Digital Medicine Clinical Scenarios: Coding Handbook

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Introduction

Physicians are increasing using digitally enabled care in their practices. Given the growing use and unique nature of digitally-enabled care services, the AMA has developed this handbook as a guide for physicians providing digital medicine services.

The AMA's Current Procedure Terminology (CPT) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other qualified health care professionals (QHPs). To ensure that CPT codes remain up to date, the AMA has established a CPT Editorial Panel, consisting of expert physicians across specialties who provide guidance on the most clinically appropriate and viable code sets. The CPT Editorial Panel has, over the past five years, significantly expanded the availability of digital medicine codes such as remote clinician-to-clinician consultations and remote monitoring services.

In addition to CPT codes, medical claims can include a Place of Service (POS) code and a Modifier code. Place of Service codes specify the entity where service(s) are rendered (e.g., school, office, assisted living facility, or others). Modifiers provide the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. The Centers for Medicare & Medicaid Services (CMS) develops and maintains the POS code set and the AMA develops and maintains modifier definitions for the CPT code set.

Historically, for visits conducted via video and/or audio-only, both the CPT Editorial Panel and Medicare directed providers to report codes for an in-person office visit and use POS codes and modifier(s) to indicate if the patient was located at home and/or if the visit was audio-only. Starting in 2025, however, the CPT Editorial Panel adopted telemedicine service codes to reflect the virtual nature of certain evaluation and management (E/M) visits. For example, starting in 2025, CPT 98000-98007 reflect synchronous audio-video visits and CPT 98016 reflects a brief synchronous communication. Additionally, starting in 2025, CPT deleted 99441, 99442, 99443, which were formerly used to report audio-only services, instead adopting CPT 98008-98015 to reflect synchronous audio-only E/M services. CMS, however, did not adopt the new CPT telemedicine codes (CPT 98000-98015) and instead indicated that providers should bill using in-person E/M codes with appropriate modifiers to indicate that the visit was conducted via video or audio-only. Because CMS does not currently recognize these new CPT telemedicine service codes for reporting and reimbursement purposes, the codes may not be included in CMS lists of telehealth codes; as such, there may not be specific guidance on how to appropriately report POS. In addition to the below guidance, it is important for providers to connect with their payers to confirm their specific reporting standards for these codes.

Given that many of these codes are new and there are several questions about how to use them appropriately, the AMA, with support from Manatt Health, developed this handbook to detail common clinical encounters and an overview of appropriate CPT guidance for each. Additionally, Appendix R, shown below, provides a taxonomy of key digital medicine services and relevant codes. For other AMA coding resources, please see here. For questions and comments, please send questions to CPTKnowledgebase@ama-assn.org.

Disclaimer: Information provided by the AMA contained within this Guide is for medical coding guidance purposes only. It does not (i) supersede or replace the AMA's Current Procedural Terminology® manual ("CPT Manual") or other coding authority, (ii) constitute clinical advice, (iii) address or dictate payer coverage or reimbursement policy, and (iv) substitute for the professional judgement of the practitioner performing a procedure, who remains responsible for correct coding.

Note: the AMA develops CPT and modifier definitions and guidance, and CMS develops POS definitions and guidance; the two can have varying approaches to billing guidance. The below aligns with the AMA's CPT 2025 guidance and includes the AMA's best understanding of POS and Medicare-implications, but if providers have specific POS or billing questions, they should reach out to their payer for specific guidance on approach.

Appendix R[1]: Digital Medicine-Services Taxonomy*

(*NOTE THAT THE CODES LISTED IN THIS TABLE ARE EXAMPLES AND NOT MEANT TO BE AN EXHAUSTIVE LIST)

	CLINICIAN[2]-TO-PATIENT SERVICES (E.G., VISIT)		CLINICIAN TO CLINICIAN (E.G., CONSULTATION)		PATIENT MONITORING AND/OR THERAPEUTIC SERVICES			DIGITAL DIAGNOSTIC SERVICES	
	Synchronous	**Asynchronous**	**Synchronous**	**Asynchronous**	**Device/Software Set Up and Education**	**Data Transfer**	**Data Interpretation**	**Patient Directed**	**Image/Specimen Directed**
Encounter Activity	Real-time audiovisual interaction	Store-and-forward digital communication	Real-time consultative communication between requesting and consulting clinicians	Store and forward consultative digital exchange of clinical information between requesting and consulting clinicians	In-person, virtual face-to-face, telephone, or other modalities of communication with patient to support device set-up education/supply	Acquisition of patient data with transfer to managing or interpreting physician/other QHP/clinical staff	Data review, interpretation, and patient management by clinical staff/physician/other QHP with associated patient communication	Automated and autonomous algorithmically enabled diagnostic support	
CPT Service	Synch audio-video visit (98000-98007)	Online digital evaluation & management (99421-99423) (98970-98972)	Interprofessional telephone/Internet/EHR consultation (Typically via telephone) (99446-99449, 99451)	Interprofessional telephone/internet/EHR consultation (99446-99449, 99451, 99452)	Remote physiologic monitoring initial set up/education (99453)		Physiologic data collection/interpretation by physician/other QHP (99091)	Autonomous retinopathy screening (92229)	
	Synch audio-only visit (98008-98015) Brief communication technology-based service (98016)		If patient is present at originating site → transition to virtual face-to-face E/M consultation *(use modifier 95)*			Remote physiologic monitoring device supply (99454)	Remote physiologic monitoring treatment management by clinical staff/physician/other QHP (99457, 99458)		Multianalyte assays with algorithmic analyses (MAAA)
					Remote therapeutic monitoring initial set up/education (98975)	Remote therapeutic monitoring device supply (98976 for respiratory system; 98977 for musculo-skeletal system)	Remote therapeutic monitoring treatment management by physician/other QHP (98980, 98981)		

[1] For the purposes of this appendix, the following terms should be understood as: (i) Digital medicine services represent the use of technologies for measurement and intervention in the service of patient health; (ii) Synchronous services represent real-time interactions between a distant-site physician or other QHP and a patient and/or family located at a remote originating side; (iii) Asynchronous services represent store-and-forward transmissions of health information over periods of time using a secure Web server, encrypted email, specially designed store-and-forward software, or electronic health record. Asynchronous services enable a patient to share health information for later review by the physician or other QHP. These services also allow a physician or other QHP to share a patient's medical history, images, physiologic/non-physiologic clinical data and/or pathology and laboratory reports with a specialist physician for diagnostic and treatment expertise.

