mymobility®
Coding Reference Guide

mymobility is a care management platform to help you deliver support and guidance to your patients through a connected experience, via patients' smartphones. mymobility delivers continuous data and patient-reported feedback to facilitate care, and track patient-reported outcomes and satisfaction regarding your patients' surgical preparation and recovery.

mymobility tracks patient progress and provides clinical and operational insights through both quantitative and qualitative data, enabling clinicians to engage with and monitor their patients to understand their progress throughout the episode of care. Additionally, it can provide information to identify patients who aren't engaged or as active as the clinician would like.

Multiple metrics are tracked across the following categories:

Mobility/Functional Data Collected

- Patient Steps
- Flights of Stairs Climbed
- Stand Hours
- Exercise Completion
- Shoulder Range of Motion***

Gait Quality Data

- Gait Speed
- Double Support Percentage
- Step Length*
- Speed Ascending/Descending Stairs*
- Asymmetry*

Additional Data Collected

- Falls Detection*
- Sleep*

Heart Rate Data Collected

- Average Resting Heart Rate
- Average Walking Heart Rate
- Heart Rate Variability
- VO2 Max*

Engagement Data Collected

- Exercise Adherence
- PROMs Adherence
- Education Adherence
- Patient-reported Pain Management Tracking**
- Patient-reported Narcotic/Non-narcotic Tracking**

* Data available separately upon request
** via patient-reported data via time check-in surveys through the app
*** Available only to iPhone 10 or higher users, using iOS 14 or newer, or Android users with ARCore.

VIRTUAL AND NON-FACE-TO-FACE SERVICES

There are three main types of virtual face-to-face services (telehealth visits, e-visits and virtual check-ins) and three non-face-to-face services (remote patient monitoring, remote therapuetic monitoring and telephone services) that physicians and other professionals can provide to patients summarized in this coding guide.

Medicare telehealth services are services that would normally occur in person, but are instead conducted via telecommunications technology and are paid at the full in-person rate. Services such as the virtual check-in, eVisits, remote evaluation, and telephone visits are not services that would normally occur in person, and are not paid as though the service occurred in person. A virtual check-in lets professionals bill for brief (5-10 min) communications with an established patient that mitigate the need for an in-person visit and can be furnished via synchronous telecommunications technology. An e-visit is similar to a virtual check-in, but should be reported when a beneficiary communicates with their health care provider through an online patient portal. Telephone visits may be furnished via audio-only telephone capabilities, whereas remote evaluation describes the evaluation of a prerecorded video or image provided by the patient.

Physician Services		
CPT® Code	**Description**	**CY 2023 Medicare Non-facility Allowable***
Remote Therapeutic Monitoring		
98975	Remote therapeutic monitoring (eg, therapy adherence, therapy response); initial set-up and patient education on use of equipment	$19
98977	Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	$50
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	$49
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)	$40
Telehealth Visits		
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	$73
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	$113
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	$167
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	$221
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.	$23
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	$57
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	$91
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	$128

CPT® Code	Description	CY 2023 Medicare Non-facility Allowable*
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	$180
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	$42
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth	$73
G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth	$106
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth	$93
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth	$131
G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth	$186
E-Visits		
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	$15
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	$29
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	$47
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	$12
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	$20
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	$31
Virtual Check-Ins		
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	$12
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	$14
Telephone Services		
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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	$56
99442	11-20 minutes of medical discussion	$91
99443	21-30 minutes of medical discussion	$128

CPT® Code	Description	CY 2023 Medicare Non-facility Allowable*
Qualified Nonphysician Telephone Services		
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	$13
98967	11-20 minutes of medical discussion	$24
98968	21-30 minutes of medical discussion	$34

* CY 2023 Medicare Physician Fee Schedule Final Rule Notice, Federal Register, November 18, 2022. No geographic adjustment.

