CPT code 99458 (*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (list separately in addition to code for primary procedure)*) describe the treatment and management services associated with RPM. Medicare stakeholders have requested that we clarify aspects of these two codes. The two most frequently asked questions include "Who can furnish the services described by CPT codes 99457 and 99458?" and "What does it mean to have an 'interactive communication' with a patient?"

We addressed who can furnish CPT codes 99457 and 99458 in the CY 2020 PFS final rule (84 FR 62697 through 62698) when we designated both codes as care management services. We explained that, like other care management services, services described by CPT codes 99457 and 99458 can be furnished by clinical staff under the general supervision of the physician or NPP. We noted that RPM services are not considered to be diagnostic tests; that is, they cannot be furnished and billed by an Independent Diagnostic Testing Facility on the order of a physician or NPP.

The services described by CPT codes 99457 and 99458 are services that are typically furnished remotely using communications technologies that allow "interactive communication,"

which we read as real-time interaction, between a patient and the physician, NPP, or clinical staff who provide the services. Stakeholders have requested that we define "interactive communication" as used in the code descriptors for CPT codes 99457 and 99458. We explained in the proposed rule that we saw this remote, non-face-to-face exchange as being similar to the exchange that occurs in providing services described by HCPCS code G2012, *Brief Communication Technology-Based Service*, which we finalized in the CY 2019 PFS final rule (83 FR 59483 through 59486). We clarified that "interactive communication" for purposes of CPT codes 99457 and 99458 involves, at a minimum, a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission. As indicated in the code descriptor for CPT code 99457, we believed during the writing of the proposed rule that the interactive communication should total at least 20 minutes of time with the patient over the course of a calendar month for CPT code 99457 to be reported. Each additional 20 minutes of interactive communication between the patient and the physician/NPP/clinical staff would be reported using CPT code 99458. We developed our definition of time using the CPT Codebook. The CPT Codebook states that unless there are code- or code-range specific instructions, parenthetical instructions, or code descriptors to the contrary, time is considered to be "face-to-face" time with the patient or patient's caregiver/medical decision-maker. See the CPT Codebook, page xvii for more information about measuring time. Although the services described by CPT codes 99457 and 99458 are not typically in-person services, we interpreted time in the code descriptor to mean the time the practitioner spent in direct, real-time interactive communication with a patient.

Lastly, we proposed to establish as permanent policy two of the changes we made on an interim basis to the requirements for furnishing RPM services in the March 31st and the May 8th

COVID-19 IFCs. (See 85 FR 19264 and 85 FR 27605 through 27606 for the interim modifications and clarifications to RPM services in response to the PHE for COVID-19).

Our goals during the PHE for COVID-19 have been to reduce exposure risks to the virus for practitioners and patients while also increasing access to health care services. We eliminated as many obstacles as possible to allow timely delivery of reasonable and necessary health care. We wanted patients to be able to access services quickly and without barriers. With the goals of reducing exposure and increasing access to services, we finalized that RPM services could be furnished to new patients, as well as established patients on an interim basis for the duration of the PHE for COVID-19. We also finalized several policies on an interim basis for the duration of the PHE for COVID-19. These include: (1) allowing consent to be obtained at the time services are furnished; (2) allowing consent to be obtained by individuals providing RPM services under contract with the billing physician or practitioner; and (3) allowing RPM codes to be billed for a minimum of 2 days of data collection over a 30-day period, rather than the required 16 days of data collection over a 30-day period as provided in the CPT code descriptors.

For CY 2021, we proposed on a permanent basis to allow consent to be obtained at the time that RPM services are furnished. Because the CPT code descriptors do not specify that clinical staff must perform RPM services, we also proposed to allow auxiliary personnel (which includes other individuals who are not clinical staff but are employees or leased or contracted employees) to furnish services described by CPT codes 99453 and 99454 under the general supervision of the billing physician or practitioner.

When the PHE for COVID-19 ends, we again will require that RPM services be furnished only to an established patient. We believe that a physician or practitioner who has an established relationship with a patient would likely have had an opportunity to provide a new patient E/M service. During the new patient E/M service, the physician or practitioner would

have collected relevant patient history and conducted a physical exam, as appropriate. As a result, the physician or practitioner would possess information needed to understand the current medical status and needs of the patient prior to ordering RPM services to collect and analyze the patient's physiologic data and to develop a treatment plan. Additionally, and in keeping with the CPT prefatory language for CPT codes 99453 and 99454, when the PHE for COVID-19 ends, we will once again require that 16 days of data be collected within 30 days to meet the requirements to bill CPT codes 99453 and 99454.