[2] The term "clinician" in the table represents a physician or other qualified health care professional (QHP) by whom the specific code may be used.

Appendix R[1]: Digital Medicine-Services Taxonomy*

(*NOTE THAT THE CODES LISTED IN THIS TABLE ARE EXAMPLES AND NOT MEANT TO BE AN EXHAUSTIVE LIST)

CLINICIAN[2]-TO-PATIENT SERVICES (E.G., VISIT)		CLINICIAN TO CLINICIAN (E.G., CONSULTATION)		PATIENT MONITORING AND/OR THERAPEUTIC SERVICES			DIGITAL DIAGNOSTIC SERVICES	
Synchronous	Asynchronous	Synchronous	Asynchronous	Device/Software Set Up and Education	Data Transfer	Data Interpretation	Patient Directed	Image/Specimen Directed
				Remote pulmonary artery pressure sensor monitoring treatment management by physician/other QHP (93264)				Computer-aided detection (CAD) imaging
				Ambulatory continuous glucose monitoring hook-up, education, recording print-out (95250 for office-equipped; 95249 for patient-equipped)		Ambulatory continuous glucose monitoring (95251)		
				External electrocardiographic recording (Recording, scanning analysis with report, review and interpretation) (93224, 93241, 93245)			External electrocardiographic recording (Autonomous algorithms used to analyze/create report) (93241–93243, 93245-93247)	
				External electrocardiographic recording (Recording) (93224, 93225, 93241, 93242, 93245, 93246)	External electrocardiographic recording (Scanning analysis with report only) (93226, 93241, 93243, 93247)	External electrocardiographic recording (Review and interpretation) (93224, 93227, 93241, 93244, 93245, 93248)		
				External mobile cardiovascular telemetry technical support (93229)		External mobile cardiovascular telemetry review and interpretation (93228)		
				Digital amblyopia services (0704T for initial set-up/education; 0705T for surveillance center technical support, including data transmission)		Digital amblyopia services (Assessment of patient performance, program data) (0706T)		
					Automated analysis of CT study (Data prep, interpretation and report) (0691T)			

Scenario #1: Established patient, synchronous audio-video visit

Scenario

A 42-year-old female with a history of asthma has visited her pulmonologist several times over the past few years. She has recently experienced a mild episode of shortness of breath and cough and is concerned that her current asthma management plan may not be sufficient. The patient schedules a video visit with her pulmonologist. During the 15-minute conversation, she describes her symptoms, including how often she uses her inhaler and the triggers she's been encountering. The pulmonologist assesses the patient's symptoms over the video call and discusses potential adjustments to her asthma medication regimen.

After four days, the patient sends a message through the patient portal to report that she has been following the physician's recommendations but is still experiencing some wheezing. The physician reviews her reported symptoms and peak flow meter readings (submitted via the patient portal), providing guidance on medication adjustments and recommends a follow-up visit if the patient's condition does not improve in the next week.

EVENT	VIDEO VISIT DAY 1	PATIENT PORTAL COMMUNICATIONS FOUR DAYS LATER
Key information	• Established patient • Patient-initiated video visit • Video visit lasts 15 minutes • During visit, the physician conducts symptoms assessment and discusses medication adjustments	• Patient-initiated communication • Communication occurs in patient portal • Physician responds to patient communication via patient portal
Who is performing	Pulmonologist	Pulmonologist
Applicable CPT codes	**CPT 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 reported separately:** occurs within seven days of video visit (see more detailed explanation below).
Place of service code	POS 10[1] Telehealth Provided in Patient's Home	None applicable.

EVENT	VIDEO VISIT DAY 1	PATIENT PORTAL COMMUNICATIONS FOUR DAYS LATER
Modifier	None applicable.	None applicable.
Medicare considerations	Historically, for visits conducted via video and/or audio-only, both CPT and Medicare directed providers to report codes for an in-person office visit and use modifier(s) and POS codes to indicate if the patient was home and/or if the visit was audio-only. Starting in 2025, CPT adopted telemedicine service codes to reflect the virtual nature of certain E/M visits. For example, starting in 2025, CPT 98000-98007 reflect synchronous audio-video services, CPT 98008-98015 reflect synchronous audio-only services, and CPT 98016 reflects brief synchronous communication. The CMS CY2025 Final Physician Fee Schedule, however, did not adopt these codes as payable and instead has indicated that providers should continue to bill using in-person E/M codes with the appropriate modifier(s) to indicate that the visit was conducted via video or audio-only.	None applicable.
Notes & other considerations	**CPT considerations** • CPT 98004 is a new telemedicine service code, eligible for reimbursement starting January 1, 2025. AMA CPT telemedicine service codes are used in lieu of an in-person service when medically appropriate to address the care of the patient and when the patient and/or family/caregiver agree to this format of care. This code does not require a specific time interval from the last in-person or telemedicine visit and may be initiated by a physician or other QHP as well as by a patient and/or family/caregiver. However, this code must be performed on a separate calendar date from another E/M service. When performed on the same date as another E/M service, the elements and time of those services are summed and reported in aggregate, ensuring that any overlapping time is only counted once. • CPT 98004 can be selected based on either level of medical decision making or time. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	**CPT considerations** • Online Digital Evaluation Management Service codes[2] (e.g., 99421,[3] 99422, 99423) are not separately reported if a patient initiates the online digital inquiry for the same or a related problem within seven days of a previous E/M service. Given that the patient in the above scenario communicated within four days of a telemedicine visit, online digital evaluation management service codes are not applicable.

Scenario #1 Notes

1. POS 10, Telehealth Provided in Patient's Home: The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. (Effective 1/1/22).
2. Online digital evaluation and management (E/M) services (99421, 99422, 99423) are patient-initiated services with physicians or other qualified health care professionals. Online digital E/M services require physician or other QHP's evaluation, assessment, and management of the patient. These services are not for the nonevaluative electronic communication of test results, scheduling of appointment, or other communication that does not include E/M. While the patient's problem may be new to the physician or other QHP, the patient is an established patient. Patients initiate these services through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms. If the patient initiates an online digital inquiry for the same or a related problem within seven days of a previous E/M service, then the online digital visit is not reported.
3. CPT 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.

Scenario #2: New patient, synchronous audio-video visit

Scenario

A patient who just moved to a new state and has not visited any physician's office presents with mild abdominal pain and nausea. During a video appointment, the physician takes a comprehensive medical history and assesses her symptoms, which include intermittent pain and nausea after eating. The patient denies fever or any urinary symptoms. In addition to providing guidance on managing her symptoms, the physician recommends the patient comes in for a physical evaluation within the next two weeks. The physician spends a total of 31 minutes on the video call.