CPT/HCPCS Modifiers	
Modifier	**Description**
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
GQ	Via asynchronous telecommunications system
GT	Via interactive audio and video telecommunication systems

Medicare Coverage Requirements for Reporting Remote Therapeutic Monitoring (RTM):

- RTM services (e.g., musculoskeletal system status, therapy adherence, therapy response) represent the review and monitoring of data related to signs, symptoms and functions of a therapeutic response. These data are reflective of therapeutic responses that provide a functionally integrative representation of patient status.[1]
- Physicians and eligible qualified healthcare professionals, are permitted to bill RTM as general medicine services. A physician or other qualified healthcare professional is defined in the CPT Codebook 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." Accordingly, RTM codes could be available for physical therapists (PT), occupational therapists (OT), speech-language pathologists, physician assistants, nurse practitioners, and clinical social workers.[2]
- Practitioners must obtain consent either in advance or at the time RTM services are furnished and document that consent in the patient's record.[3]
- For new patients or patients not seen within the year by billing practitioner, RTM services must be initiated during an in-person visit.[3]
- RTM services may be provided to patients with either acute or chronic conditions.[3]
- Code 98975 may be billed once per episode of care. An episode of care begins when the remote therapeutic monitoring service initiates and ends with the attainment of targeted treatment goals. Codes 98977 may be billed once per 30 days. Code 98980 may be billed once per calendar month regardless of the number of therapeutic monitoring modalities performed in a given calendar month. Code 98981 may be billed once per calendar month for each additional 20 minutes completed within such month.[1]
- CPT codes 98975 and 98977 require the RTM device to monitor at least 16 days of data per each 30-day period, in total.[1]
- The medical device supplied to a patient as part of CPT code 98977 must be a medical device as defined by Section 201(h) of the Federal Food, Drug and Cosmetic Act.[2]
- In the final rule, CMS stated that self-reported/entered data may be part of the non-physiologic data for purposes of RTM codes. RTM data can be self-reported by the patient, as well as digitally uploaded via the device. While RTM codes still require the device used to meet the FDA's definition of a medical device, self-reported RTM data via a smartphone app or online platform classified as Software as a Medical Device (SaMD) may qualify for reimbursement.[2]

References:

[1] CPT® 2022 Professional Edition. American Medical Association. p. 50.

[2] Calendar Year 2022 Medicare Physician Fee Schedule, Final Rule. Federal Register, November 19, 2021.

[3] Calendar Year 2021 Medicare Physician Fee Schedule, Final Rule. Federal Register, December 28, 2020.

Medicare Coverage Requirements for Reporting Telehealth Visits:

"Under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act, the Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. Medicare can, under this new waiver, pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range

of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients."[1]

"Physicians and other health care professionals may use telecommunication technology for office, hospital visits and other services that generally occur in-person."[1]

- "The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals."[1]
    - "For the duration of the COVID-19 Public Health Emergency (PHE), CMS is adding an exception to the definition of "interactive telecommunications system" to allow for the use of mobile phones that have audio/video capability. The temporary new definition is "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner."[2]
- "These visits are considered the same as in-person Evaluation & Management (E/M) services and are paid at the same rate as regular, in-person E/M visits."[1]
- "During the COVID-19 PHE, the CPT telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth."[3]
- "Physicians and practitioners who bill for Medicare telehealth services should report the place of service (POS) code that would have been reported had the service been furnished in person."[3]
- "Starting March 6, 2020 and for the duration of the PHE, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings."[1]
    - "While they must generally travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the PHE, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home."[1]
- "The Medicare coinsurance and deductible would generally apply to these services. However, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs."[1]
- "To the extent the 1135 waiver requires an established relationship, HHS has announced that it will not conduct audits to ensure that such a prior relationship existed for claims submitted during the PHE."[1]

References:

[1] Medicare Telemedicine Health Care Provider Fact Sheet. Centers for Medicare and Medicaid Services. March 17, 2020. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

[2] Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Interim Final Rule. Federal Register, April 6, 2020.