In response to the May 19, 2020 E.O. 13924, "Regulatory Relief To Support Economic Recovery," (85 FR 31353 through 31356), we solicited comment from the medical community and other members of the public on whether current RPM coding accurately and adequately describes the full range of clinical scenarios where RPM services may be of benefit to patients. We requested information that would help us to understand whether it would be beneficial to consider establishing coding and payment rules that would allow practitioners to bill and be paid for RPM services with shorter monitoring periods. We expressed interest in understanding whether one or more codes that describe a shorter duration, for example, 8 or more days of remote monitoring within 30 days, might be useful. For example, CPT codes 99453 and 99454 currently require use of a medical device as defined by the FDA in section 201(h) of FFDCA that digitally collects and transmits 16 or more days of data every 30 days in order for the codes to be billed; however, some patients may not require remote monitoring for 16 or more days in a 30-day period. For some patients, continuous short-term monitoring might be more appropriate. For example, a post-surgical patient who is recovering at home might benefit from remote monitoring of his or her body temperature as a means of assessing infection and managing medications or dosage. In some clinical situations, monitoring several times throughout a day, over a period of 10 days, may be reasonable and necessary. Sixteen or more days might be

unnecessary. We requested information that would help us to understand whether it would be beneficial to consider establishing coding and payment rules that would allow practitioners to bill and be paid for RPM services with shorter monitoring periods. Specifically, we were interested in understanding whether one or more codes that describe a shorter duration, for example, 8 or more days of remote monitoring within 30 days, might be useful. We welcomed comments including any additional information that the medical community and other members of the public believe might provide further clarification on how RPM services are used in clinical practice, and how they might be coded, billed, and valued under the Medicare PFS.

We received public comments on our clarifications and proposals related to digitally stored data services/remote physiologic monitoring/treatment management services. The following is a summary of comments we received and our responses.

Comment: Overall, commenters expressed appreciation and support for the clarifications proposed by CMS regarding RPM CPT codes 99453, 99454, 99091, and 99457 (and the add-on code, CPT code 99458).

Response: We thank commenters for their support, as well as for suggesting additional ways we might interpret the RPM codes. We hope to continue this dialogue as CPT creates more RPM codes.

Comment: A group of commenters disagreed with our clarification that CPT codes 99453, 99454, 99091, 99457, and 99458 can be ordered and billed only by physicians and NPPs who are eligible to bill Medicare for E/M services. Some commenters suggested that we allow the CPT Editorial Panel and the RUC to establish appropriate coding for other practitioners.

Response: We believe that as E/M codes, CPT codes 99453, 99454, 99091, 99457, and 99458, can be ordered and billed only by physicians or NPPs who are eligible to bill Medicare

for E/M services. We agree with commenters that additional coding would be necessary, specifically for practitioners who cannot order and bill E/M services.

Comment: Commenters disagreed with our suggestion that CPT codes 99091 and 99457 can be billed together. Commenters reported that these two codes are incompatible and cannot be reported in the same calendar month or in conjunction with one another.

Response: We continue to believe that, if reasonable and necessary, CPT codes 99091 (*Collection & interpretation physiologic data*) and 99457 (*Remote physiologic monitoring treatment management*), given their descriptions of services in the CPT Codebook, could be reported for the same patient. We believe the two codes, as currently described, provide different types of services. We agree with commenters that the CPT Codebook states on page 53, "Do not report 99091 in conjunction with 99457." However, the next section states, "Do not report 99091 for time in a calendar month when used to meet the criteria for 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99457, and 99491." We note that these two statements suggest that there may be instances where both codes could be billed for the same patient in the same month as long as the same time was not used to meet the criteria for both CPT codes 99091 and 99457. We remind readers that the valuation for CPT code 99091 includes a total time of 40 minutes of physician or NPP work broken down as follows: 5 minutes of pre-service work (for example, chart review); 30 minutes of intra-service work (for example, data analysis and interpretation, report based upon the physiologic data, as well as a possible phone call to the patient); and 5 minutes of post-service work (that is, chart documentation). We believe that in some instances when complex data are collected, more time devoted exclusively to data analysis and interpretation by a physician or NPP may be necessary such that the criteria could be met to bill for both CPT codes 99091 and 99457 within a 30-day period. The medically necessary services associated with all the medical devices for a single patient can be billed by

only one practitioner, only once per patient per 30-day period, and only when at least 16 days of data have been collected.

Comment: Commenters suggested that other devices that do not meet the FDA's definition of medical device, but collect physiologic data, should satisfy the requirements of RPM services.

Response: We disagree with the commenters. The prefatory language and code descriptors developed by the CPT Editorial Panel indicate the device must meet the FDA definition of a medical device as found in section 201(h) of the FFDCA.

Comment: One commenter stated that a coding gap exists between physiologic and non-physiologic remote monitoring and stated that additional coding is required for non-physiologic parameters.

Response: We thank the commenter for this insight. We look forward to engaging with stakeholders on this topic to inform how we might consider a "coding gap" that exists for services related to remote monitoring for non-physiologic measures of health.