EVENT	 VIDEO VISIT
Key information	• New patient • Patient-initiated video visit • Video visit lasts 31 minutes • During visit, the physician takes medical history, conducts symptoms assessment, and provides clinical guidance
Who is performing	Physician
Applicable CPT codes	**CPT 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.
Place of service code	POS 10 Telehealth Provided in Patient's Home
Modifier	None applicable.

EVENT	 VIDEO VISIT
Medicare considerations	Historically, for visits conducted via video and/or audio-only, both CPT and Medicare directed providers to report codes for an in-person office visit and use modifier(s) and POS codes to indicate if the patient was home and/or if the visit was audio-only. Starting in 2025, CPT adopted telemedicine service codes to reflect the virtual nature of certain E/M visits. For example, starting in 2025, CPT 98000-98007 reflect synchronous audio-video services, CPT 98008-98015 reflect synchronous audio-only services, and CPT 98016 reflects brief synchronous communication. The CMS CY2025 Final Physician Fee Schedule, however, did not adopt these codes as payable and instead has indicated that providers should continue to bill using in-person E/M codes with the appropriate modifier(s) to indicate that the visit was conducted via video or audio-only.
Notes & other considerations	None applicable.

Scenario #3: Established patient, audio-only visit

Scenario

An established patient who has not been seen in the past month calls the office because, after a recent insect bite, they develop a mild rash. The physician talks to the patient about possible reactions and notifies the patient of symptoms to be aware of. The physician spends a total of 13 minutes on the phone, including 11 minutes in medical discussion with the patient.

EVENT	AUDIO-ONLY VISIT
Key information	• Established patient • Patient has had no recent clinical appointments • Patient-initiated audio-only visit • Audio-only visit lasts 13 minutes • Medical discussion lasts 11 minutes
Who is performing	Physician
Applicable CPT codes	**CPT 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.
Place of service code	POS 10 Telehealth Provided in Patient's Home
Modifier	None applicable

EVENT	AUDIO-ONLY VISIT
Medicare considerations	Historically, both CPT and Medicare directed providers to report 99441, 99442, and 99443 for E/M services conducted via audio-only (i.e., telephone). Effective January 2025, CPT deleted these codes and adopted telemedicine E/M codes (e.g., CPT 98000-98015) to reflect the virtual nature of certain E/M visits, which include audio-only E/M codes for new and established patients (CPT 98008-98015). The CMS CY2025 Final Physician Fee Schedule, however, did not adopt these telemedicine E/M CPT codes as payable. The AMA encourages the use of the new telemedicine E/M codes, but providers should confirm with payers the preferred billing approach to ensure appropriate reimbursement.
Notes & other considerations	None applicable.

Scenario #4: Established patient, brief audio-only visit

Scenario

An established patient who has not been seen in the past month calls the office because, after a recent insect bite, they develop a mild rash. During a 7-minute phone call, the physician talks to the patient about possible reactions, notifies the patient of symptoms to be aware of, and recommends that the patient come into the office for a more full evaluation if the patient does not see improvement. After a few days, the patient's rash subsides; despite there being an opening on the physician's calendar, the patient opts not to return to the physician's office for further evaluation.

EVENT	BRIEF SYNCHRONOUS COMMUNICATION
Key information	• Established patient • Patient has had no recent clinical appointments • Patient-initiated audio-only visit • Audio-only visit lasts 7 minutes
Who is performing	Physician
Applicable CPT codes	**CPT 98016**, Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion.
Place of service code	POS 10 Telehealth Provided in Patient's Home

EVENT	BRIEF SYNCHRONOUS COMMUNICATION
Modifier	None applicable.
Medicare considerations	Historically, both CPT and Medicare directed providers to report 99441, 99442, and 99443 for E/M services conducted via audio-only (i.e., telephone). Effective January 2025, CPT deleted these codes and adopted telemedicine E/M codes (e.g., CPT 98000-98015) to reflect the virtual nature of certain E/M visits, which include audio-only E/M codes for new and established patients (CPT 98008-98015). The CMS CY2025 Final Physician Fee Schedule, however, did not adopt these telemedicine E/M CPT codes as payable. The AMA encourages the use of the new telemedicine E/M codes, but providers should confirm with payers the preferred billing approach to ensure appropriate reimbursement.
Notes & other considerations	CPT 98016 is reported for established patients only. The service is patient-initiated and intended to evaluate whether a more extensive visit type is required. Video technology is not required. CPT 98016 describes a service of shorter duration than the audio-only services and has other restrictions that are related to the intended use as a "virtual check-in" or triage to determine if another E/M service is necessary. When the patient-initiated check-in leads to an E/M service on the same calendar date, and when time is used to select the level of that E/M service, the time from 98016 may be added to the time of the E/M service for total time on the date of the encounter. Do not report 98016 in conjunction with 98000-98015.

Scenario #5: Online digital evaluation & management service

Scenario

A 55-year-old male with type 2 diabetes and hypertension presents for a routine follow-up visit to review his blood pressure and glucose management. During the in-person visit, the endocrinologist adjusts the patient's medications and provides lifestyle counseling. The patient is instructed to follow up via the patient portal if there are any concerns about his blood sugar levels or medication side effects. The appointment lasts 18 minutes.

Two weeks later, the patient messages the endocrinologist via the patient portal, concerned about his fluctuating glucose levels and the side effects of his new medication. The endocrinologist reviews the patient's recent glucose logs and advises adjustments to his diet and medication timing. Over the course of three days, the physician spends a total of 10 minutes exchanging secure messages with the patient.

