Healthcentric Advisors
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Medicare Telehealth and Remote Patient Monitoring (RPM) Services

Coding & Guidelines Summary

COVID-19 Response

Updated 5/4/2020

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Who May Render or Bill for Telehealth?

- Physicians (MD, DO)
- Nurse practitioners (NP)
- Physician assistants (PA)
- Nurse-midwives (CNM)
- Clinical nurse specialists (CNS)
- Certified registered nurse anesthetists (CRNA)
- Registered dietitians or nutrition professional (RD, DSME)
- Physical, Occupational & Speech Therapists *updated 4/30/2020*
- Behavioral Health Specialists
  - Clinical psychologists (CPs)
  - Clinical social workers (CSWs)

Note: CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or be paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.

Other Highlights

- Providers may work cross-state lines regardless of licensure state. (See provider enrollment FAQs in resources)
- Services may be for all diagnoses; not just COVID-19
- OIG is allowing practices to reduce or waive fees or co-insurance
- Removal of E&M frequency limitations on Medicare Telehealth

Physician Office Telehealth Services (non-FQHC/RHC)

Modifier CS – *Covid-19 Testing-related service.* Waives deductible & co-insurance for testing-related services 3/1/20 to end of PHE. However, claims will not process at 100% payable until system update 7/1/2020 at which time NGS will reprocess all claims with CS modifier. Do not bill coinsurance or deduct to patients for testing –related services. Reopen claims to add this modifier if necessary.
Modifier CR – ***Catastrophe-related service*** Informational on claims relevant to the PHE; phone calls, eVisits, and on-line assessments. Not for use on claims for telehealth (audio-visual) services, or those services allowed prior to the Coivd-19 public health emergency (PHE). Claims will pay with or without this modifier.
Modifier 95 – Telemedicine modifier Add to all newly allowed telehealth (audio-visual) services for the Covid-19 PHE as per CMS list (see resources)

Services Definition & Codes	Documentation	Notes / Medicare Billing
Evaluation and Management Visits – All Settings • 99201 – 99205 office visits, established patient • 99211 – Nurse/ MA visit • 99212 – 99215 office visit new patient • 99304 – 99306 NH/SNF Admission • 99307 – 99310 NH/SNF Visits • 99315 – 99316 NH/SNF Discharge • 99324 – 99328 Assisted Living, new patient • 99334 – 99337 Assisted Living, established patient Full list of telehealth CPT codes https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes *Several codes added, and several codes allowed for audio-only interactions as of 4.30.2020*	▪ Document (annually) patient consent to telehealth visits ▪ Document the location of the patient, and others present. ▪ Use any private platform (i.e Skype, FaceTime, Zoom) ▪ Document time if coding by time. Code by time for new patient; may select established patient coding based on E&M criteria or time. ▪ Self-reported exam OK. May document that exam is limited by telehealth for full credit. ▪ Real-time video storage is not required. ▪ Scribes may participate in the telehealth visit.	• New patient's encounters are allowed via telehealth without regard to the 3-year rule. • Bill with usual designated location, i.e. office or clinic POS 11 • Modifier 95 (Modifier GT for CAH II, Modifier G0 for acute stroke services). Do not report telehealth modifier for through-window services. • POS 02 paid at the facility rate. POS where services are usually rendered will be paid at the full non-facility rate. May reopen claims to reprocess for increased payment. Billing guidance. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-03-31-mlnc-se
Virtual Check-Ins (per CMS *Dear Clinician* Letter) https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf Brief communication service with practitioners via a number of communication technology modalities (phone, email, secure text, patient portal) including synchronous **discussion over a telephone** or **exchange of information through video or image**. • G2012 – virtual check-in, 5 to 10 minutes • G2010 – remote evaluation of recorded images with interpretation and follow-up **Note: FQHC/RHC:** • G0071 – virtual check-in or remote evaluation of recorded images, 5 minutes or more	Document patient consent to Virtual Check-in, modality used, content of discussion (changes to care plan, necessary follow-up) and time spent.	• Initiation by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation. • not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours • patient must verbally consent to receive virtual check-in services • Billing provider only (not for nurse/MA visits). • **Podiatrists & Optometrists may bill.** • Place of service (POS) is where physician usually provides services i.e. office