Comment: Several commenters suggested that CMS should allow RPM services to be furnished to new patients, as well as to established patients. Other commenters supported our decision to require that patients be known to the practitioner (established patients) prior to the start of RPM services.

Response: We continue to believe that a physician or NPP who has an established relationship with a patient would possess the information needed to understand the current medical status and needs of the patient prior to ordering RPM services to collect and analyze the patient's physiologic data and to develop a treatment plan. We note that during the PHE for COVID-19, RPM services may be furnished and billed for both new and established patients. We refer readers to the March 31st COVID-19 IFC (85 FR 19264) where we adopted the policy on an

interim basis for the duration of the PHE for COVID-19 that RPM services could be furnished to new patients as well as established patients.

After considering public comments, we are not extending this interim policy beyond the end of the PHE for COVID-19. At the conclusion of the PHE, there will need to be an established patient-practitioner relationship in order to bill Medicare for CPT codes 99453, 99454, 99457, and 99458.

Comment: Some commenters suggested that we permit fewer than the required 16 days of monitoring per month that are required to bill CPT codes 99453 and 99454. One commenter indicated that patients and health care personnel are served best by a maximum data collection requirement of 6 days. Another commenter stated that the 8 days we suggested would be best. Another commenter suggested that at least 16 days of data should be required, and when 16 days of data are not collected within the 30-day period, that a modifier should be reported as a means of communicating that the service duration was reduced with an associated reduction in payment.

Response: While we agree that a full 16 days of monitoring may not always be reasonable and necessary, we requested detailed information about meaningful, clinical situations that require fewer days or shorter durations of remote monitoring. We were interested in understanding under what clinical circumstances fewer days of monitoring would be medically reasonable and necessary and allow a practitioner to establish clinically meaningful care. Although we received general support for a reduction in the number of days of data collection required to bill for CPT codes 99453 and 99454, we did not receive specific clinical examples.

After considering public comments, we are not extending the interim policy to permit billing for CPT codes 99453 and 99454 for fewer than 16 days in a 30-day period beyond the end of the PHE for COVID-19. At the conclusion of the PHE for COVID-19, we will require, in

accordance with the code descriptors for CPT codes 99453 and 99454, that 16 days of data each 30 days must be collected and transmitted to meet the requirements to bill CPT codes 99453 and 99454.

Comment: A few commenters requested that Independent Diagnostic Testing Facilities (IDTFs) be allowed to bill for RPM services.

Response: As we noted in the proposed rule, RPM services are not considered to be diagnostic tests; therefore, RPM services cannot be furnished and billed by an IDTF on the order of a physician or NPP.

Comment: Commenters agreed with our clarification that practitioners should be allowed to furnish RPM services to patients with acute conditions, as well as patients with chronic conditions.

Response: We thank commenters for their support of our clarification that practitioners may furnish RPM services to patients with acute conditions, as well as patients with chronic conditions.

In the CY 2021 PFS proposed rule, we proposed to make permanent two policies that we adopted in the March 31st COVID-19 IFC (85 FR 19264). We received comments on our proposed policies. The following is a summary of the comments we received and our responses.

Comment: Commenters wrote in favor of our proposal to allow consent to be obtained at the time the services of CPT codes 99453 and 99454 are furnished.

Response: We thank our stakeholders for their comments and support of this proposal.

Comment: Commenters agreed with our proposal to allow auxiliary personnel to furnish the services of CPT codes 99453 and 99454 under the general supervision of the billing physician or practitioner.

Response: We thank commenters for their support of this proposal.

After considering comments related to these two proposals, we are finalizing both as proposed.

3. Transitional Care Management (TCM)

Payment for TCM CPT codes 99495 (*Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two 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*) and 99496 (*Transitional Care Management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge; medical decision making of at least high complexity during the service period; face-to-face visit within seven calendar days of discharge*) was finalized in the CY 2013 PFS final rule (77 FR 68979 through 68993). At that time, we identified a list of 57 HCPCS codes (see 77 FR 68990 for the original guidance) that we stated could not be billed concurrently with TCM services because of potential duplication of services.

For CY 2020, recognizing that use of TCM services was low when compared to the number of Medicare beneficiaries with eligible discharges and that increased utilization of medically necessary TCM services could improve patient outcomes, one of our proposals included modifying our prior rule that prohibited the billing of TCM services with many other services that we had viewed as duplicative (77 FR 68990). In the CY 2020 PFS final rule (84 FR 62685 through 62687), we finalized a policy to allow concurrent billing of TCM services, when reasonable and necessary, with 16 actively priced (that is, not bundled or non-covered) codes during the 30-day period covered by TCM services. We stated at the time that we would continue to refine our billing policies for TCM through future notice and comment rulemaking.