EVENT	IN-PERSON FOLLOW UP VISIT DAY 1	PATIENT PORTAL MESSAGING DAYS 14–17
Key information	• In-person visit lasts 18 minutes • During visit, endocrinologist provides lifestyle counseling and adjusts medications • Patient has two chronic conditions, type 2 diabetes and hypertension	• Online communication via patient portal • Patient portal communication is focused on follow up events related to E/M visit • Patient portal communication occurs 2 weeks after the in-person E/M visit • Physician spends a total of 10 minutes over three days responding to patient portal messages
Who is performing	Endocrinologist	Endocrinologist
Applicable CPT codes	**CPT 99212**, Office or other outpatient visit for the evaluation and management of an establish 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.	**CPT 99421**,[1] Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes.
Place of service code	POS 11[2] Office	POS 11 Office

EVENT	IN-PERSON FOLLOW UP VISIT DAY 1	PATIENT PORTAL MESSAGING DAYS 14–17
Modifier	None applicable.	None applicable.
Medicare considerations	None applicable.	None applicable.
Notes & other considerations	• None applicable.	**CPT considerations** • If the patient initiates an online digital inquiry for the same or a related problem within seven days of a previous E/M service, then the online digital visit is not reported. In this scenario, the patient initiates an online digital inquiry for the same or a related problem more than seven days out from an E/M service and therefore an online digital evaluate and management service is appropriate. • If within seven days of the initiation of an online digital E/M service, a separately reported E/M visit occurs, then the physician or other QHP work devoted to the online digital E/M service is incorporated into the separately reported E/M visit. • If this service is provided by a non-physician qualified health care professional, they would bill CPT 98970.[3] **POS considerations** • Although POS typically refers to where the patient is located during a clinical encounter, CPT 99421 describes an activity that a clinical team conducts **without** the patient present. Thus, the POS relevant for CPT 99421 is POS 11, indicating that the clinical team is located in the clinical office at the time of data analysis as a typical site of service.

Scenario #5 Notes

1. Online digital evaluation and management services (99421, 99422, 99423) are patient-initiated services with physicians or other qualified health care professionals. Online digital E/M services require physician or other QHP's evaluation, assessment, and management of the patient. These services are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M. Online digital E/M services are reported once for the physician's or other QHP's cumulative time devoted to the service during a seven-day period. The seven-day period begins with the physician's or other QHP's initial personal review of the patient-generated inquiry. Physician's or other QHP's cumulative service time includes review of the initial inquiry, review of patient records or data pertinent to assessment of the patient's problem, personal physician or other QHP interaction with clinical staff focused on the patient's problem, development of management plans, including physician or other QHP generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email or other digitally supported communication, which does not otherwise represent a separately reported E/M service.
2. POS 11, Office: Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
3. CPT 98970, Nonphysician qualified 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.

Scenario #6: Self-measured blood pressure (SMBP)[1]

Scenario

In a previous visit, a patient without a diagnosis of hypertension has multiple high blood pressure readings and the physician orders initiation of a self-measured blood pressure program at home. The patients obtains a validated blood pressure device with an appropriately sized cuff and comes back into the office to have it checked and be trained on how to use the device.

When the patient returns, a nurse confirms the cuff size is correct, ensures the device is calibrated, and then educates the patient on how to use the device, best practices to take readings, and how to record and communicate readings back to the care team. The nurse spends 20 minutes with the patient.

Four weeks later, the patient uploads blood pressure readings taken over the course of a week to the patient portal for the care team to review. The patient took two readings 1 minute apart for three mornings and three evenings. A medical assistant averages the readings and alerts the patient's physician, who confirms the diagnosis of hypertension for this patient. The physician develops and documents a treatment plan which includes initiation of an antihypertensive medication. The physician calls the patient to discuss the treatment plan and instructs them to continue monitoring their blood pressure and relay readings to the care team. The physician spends 15 minutes on the phone with the patient, who was located at home.

[1] For additional SMBP coding resources, please see: 7-Step SMBP Coding Guide; SMBP Coverage Insights: Medicaid; The 7-step self-measured blood pressure (SMBP) quick guide.

EVENT	IN-PERSON VISIT WITH BLOOD PRESSURE DEVICE DAY 1	REMOTE BLOOD PRESSURE READINGS DAY 46
Key information	• Patient-supplied blood pressure device • During visit, nurse calibrates devices and educates patient on device use, when/how to take readings, and how to share readings with clinical team • In-person visit lasts 20 minutes	• Patient uploads data from 12 blood pressure readings: two readings 1 minutes apart for three mornings [six total readings] and two readings 1 minute apart for three evenings [six total readings]). • Physician develops, documents, and communicates treatment plan to patient
Who is performing	Nurse	Medical Assistant and Physician
Applicable CPT codes	**CPT 99473**, Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration.	**CPT 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.
Place of service code	POS 11 Office	POS 10 Telehealth Provided in Patient's Home
Modifier	None applicable.	None applicable.
Medicare considerations	None applicable.	None applicable.

EVENT	IN-PERSON VISIT WITH BLOOD PRESSURE DEVICE DAY 1	REMOTE BLOOD PRESSURE READINGS DAY 46
Notes & other considerations	**CPT considerations** • RPM code CPT 99453 would not be appropriate here because SMBP code CPT 99473 is more specific to self-monitored blood pressure. There is often confusion between RPM codes and SMBP codes. A few key differences: – *Specificity:* CPT 99473 is more specific to blood pressure and self-monitoring of blood pressure; CPT 99453 is applicable to a wider range of physiologic parameters. – *Type of device:* CPT 99473 specifies that the device must be validated for clinical accuracy. – *Length of monitoring:* CPT 99473 includes no specifications around length of monitoring that must be anticipated for the device. Conversely, CPT 99453 indicates that it must only be reported for monitoring greater or equal to 16 days. – *Data transfer:* CPT 99473 is reported for self-monitoring of blood pressure, rather than remote or automatic monitoring. As such, patients in SMBP programs may have to independently (e.g., manually) record and report their blood pressure data. However, when reporting CPT 99453, the data collected by the device must be automatically transferred to the clinical team. • Do not report 99473 more than once per device. • For ambulatory blood pressure monitoring, see CPT 93784, 93786, 93788, 93790. • A supervising physician or QHP may report CPT 99473 on behalf of the clinical staff work being performed. Clinical staff are defined as "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 who does not individually report that professional service." Typical examples of clinical staff include RNs, LPNs and/or medical technicians, but may include others, such as pharmacists, if the appropriate requirements for supervision are met.	**CPT considerations** • RPM code CPT 99454 would not be appropriate here because CPT 99474 is more specific to self-monitored blood pressure. Additionally, CPT 99474 allows for data to be collected and reported by a patient and/or caregiver to the clinical team; CPT 99454 requires daily recordings or programmed alert transmissions. Furthermore, CPT 99474 and CPT 99454 have different monitoring length requirements (i.e., CPT 99474 requires specific number of readings over a 30-day period; CPT 99454 requires at least 16 days of recordings). • Do not report 99473, 99474 in the same calendar month as 93784, 93786, 93788, 93790, 99091, 99424, 99425, 99426, 99427, 99437, 99439, 99453, 99454, 99457, 99487, 99489, 99490, 99491. • Do not report 99474 more than once per calendar month. • CPT 99474 is applicable because this service is conducted outside of a typical E/M visit. If, during an E/M visit, a patient was educated on an SMBP program and/or provided an SMBP device, CPT 99474 would not be applicable, and instead the E/M code alone would be used.