[3] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Medicare Coverage Requirements for Reporting E-Visits:

"Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. These services can only be reported when the billing practice has an established relationship with the patient. For these E-Visits, the patient must generate the initial inquiry and communications can occur over a 7-day period."[1]

- "Practitioners who may independently bill Medicare for evaluation and management visits (e.g., physicians and nurse practitioners) can bill the following codes: 99421, 99422 and 99423."[1]
- "Clinicians who may not independently bill for evaluation and management visits (e.g., physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes: 98970, 98971 and 98972."[1]
- "Patients communicate with their doctors without going to the doctor's office by using online patient portals."[1]
- "Beneficiary consent to receive e-visits is required although it may be obtained once annually and, during the PHE for the COVID-19 pandemic, consent may be obtained at the same time the service is furnished."[2]
- "Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation."[1]

- "These services can only be reported when the billing practice has an established relationship with the patient."[1]
- "This is not limited only to rural settings. There are no geographic or location restrictions for these visits."[1]
- "The Medicare coinsurance and deductible would generally apply to these services."[1]

References:

[1] Medicare Telemedicine Health Care Provider Fact Sheet. Centers for Medicare and Medicaid Services. March 17, 2020. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

[2] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Medicare Coverage Requirements for Reporting Virtual Check-Ins:

"Medicare patients in their home may have a brief communication service with practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image to avoid unnecessary trips to the doctor's office. These virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available)."[1]

"Doctors and certain practitioners may bill for these virtual checks-in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012). The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal. In addition, separate from these virtual check-in services, captured video or images can be sent to a physician (HCPCS code G2010)."[1]

- "Virtual check-in services can only be reported when the billing practice has an established relationship with the patient."[1]
- "This is not limited to only rural settings or certain locations."[1]
- "Individual services need to be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement."[1]
- "Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication."[1]
- "Beneficiary consent to receive virtual check-ins is required although it may be obtained once annually and, during the PHE for the COVID-19 pandemic, consent may be obtained at the same time the service is furnished."[2]
- "The Medicare coinsurance and deductible would generally apply to these services."[1]

References:

[1] Medicare Telemedicine Health Care Provider Fact Sheet. Centers for Medicare and Medicaid Services. March 17, 2020. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

[2] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Medicare Coverage Requirements for Reporting Telephone Services:

- "Telephone services are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a physician or other qualified health care professional, who may report evaluation and management services."[1]
- "For the duration of the PHE for the COVID-19 pandemic, Medicare is making payment for CPT codes 99441–99443, which describe real-time audio-only (synchronous) telephone E/M phone visits for practitioners who can independently bill for E/M services. While these codes are ordinarily limited to established patients, during the PHE, Medicare will make payment for them for both new and established patients."[2]
- "As for all Medicare telehealth services furnished during the PHE, please report the place of service code that would have applied if the service had occurred in person for these telephone-only telehealth service codes."[2]
- "Do not report if the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment or originated from a related E/M service provided within the previous 7 days."[1]
- "Medicare payment rates for audio-only telephone evaluation and management visits are aligned with the payment rates for the established patient office/outpatient E/M visit levels 2–4 (CPT codes 99212–99214) during the COVID-19 PHE."[2]
- "While CMS did not add the codes to the Medicare telehealth services list, during the PHE for COVID-19, CMS makes separate payment for CPT codes 98966–98968, which describe audio-only telephone assessment and management visits with health

care practitioners who cannot independently bill for E/M phone visits; for example, certain therapists, social workers, and clinical psychologists."[2]

References:

[1] CPT® 2022 Professional Edition. American Medical Association. p. 50.

[2] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

ADDITIONAL RESOURCES

AAOS Telemedicine Startup Checklist	https://www.aaos.org/quality/practice-management/telemedicine
AAOS Telemedicine Resource Guide	https://aaos.org/globalassets/about/covid-19/aaos-telemedicine-resource-guide.pdf
AMA Telehealth Playbook	https://www.ama-assn.org/system/files/2020-04/ama-telehealth-playbook.pdf
CMS Telehealth Services Fact Sheet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf
HHS Telehealth Information	https://telehealth.hhs.gov/

For further assistance with reimbursement questions, contact the Zimmer Biomet Reimbursement Hotline at 866-946-0444 or reimbursement@zimmerbiomet.com, or visit our reimbursement web site at zimmerbiomet.com/reimbursement.

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