Services Definition & Codes	Documentation	Notes / Medicare Billing
eVisits – *new or established patients* On-line digital E&M service **(via on-line patient portal)** • 99421 – digital E&M service up to 7 days, cumulative time; 5 to 10 minutes • 99422 - digital E&M service up to 7 days, cumulative time; 11 to 20 minutes • 99423 - digital E&M service up to 7 days, cumulative time; 21 or more minutes	Document that the visit was via digital technology, content of discussion changes to care plan, necessary follow-up, and time.	• Billed every 7 days • Place of service (POS) is where physician usually provides services i.e. office • **Add CR modifier.** No modifier 95
Telephone Services (non-face-to-face) MD, DO, DPM, OD, DMD, DDS, NP, PA, CNM, CNS • 99441 – telephone E&M, 5 to 10 minutes of medical discussion • 99442 - telephone E&M, 11 to 20 minutes of medical discussion • 99443 - telephone E&M, 21 to 30 minutes of medical discussion	Document patient consent to a telephone visit, content of discussion, follow-up plan, and time. *Added to telehealth Code list* *Payment rates increased $14-$41 to about $46-$110. Effective 3/1/2020.*	• Billed every 7 days • not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours • established patient rule waived for Covid-19 • E&M Billing provider only phone calls • Place of service (POS) is where physician usually provides services i.e. office • modifier 95
Telephone Services (non-face-to-face) NP, PA, CNS, CNM, Psychologist, PT/OT/SPL, OD, LCSW (RD, DSME bill regular dietician codes) • 98966 – telephone E&M, 5 to 10 minutes of medical discussion • 98967 - telephone E&M, 11 to 20 minutes of medical discussion • 98968 - telephone E&M, 21 to 30 minutes of medical discussion	As above	• Billed every 7 days • not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours • established patient rule waived for COVID-19 • Non E&M Billing provider only phone calls • Place of service (POS) is where clinician usually provides services i.e. office • **Add modifier CR** (no modifier 95)
++ Telephone Services Prolonged (nonF2F): • 99358 - bill in additional to 99443 or 98969 for 31 minutes to 1 hour of phone time • + 99359 – add to 99358 for 76 mins or more	As above	• Use non face-to-face prolonged service codes for extended telephone time over the 7-day period. • **add to either telephone code range** • **add CR modifier**
Annual Wellness Visits • G0438 – Annual Wellness Visit – *initial* • G0439 – Annual Wellness Visit – *subsequent* • G0444 – Annual depression screening *May not perform the initial IPPE via telehealth*	Usual AWV components, including Depression screening Patient Safety/ SDOH Create preventive screening list Send copy of care plan to patient Referrals as needed Vital signs optional for PHE *update*	Check in with Medicare beneficiaries to see how they are coping with the pandemic, monitor health status, provide referrals for food insecurity, depression/ anxiety, and to support self-care. ***Add modifier 95*** May perform acute visit if needed (add modifier 25 & 95).

Services Definition & Codes	Documentation	Notes / Medicare Billing
Consulting Physician Services Interprofessional telephone/internet/EHR assessment & management • 99466 – 5 to 10 minutes • 99447 – 11 to 20 minutes • 99448 – 21 to 30 minutes • 99449 – 31 + minutes	Verbal and written report Written report only, use 99451 (5+ minutes)	**Other consultative services:** • 99452 - Treating physician or QHP (i.e. PCP) service, 30 minutes • Usual telehealth (audio/visual) consults codes available, i.e G0425 – G0427; G0406 – G0408, G0508-G0509 ***update***

Physical, Occupational, Speech Therapy Telehealth Services (non-FQHC/RHC)

Services Definition & Codes	Documentation	Notes / Medicare Billing
Update - Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)	Document patient consent along with usual documentation.	POS usually customary
*PT/OT/SPL Therapists may also bill **telephone services** and these assessment codes to NGS:* On-line assessment by qualified non-physician healthcare professional • G2061 – On-line assessment for up to 7 days; 5 to 10 minutes • G2062 - On-line assessment for up to 7 days; 11 to 20 minutes • G2063 - On-line assessment for up to 7 days; 21 or more minutes	Document platform, patient consent, and time spent at each encounter. Document care plan updates, and necessary follow-up.	• May not include new patients • Bill cumulative time every 7 days