Scenario #7: Self-measured blood pressure (SMBP)

Scenario

An established patient, currently doing SMBP and taking antihypertensive medication, communicates their blood pressure readings to a nurse in a 5-minute telephone call. The nurse checks with the patient's physician, who interprets the report (including readings of individual and mean systolic and diastolic pressures), and modifies the treatment plan accordingly. The nurse calls the patient back and relays the changes to treatment plan in a 10-minute phone call. No other services are provided.

EVENT	TELEPHONE CALL
Key information	• Patient communicates blood pressure readings via telephone call to a nurse • Physician interprets readings and adjusts treatment plan • Nurse relays changes to treatment plan to patient via phone call
Who is performing	Patient Nurse Physician
Applicable CPT codes	**CPT 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.
Place of service code	POS 10 Telemedicine in Patient's Home
Modifier	None applicable.

EVENT	 TELEPHONE CALL
Medicare considerations	None applicable.
Notes & other considerations	**CPT considerations** • There is nothing in CPT 99474 code definition that precludes a patient from communicating their self-measured blood pressure readings to the clinical team over the phone and thus CPT 99474 is appropriate for this scenario. If the patient communicated their self-measured blood pressure readings over a video visit, CPT 99474 would also be applicable (presuming that the video visit was not an E/M visit and solely conducted to report blood pressure readings). • CPT 99474 is applicable because this service is conducted outside of a typical E/M visit. If a patient communicated their required SMBP readings to a physician during an E/M visit, CPT 99474 would not be applicable and instead the E/M code alone would be used. • To bill CPT 99474, a physician must review the blood pressure data submitted, and is responsible for determining any needed adjustments to the treatment plan, but a registered nurse or other clinical staff can support the process of data collection and patient communication.

Scenario #8: Ambulatory continuous glucose monitoring

Scenario

A patient with type 2 diabetes has consistently struggled to manage their blood glucose levels, despite being on oral medications and insulin. Their endocrinologist is concerned about frequent episodes of hyperglycemia. During a routine, in-person check-in appointment, the endocrinologist decides to provide the patient with a continuous glucose monitor (CGM). The endocrinologist provides education on how to use the CGM, including how to attach the sensor to the patient's body and how to log readings into a mobile application. The patient wears the CGM for the next month (replacing the disposable sensor approximately every seven days). Data are sent automatically from the sensor to the clinical team. The clinical team is able to print out the recording of measurements and readings.

In the following month, the endocrinologist spends 8 minutes reviewing and interpreting the data and preparing a summary report for communication with the patient and other health care professionals.

EVENT	PATIENT EDUCATION & SET UP DAY 1, START OF MONTH	PATIENT LOGS DATA THROUGHOUT MONTH	CLINICAL TEAM REVIEWS DATA THROUGHOUT MONTH
Key information	• Routine in-person appointment • During appointment, physician provides patient with CGM and educates patient on use of CGM and how to log readings • Clinical team prints out recording data	• Patient wears CGM consistently for 30 days, replacing sensor every seven days • Data from CGM automatically sent to clinical team	• Physician reviews data for total of 8 minutes over course of month • Physician prepares summary report for communication with patient and other health care professionals
Who is performing	Endocrinologist	Patient	Endocrinologist
Applicable CPT codes	**CPT 99212**, Office or other outpatient visit for the evaluation and management of an establish 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. **CPT 95250**, Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.	None applicable.	**CPT 95251**, Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report.
Place of service code	POS 11 Office	None applicable.	POS 11 Office (see considerations below)
Modifier	Modifier 25	None applicable.	None applicable.
Medicare considerations	None applicable.	None applicable.	None applicable.

EVENT	PATIENT EDUCATION & SET UP DAY 1, START OF MONTH	PATIENT LOGS DATA THROUGHOUT MONTH	CLINICAL TEAM REVIEWS DATA THROUGHOUT MONTH
Notes & other considerations	**CPT considerations** • Do not report 95250 more than once per month. • Do not report CPT 95250 in conjunction with 99091,[1] 0446T.[2] • CPT 95249[3] is not applicable because in this scenario the clinician (vs. the patient) provided the CGM. • RPM codes (e.g., CPT 99453,[4] CPT 99454) would not be applicable because CPT 95250 is more specific and applicable to CGM. **POS considerations** • CPT 95250 and CPT 95249 require the physician and patient to be in-person together, and thus the POS must indicate the same (i.e., CPT 95250 and CPT 95249 cannot be billed with POS 10, 02, etc.) **Modifier considerations** • Modifier 25 helps delineate that the E/M visit was distinct from the CGM services provided. The patient did not go to the clinic to set up their CGM; they attended the appointment for a routine E/M visit and activities related to the CGM were in addition to the E/M visit.	• The patient logging data is a requisite step for the clinical team to be able to review data (and bill CPT 95251; see column to the right). However, the patient logging data does not independently warrant the billing of a code.	**CPT considerations** • CPT 95251 is not time-bound, but can only be billed once per month. • Do not report 95251 in conjunction with 99091, 0446T. • An RPM code was not used because the CGM Code (CPT 95251) is more specific. Also, an RPM code is not applicable because (i) there was no patient interaction, which is a requirement for RPM codes (e.g., CPT 99457[5] and CPT 99458 require interactive communication with the patient/caregiver); (ii) the clinical team did not meet the time requirements of RPM codes (e.g., CPT 99457 requires at least 20 minutes of clinical staff time). **POS considerations** • Although POS typically refers to where the patient is located during a clinical encounter, CPT 95251 describes an activity that a clinical team conducts **without** the patient present. Thus, the POS relevant for CPT 95251 is POS 11, indicating that the clinical team is located in the clinical office at the time of data analysis.

Scenario #8 Notes

1. CPT 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.
2. CPT 0446T, Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training. Note: this will be sunset January 2027. Do not report 0446T in conjunction with 95251, 0447T, 0448T.
3. CPT 95249, Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording. Do not report 95249 more than once for the duration that the patient owns the data receiver. Do not report 95249 in conjunction with 99091, 0446T.
4. CPT 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. Do not report 99453 more than once per episode of care. Do not report 99453 for monitoring of less than 16 days. Do not report 99453 in conjunction with 0811T.
5. CPT 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.

