PHYSICAL ACTIVITY ALLIANCE

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Physical Activity Related Current Procedural Terminology (CPT)® Codes

(Updated November 2021)

Research indicates regular physical activity (PA) has health benefits for patients of any age and body weight, and is critical for long-term weight management. With the evolving science in this field healthcare practitioners and PA subject matter expertise continue to expand; encompassing areas such as physical activity guidelines, practice implementation, patient counseling, as well as, provider billing and coding guidance. The American College of Sports Medicine has been a leader in educating health care providers on fitness and health guidance through their Exercise is Medicine Initiative. Please refer to the American College of Sports Medicine's comprehensive resource page for additional tools and materials to support patient physical activity assessments: https://www.exerciseismedicine.org/support_page.php/resources/. However, challenges continue with expanding reimbursement for physical activity related assessments and interventions for physician extenders and paraprofessionals.

CPT codes are the codes used by physicians and other qualified health care professionals to report the services or procedures they provide to patients, and to bill those services or procedures. When a claim is filed with the CPT procedure code along with the appropriate ICD-10 diagnosis code, payment is made to the providing practitioner or billing entity. The CPT system is maintained and implemented by the American Medical Association (AMA). Effective Jan 1, 2020, the AMA approved the release of new category III CPT codes specifically designated for health and wellness coaching. Prior to the approval of these code, there were no CPT code(s) existing specifically for health coaching services.

The following table provides a comprehensive list of CPT codes applicable to physical activity related patient assessments, management, and follow up care.

PHYSICAL ACTIVITY RELATED CPT*CODES					
CPT/ HCPCS Code	**Description**	**Released to AMA Website**	**Effective Date**	**Publication**	**Clinician eligible to bill code**
Health and Wellness Coaching					
0591T	Health and well-being face-to-face; individual; initial assessment	July 1, 2019	January 1, 2020	CPT 2020	Physician and qualified health care professionals
0592T	Individual follow-up session; at least 30 minutes *Do not report 0592T in conjunction with 98960, 0488T, 0591T	July 1, 2019	January 1, 2020	CPT 2020	Physician and qualified health care professionals
0593T	Group (2 or more individuals), at least 30 minutes *Do not report 0593T in conjunction with 97150, 98961, 98962, 0403T	July 1, 2019	January 1, 2020	CPT 2020	Physician and qualified health care professionals
Notes: Health and Well-Being Coaching: Health and well-being coaching is a patient-centered approach wherein patients determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach. The coach is a nonphysician health care professional certified by the National Board for Health and Wellness Coaching or National Commission for Health Education Credentialing, Inc. Coaches' training includes behavioral change theory, motivational strategies, communication techniques, health education and promotion theories, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and well-being.					
Patient Self-Management					
98960	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minute; individual patient				Licensed MD/DO or mid-level practitioner
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized				Licensed MD/DO or

	curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients				mid-level practitioner
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients				Licensed MD/DO or mid-level practitioner
Behavioral Counseling in Primary Care to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Procedure Code(s)					
99401	Preventive medicine counseling and/or risk factor intervention/s provided to an individual (separate procedure); approximately 15 minutes				Physician and qualified health care professionals
99402	Preventive medicine counseling and/or risk factor intervention/s provided to an individual (separate procedure); approximately 30 minutes				Physician and qualified health care professionals
99403	Preventive medicine counseling and/or risk factor reduction intervention/s provided to an individual (separate procedure); approximately 45 minutes				Physician and qualified health care professionals
99404	Preventive medicine counseling and/or risk factor reduction intervention/s provided to an individual (separate procedure); approximately 60 minutes				Physician and qualified health care professionals
G0447	Face-to-face behavioral counseling for obesity, 15 minutes – for billing for behavioral counseling for obesity				Physician and qualified health care professionals

Notes:

- CPT codes 99401–99409 report counseling risk factor reduction and behavioral change intervention services provided at an encounter separate from the preventive medicine examination. Individual preventive medicine counseling codes 99401–99404 are used to report counseling services in areas such as family problems, diet, and exercise. This code set is for evaluation and management (E/M) services.

• New 2008 CPT codes 99406–99409 for individual behavioral change are available to report intervention services for patients with a behavior typically regarded as an illness, such as smoking or obesity. Group counseling and other preventive medicine services are reported with codes 99411–99429. These code sets are for evaluation and management (E/M) services.					
Chronic Care Management Services					
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline Comprehensive care plan established, implemented, revised, or monitored Assumes 15 minutes of work by the billing practitioner per month.		January 1, 2019	CPT 2019	Physician or Non-Physician Provider (Nurse Practitioner or Physician Assistant)
G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). (Do not report G2058 for care management services of less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month). (Use G2058 in conjunction with 99490). (Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491)).		January 1, 2020	HCPCS 2020	Licensed Physicians, Physician Assistants, Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse Specialists
99491	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:		January 1, 2019	CPT 2019	Licensed Physicians, Physician Assistants,

	Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline Comprehensive care plan established, implemented, revised, or monitored				Nurse Practitioners, Certified Nurse Midwives, Clinical Nurse Specialists
COMPLEX CHRONIC CARE MANAGEMENT SERVICES					
99487	Complex chronic care management services, with the following required elements: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline Establishment or substantial revision of a comprehensive care plan Moderate or high complexity medical decision making 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month		January 1, 2019	CPT 2019	Physician or Non-Physician Provider (Nurse Practitioner or Physician Assistant)
99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). Complex CCM services of less than 60 minutes in duration, in a calendar month, are not reported separately. Report 99489 in conjunction with 99487. Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex CCM services during a calendar month.		January 1, 2019	CPT 2019	Physician or Non-Physician Provider (Nurse Practitioner or Physician Assistant)
PRINCIPAL CARE MANAGEMENT SERVICES					