Scenario #9: Remote physiologic monitoring (RPM)

Scenario

A 32-year-old pregnant patient has attended five routine, in-person prenatal visits with no complications. During the patient's sixth prenatal visit, occurring at 26 weeks gestation, the patient shares recently-learned family history that indicates she may have risk factors for gestational diabetes. During the visit, the OB/GYN conducts a glucose test by testing the patient's blood on a glucose test strip.

To confirm whether the patient has gestational diabetes, the OB/GYN schedules a glucose tolerance test (GTT). Two days later, the patient fasts overnight for 8 hours, comes into the clinic for a blood draw, drinks a liquid with set amount of glucose, and has subsequent blood draws at regular intervals over the next 2–3 hours. Based on the results of the GTT, the OB/GYN diagnoses the patient with gestational diabetes. The OB/GYN provides the patient with a glucose monitor (glucometer) and educates the patient on its use, as well as how to log readings and transmit data to her healthcare team. The OB/GYN ensures the glucometer is appropriately calibrated.

For the remainder of her pregnancy (about 3 months), the patient takes routine blood glucose readings and logs them into a mobile app, which automatically sends the data to her care team. A nurse practitioner reviews the patient's glucose levels every other day for approximately 2 minutes each time, providing feedback directly through the mobile application and answering the patient's questions. The patient's OB/GYN spends 5 minutes each month reviewing the data to ensure the blood sugar levels remain within the target range.

EVENT	PRENATAL VISITS 1–6 MONTHS 1–6	GLUCOSE TOLERANCE TEST & GLUCOSE MONITOR MONTH 6	CLINICAL REVIEW OF PATIENT GLUCOSE LEVELS MONTHS 7, 8, AND 9
Key information	• Routine, in-person visit • Glucose test strip conducted with blood	• In-person visit • Glucose tolerance test conducted • OB/GYN calibrates glucose monitor and educates patient on its appropriate use and how to transmit data to the clinical team	• Nurse practitioner spends 2 minutes every other day reviewing data (approximately 30 minutes per month) • Nurse practitioner provides feedback directly to patient • OB/GYN spends 5 minutes each month reviewing data
Who is performing	OB/GYN	OB/GYN	Nurse Practitioner OB/GYN
Applicable CPT codes	**CPT 82948**, Glucose; blood, reagent strip. Note: CPT 59400 is also likely applicable (CPT 59400, Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care), but is billed as a global bundle for routine obstetric care, including antepartum, vaginal delivery, and postpartum care. Thus, CPT 59400 is billed after the delivery has occurred and would not be billed during these routine in-person appointments.	**CPT 82951**, Glucose; tolerance test (GTT), 3 specimens (includes glucose). **CPT 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 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. Note: CPT 59400 is also likely applicable. See note in previous column.	**CPT 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.
Place of service code	POS 11 Office	POS 11 Office	POS 11 Office
Modifier	None applicable.	None applicable.	None applicable.

EVENT	PRENATAL VISITS 1–6 MONTHS 1–6	GLUCOSE TOLERANCE TEST & GLUCOSE MONITOR MONTH 6	CLINICAL REVIEW OF PATIENT GLUCOSE LEVELS MONTHS 7, 8, AND 9
Medicare considerations	None applicable.	None applicable.	None applicable.
Notes & other considerations	**CPT considerations:** • CPT 59400 is not reportable because it is a global bundle that is reported after vaginal delivery. • CPT 82948 is reported separately because services and activities that fall outside the global bundle (CPT 59400) should be reported separately.	**CPT considerations:** • To report CPT 99453, 99454, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. • Do not report CPT 99453 more than once per episode of care. • Do not report CPT 99453 for monitoring of less than 16 days. • Do not report CPT 99453 in conjunction with 0811T.	**CPT considerations:** • RPM CPT 99457 is not applicable to this scenario because CPT 99457 requires an interactive communication with the patient/caregiver, which does not occur in this scenario. • CPT 99091 is appropriate because the total time spent reviewing data is greater than 30 minutes. Assuming the nurse practitioner qualifies as a qualified health professional, both the time spent by the physician (5 minutes) and that spent by the nurse practitioner (30 minutes) during the month contributes to the total time. • CPT 99091 should be reported no more than once in a 30-day period to include the physician or other qualified health care professional time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to patient and/or caregiver), and associated documentation. • Do not report CPT 99091 in conjunction with 99457, 99458. • Do not report CPT 99091 for time in a calendar month when used to meet the criteria for 99374, 99375, 99377, 99378, 99379, 99380, 99424, 99425, 99426, 99427, 99437, 99457, 99487, 99491. **POS considerations:** • Although POS typically refers to where the patient is located during a clinical encounter, CPT 99091 describes an activity that a clinical team conducts **without** the patient present. Thus, the POS relevant for CPT 99091 is POS 11, indicating that the clinical team is located in the clinical office at the time of data analysis.

Scenario #10: Remote therapeutic monitoring (RTM)

Scenario

A patient with osteoarthritis in her knees has been prescribed physical therapy exercises, pain management medications, and lifestyle changes by her physical therapist (PT). Four months ago she was given a wearable activity tracker that tracks her daily activity (steps); she also has a connected mobile application where she logs her pain levels and adherence to certain exercises. This month, the patient's PT reviews the patient's activity and pain data for 15 minutes and spends 9 minutes summarizing data findings, making exercises changes to complete in the next month, and responding to patient questions through a patient portal.

EVENT	REMOTE THERAPEUTIC MONITORING (RTM)[1] MONTH 4
Key information	• Physical therapist reviews data for 15 minutes • Physical therapist writes summary, makes recommendations, and responds to patient questions for 9 minutes • Physical therapist spends a total of 24 minutes (15 minutes plus 9 minutes) over the month
Who is performing	Physical Therapist
Applicable CPT codes	**CPT 98980**, Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes.
Place of service code	POS 11 Office
Modifier	None applicable.
Medicare considerations	None applicable.

EVENT	REMOTE THERAPEUTIC MONITORING (RTM)[1] MONTH 4
Notes & other considerations	**CPT considerations** • An RTM code (rather than an RPM code) is used because non-physiological data (vs. physiologic data) is collected. • CPT 98980 requires at least one interactive communication with the patient or caregiver. The interactive communication contributes to the total time, but it does not need to represent the entire cumulative reported time of the treatment management service. • Do not count any time directly related to other reported services in the cumulative time of the remote therapeutic monitoring treatment management service during the calendar month of reporting. • To report CPT 98980, any device used must be a medical device as defined by the FDA. • If the total time in the month was >=40 minutes, CPT 98981[2] could also be reported separately. • Report 98980 once each 30 days, regardless of the number of therapeutic parameters monitoring. • Do not report CPT 98980, CPT 98981 for services of less than 20 minutes. • Do not report CPT 98980 in conjunction with 93264, 99091, 99457, 99458. • Do not report CPT 98980 in the same calendar month as 99473, 99474.

Scenario #10 Notes

1. Remote therapeutic monitoring treatment management services are provided when a physician or other qualified health care professional uses the results of remote therapeutic monitoring to manage a patient under a specific treatment plan.
2. CPT 98981, Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (List separately in addition to code for primary procedure).

Scenario #11: Synchronous audio-video & RPM

Scenario

A 65-year-old male is being treated for hypertension, type 2 diabetes, and heart failure. His conditions have been difficult to control despite medication adherence and lifestyle modifications. During a routine telemedicine video visit with the physician treating him for these conditions, the physician spends 22 minutes with the patient and advises that the patient enroll in a comprehensive RPM program to monitor blood pressure, blood glucose, weight, and oxygen saturation.

To receive relevant education and equipment, three days later the patient comes into the physician's office for enrollment in the RPM program. The physician calibrates all relevant devices and provides them to the patient, including a blood pressure monitor, weight scale, and pulse oximeter that automatically transmits data to the care team daily. All devices are FDA approved. The physician spends 28 minutes with the patient. The patient is expected to use the device for the next 6 months, and regular visits (in-person and telemedicine) are scheduled over that time.

EVENT	TELEMEDICINE VIDEO VISIT DAY 1	RPM SET-UP DAY 4
Key information	• Established patient • Video visit • Visit lasts 22 minutes	• Patient is provided with RPM devices • Patient is educated on how to use RPM devices • All devices are FDA approved
Who is performing	Physician	Physician

EVENT	TELEMEDICINE VIDEO VISIT DAY 1	RPM SET-UP DAY 4
Applicable CPT codes	**CPT 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.	**CPT 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 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.
Place of service code	POS 10 Telehealth provided in patient's home	POS 11 Office
Modifier	None applicable.	None applicable.
Medicare considerations	None applicable.	None applicable.
Notes & other considerations	None applicable.	**CPT considerations:** • CPT 99453 should be billed once to cover the set up and patient education for all relevant devices per episode of care. • CPT 99454 can be billed every 30 days. • Neither CPT 99453 nor CPT 99454 can be reported in the same calendar month as CPT 99473 or CPT 99474. • To report CPT 99453, CPT 99454, the device must be a medical device as defined by the FDA, and the service must be ordered by a physician or other QHP.

Scenario #12: Chronic care management

Scenario

A patient with chronic obstructive pulmonary disease (COPD) and major depressive disorder is struggling with treatment adherence due to worsening mental health. At the beginning of the month, in an in-person, 20-minute visit, the patient's pulmonologist reviews the patient's care plan and spirometry data and subsequently adjusts inhaler and oxygen therapies and educates the patient on lifestyle modifications to reduce COPD exacerbations.

Throughout the month, a registered nurse, under the supervision of the pulmonologist, monitors the patient's progress, conducts several short phone-call check-ins, reviews symptoms and medication adherence, and makes small adjustments as appropriate. Throughout the month, the registered nurse spends 28 minutes on patient activity.

To address the patient's depression, the pulmonologist consults with a psychiatrist through a secure EHR communication who reviews the patient's mental health history and recommends medication adjustments; the psychiatrist sends a written response to the pulmonologist which takes 8 minutes.

EVENT	IN-PERSON VISIT DAY 1	CARE MANAGEMENT ACTIVITIES DAY 1–30	BEHAVIORAL HEALTH INTERPROFESSIONAL CONSULTATION DAY 10
Key information	• Patient has two chronic conditions • In-person visit lasts 20 minutes	• Clinical team monitors patient's progress, conducts several short phone-calls, reviews symptoms and medication adherence • Clinical team spends 28 minutes monitoring and communicating with the patient	• Written communication through secure EHR • Psychiatrist spends 8 minutes writing the note • Communication is all written; no verbal discussion
Who is performing	Pulmonologist	Registered Nurse, under supervision of pulmonologist	Psychiatrist

EVENT	IN-PERSON VISIT DAY 1	CARE MANAGEMENT ACTIVITIES DAY 1–30	BEHAVIORAL HEALTH INTERPROFESSIONAL CONSULTATION DAY 10
Applicable CPT codes	**CPT 99212**, Office or other outpatient visit for the evaluation and management of an establish 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.	**CPT 99490**, 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 that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, • comprehensive care plan established, implemented, revised, or monitored; • first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	**CPT 99451**, Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treatment/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.
Place of service code	POS 11 Office	POS 11 Office	POS 11 Office
Modifier	None applicable.	None applicable.	None applicable.
Medicare considerations	None applicable.	The CY2025 Physician Fee Schedule details a number of existing and new HCPC G-codes specific to care management (G0556, G0557, G0558). Providers who are a patient's primary source of clinical care may be eligible to bill care management codes and should consult the Physician Fee Schedule.	None applicable.
Notes & other considerations	None applicable.	**CPT considerations** • Care management services are management and support services provided by clinical staff and include a myriad of activities aimed at improving care coordination, reducing avoidable hospital services, improvement patient engagement, and decreasing care fragmentation. To be eligible to bill for care management services, clinicians must not only undertake relevant care management activities, but the care management office and practice must have specific capabilities necessary for the clinical team to comprehensively provide care management services. **POS considerations** • For POS designation, CMS has noted that the billing practitioner should report the POS for the location where they would ordinarily provide face-to-face care to the beneficiary.	**CPT considerations** • CPT 99451 is the most appropriate interprofessional consultation code. CPT 99446 (Interprofessional telephone/Internet/electronic health record assessment and management service) is not an appropriate code to use in this clinical scenario because CPT 99446 requires a verbal (as well as written) report to the patient's treating physician. The above scenario includes only a written report, and no verbal component, and thus CPT 99451 is more appropriate.