G2064	Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities		January 1, 2020	HCPCS 2020	Physician and qualified health care professionals
G2065	Comprehensive care management for a single high-risk disease services, e.g. principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities		January 1, 2020	HCPCS 2020	Physician and qualified health care professionals

Notes:

- In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions.
- CCM may be billed most frequently by primary care practitioners, although in certain circumstances specialty practitioners may provide and bill for CCM. The CCM service is not within the scope of practice of limited-license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, although practitioners may refer or consult with such physicians and practitioners to coordinate and manage care.
- *Code 99091 requires at least 30 minutes of a physician's time and can be billed concurrently with the CPT code 99490

Physicians and qualified health care professionals may bill CCM services: Certified Nurse Midwives, Clinical Nurse Specialists, Nurse Practitioners, Physician Assistants					
Digitally Stored Data Services / Remote Physiologic Monitoring Treatment Management Services					
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		January 1, 2018	CPT 2018	Physician and qualified health care professionals
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		January 1, 2019	CPT 2019	Physician and qualified health care professionals
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		January 1, 2019	CPT 2019	Physician and qualified health care professionals
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; initial 20 minutes		January 1, 2019	CPT 2019	Physician and qualified health care professionals
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; additional 20 minutes		January 1, 2020	CPT 2020	Physician and qualified health care professionals
Notes: • Starting January 2020, health care professionals will utilize the CPT 99458 for patients who received the remote physiologic monitoring treatment management service for each additional 20 minutes of service in a given month *In January 2018, the CMS introduced the first remote patient care dedicated code by unbundling CPT code 99091. Code 99091 requires at least 30 minutes of a physician's time and can be billed concurrently with the CPT code 99490					

ONLINE DIGITAL EVALUATION SERVICE (e-Visit) / ONLINE DIGITAL ASSESSMENTS					
98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes		January 1, 2021		Qualified non-physician health care professional
98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes		January 1, 2021		Qualified non-physician health care professional
98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes		January 1, 2021		Qualified non-physician health care professional
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		January 1, 2020		Physician and qualified health care professionals
99422	Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11-20 minutes		January 1, 2020		Physician and qualified health care professionals
99423	Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 21 or more minutes		January 1, 2020		Physician and qualified health care professionals
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COMMUNICATION TECHNOLOGY BASED SERVICES					

G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment		January 1, 2019	HCPCS 2019	Physician and qualified health care professionals
G2012	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 e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion		January 1, 2019	HCPCS 2019	Physician and qualified health care professionals
Transitional Care Evaluation & Management Services					
99495	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of at least moderate complexity during the service period; Face-to-face visit, within 14 calendar days of discharge		January 1, 2019	CPT 2019	Physician and qualified health care professionals
99496	Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision making of high complexity during the service period; Face-to-face visit, within 7 calendar days of discharge		January 1, 2019	CPT 2019	Physician and qualified health care professionals

Notes:

The requirements for TCM services include:

- Services during the beneficiary's transition to the community setting following particular kinds of discharges
- Health care professionals accepting care of the beneficiary post-discharge from the facility setting without a gap
- Health care professionals taking responsibility for the beneficiary's care
- Moderate or high complexity medical decision making for beneficiaries who have medical and/or psychosocial problems

The 30-day TCM period begins on the beneficiary's inpatient discharge date and continues for the next 29 days.

KEY TERMS / DEFINITIONS:

CPT© - Current Procedural Terminology

CPT codes are the codes used for reporting services and procedures and getting paid. When a claim is filed with the CPT procedure code along with the appropriate ICD-10 diagnosis code, payment is made to the providing practitioner.

The CPT© system is maintained and implemented by the American Medical Association.
There are three categories of CPT codes:

- CPT category I - used for reporting claims and getting paid. This may be an office visit or Emergency department visit. The correct code level is selected based on some set criteria.
  - Example, reporting code 99285 will get you payment for an Emergency department visit.
- CPT Category II – Set of supplemental tracking codes that can be used for performance measurement. Example, reporting 2000F will inform the payer that during the 99285 Emergency Department visit above, blood pressure assessment was also done. Often these codes are not recorded because they do not generate revenue.
- CPT Category III – These codes are not federally regulated and are fairly new to the healthcare industry. They are reported to help health facilities and government agencies track the efficacy of new, nascent medical techniques. Using Category III codes is important as it keeps the medical fraternity up to date with new cutting-edge developments and medical breakthrough technology.

A **"physician or other qualified health care professional"** is 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." A clinical staff member is 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.

HCPCS - Healthcare Common Procedures Coding System

HCPCS codes are used to report supplies, equipment, and devices provided to patients as well as procedures not contained in the CPT code system. It is an additional or supplemental resource to CPT codes. HCPCS codes are referred to as Level II CPT codes. HCPCS is alphanumeric and is implemented by the Centers for Medicare and Medicaid Services (CMS).

CMS includes two levels in its Healthcare Common Procedures Coding System:

- HCPCS Level I codes is the CPT coding system (Both are one and the same)
- HCPCS Level II codes are usually referred to as HCPCS codes

Health Coach: The AMA currently defines a health coach as a non-physician health care professional certified by National Board for Health & Wellness Coaching (NBHWC) or The National Commission for Health Education Credentialing, Inc (NCHEC)