Scenario #13: Transitional care management

Scenario

A 75-year-old male with type 2 diabetes, was discharged from the hospital on August 5, 2024, after being treated for hyperglycemia. On August 7, two business days after discharge, a nurse practitioner contacts the patient by phone to review his discharge instructions and ensure he was following his new insulin regimen correctly; the nurse also reviews this information with the patient's caregiver. The patient subsequently has a 30-minute face-to-face visit with his primary care physician (PCP) on August 11, 2024, where his blood sugar levels were assessed and his medication plan adjusted. The physician also provided education on diet and exercise to manage his diabetes, connected the patient with community groups focused on diabetes management, and scheduled a follow-up call to monitor his progress.

EVENT	COMMUNICATION POST DISCHARGE AUGUST 7	IN-PERSON FOLLOW UP AUGUST 11
Key information	• Communication occurred two business days after discharge • Communication occurs over the phone	• In-person visit • Visit occurred six days after discharge • Moderate level of medical decision-making necessary • Visit lasted 30 minutes • Visit included medication management
Who is performing	Nurse practitioner	Physician
Applicable CPT codes	**Not reported separately** (see more detailed explanation below).	**CPT 99495**, Transitional care management services with the following required elements: (i) Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; (ii) At least moderate level of medical decision making during the service period; (iii) Face-to-face visit, within 14 calendar days of discharge.[1]
Place of service code	None applicable.	POS 11 Office
Modifier	None applicable. If another individual provides TCM services within the postoperative period of a surgical package, modifier 54 is not required.	

EVENT	COMMUNICATION POST DISCHARGE AUGUST 7	IN-PERSON FOLLOW UP AUGUST 11
Medicare considerations	None applicable.	None applicable.
Notes & other considerations	**CPT considerations:** • CPT 99495 and CPT 99496, transitional care management (TCM) services, are for a new or established patient whose medical and/or psychosocial problems require a moderate or high level of medical decision making during transitions in care from an inpatient hospital setting, partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility to the patient's community setting (e.g., home, rest home, or assisted living). Home may be defined as a private residence, temporary lodging, or short-term accommodation (e.g., hotel, campground, hostel, or cruise ship). • TCM services require a face-to-face visit, initial patient contact, and medication reconciliation within specified time frames. TCM commences upon the date of discharge and continues for the next 29 days. • The first face-to-face visit is part of the TCM service and not reported separately. Additional E/M services provided on subsequent dates after the first face-to-face visit may be reported separately. • Non-face-to-face services provided by clinical staff, under the direction of the physician or other qualified health care professional, include a wide range of activities, from communicating with patients or home health agencies to assessing treatment adherence and medication management. • Only one individual may report these services and only once per patient within 30 days of discharge. • The required contact with the patient or caregiver, as appropriate, may be by the physician or qualified health care professional or clinical staff and must occur before the end of the second business day after discharge. The contact must include capacity for prompt interaction communication addressing patient status and needs beyond scheduling follow-up care. If two or more separate attempts are made in a timely manner, but are unsuccessful and other transitional care management criteria are met, the service may be reported.	

Scenario #13 Notes

1.

LEVEL OF MEDICAL DECISION MAKING	FACE-TO-FACE VISIT WITHIN 7 DAYS	FACE-TO-FACE VISIT WITHIN 8 TO 14 DAYS
Moderate	99495	99495
High	99496	99495

Scenario #14: Interprofessional electronic consultation

Scenario

During an 22-minute video visit, a 42-year-old female presents to her primary care physician (PCP) with complaints of persistent skin lesions on her elbows and knees. The PCP suspects psoriasis and decides to use an eConsult platform to obtain a specialist's opinion from a dermatologist. The PCP shares written overview of patient's complains and photos of the lesions. The dermatologist, who has never seen this patient before, spends 3 minutes reviewing the patient's information and photos. A day later, the dermatologist calls the PCP. In a 4-minute call, the dermatologist confirms the diagnosis of psoriasis and recommends a treatment plan, which includes corticosteroids and the possibility of phototherapy if symptoms do not improve. Following the call, the dermatologists spends 5 minutes writing a summary and sends it to the PCP through the eConsult platform.

The PCP calls the patient and spends 8 minutes discussing the dermatologist's recommendations. The patient begins their prescribed treatment plan and schedule a follow-up appointment in six weeks to monitor progress.

EVENT	PATIENT VISITS PCP DAY 1	INTERPROFESSIONAL CONSULTATION[1] DAY 1–3	PATIENT FOLLOW UP CALL WITH PATIENT DAY 4
Key information	• Video visit • Established patient • Visit lasts 22 minutes	• Dermatologist reviews photos and information asynchronously for 3 minutes • PCP and dermatologist have 4-minute phone call • Dermatologist writes summary response for 5 minutes • Dermatologist has no previous clinical relationship with patient	• Audio-only visit • Established patient • Call lasts 8 minutes
Who is performing	PCP	Dermatologist	PCP

EVENT	PATIENT VISITS PCP DAY 1	INTERPROFESSIONAL CONSULTATION[1] DAY 1–3	PATIENT FOLLOW UP CALL WITH PATIENT DAY 4
Applicable CPT codes	**CPT 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.	**CPT 99447**, Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, 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.	**Not reported separately:** occurs within seven days of E/M visit (see more detailed explanation below).
Place of service code	POS 10 Telehealth provided in patient's home	POS 11 Office	None applicable.
Modifier	None applicable.	None applicable.	None applicable.
Medicare considerations	None applicable.	None applicable.	None applicable.
Notes & other considerations	• None applicable.	• None applicable.	**CPT considerations** • Brief synchronous communication technology services (CPT 98016) are not separately reported if they are related to an E/M service in the prior 7 days or leading to the E/M visit in the next 24 hours. Because the phone call between the PCP and patient occurs within 7 days of the initial video E/M visit, this follow-up call would not be reported separately.

Scenario #14 Notes

1. An interprofessional telephone/Internet/electronic health record consultation is an assessment and management service in which a patient's treating (e.g., attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician or other qualified health care professional with specific specialty expertise (the consultant) to assist the treating physician or other qualified health care professional in the diagnosis and/or management of the patient's problem without patient face-to-face contact with the consultant. The consultant should not have seen the patient in a face-to-face encounter within the last 14 days. When the telephone/Internet/electronic health record consultation leads to a transfer of care or other face-to-face service (e.g., a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported. The majority of the service time reported must be devoted to the medical consultative verbal or Internet discussion. If more than one telephone/Internet/electronic health record contract(s) is required to complete the consultation request, the entirety of the service and the cumulative discussion and information review time should be reported with a single code.