Facility Billing

Services Definition & Codes	Notes
Facility Fee – Q3014 Billable by a facility where the patient is located.	• A hospital may bill Q3014 for registered outpatients who receive services from home via telehealth. • Nursing Homes may bill Q3014 for their role in telehealth provided to patients

Telehealth in FQHC/RHC for Medicare Beneficiaries

(i) the Secretary shall pay for telehealth services that are furnished via a telecommunications system by a Federally qualified health center or a rural health clinic to an eligible telehealth individual enrolled under this part notwithstanding that the Federally qualified health center or rural clinic providing the telehealth service is not at the same location as the beneficiary;

Services Definition & Codes	Documentation	Notes / Medicare Billing
(F) TELEHEALTH SERVICE— (i) IN GENERAL—The term "telehealth service" means professional consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes ~~99241–99275~~, 99201–99215, 90804–90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary. (ii) YEARLY UPDATE.—The Secretary shall establish a process that provides, on an annual basis, for the addition or deletion of services (and HCPCS codes), as appropriate, to those specified in clause (i) for authorized payment under paragraph (1). Full list of telehealth CPT codes here https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	▪ Document (**annually**) patient consent to a telehealth visit, platform i.e Skype, FaceTime, and location of patient. ▪ Document time if coding by time. Select E&M level by time by time or by E&M criteria. ▪ Provider documentation is sufficient; real-time video storage is not required.	**Through 6/30/2020** FQHC • Encounter G code ie. G046/67/69/70 • telehealth list CPT code with 95 modifier • G2025 (optional) 95 modifier RHC • telehealth list CPT code with CG and 95 modifier • G2025 (optional) CG modifier **As of 7/1/2020** FQHC • G2025 (no modifier), RHC • G2025 (No CG modifier, 95 modifier optional) FQHC & RHC - Add CS modifier on the service line for Covid-19 testing related services (co-insurance and deductible waived) • UB04 or 837I • rev code 0521, 0781 or 0900 • Payment will be AIR/PPS rate initially, then $92.03 *all previous claims with 95 modifier will be reprocessed for new payment*
FQHC/RHC: virtual check-in or digital eVisit: G0071 – virtual check-in or remote evaluation of recorded images, 5 minutes or more. Initiation by the patient; however, practitioners may need to educate beneficiaries that services are available.	▪ Document patient consent to Virtual Check-in, or digital eVisit, content of discussion, changes to care plan, necessary follow-up, and time spent.	▪ Paid at new rate of $24.90 as of 3/1/2020 to end of public health emergency (PHE). *NGS will reprocess claims.* ▪ not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours ▪ billable alone or with other payable services ▪ UB04 or 837I rev code 0521 ▪ FQHC No modifier, RHC may need CG modifier

Diagnosing COVID-19 - *effective April 1, 2020*

- **U07.1** COVID-19 with laboratory confirmation
- **U07.2** COVID-19 without laboratory confirmation
- **Z03.818** encounter for observation of suspected exposure to other biological agents, ruled out
- **Z20.828** Contact with and (suspected) exposure to other viral communicable diseases
- **Z11.59** Encounter for screening for other viral diseases

Prior to April 1, 2020, the following ICD-10 diagnosis code may be used

- **B34.2** Coronavirus, unspecified

Specimen Collection *effective March 1, 2020 – billable in all settings – update 4.30.2020*

- **G2023** - specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any source
- **G2024** - specimen collection for severe acute respiratory syndrome coronavirus2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source
  G2024 is applicable to patients in a non-covered stay in a SNF and not to those residents in Medicare-covered stays Updated: 4/17/20

Lab Specimen Collection from a Patient	**Approx $23-$25**	HCPCS code C9803 billed by hospital outpatient department HCPCS code 99211 billed by a physician office HCPCS code G2023/G2024 for home/nursing home collection by a lab or on behalf of a home health agency

Testing for COVID-19

1. New HCPC codes for **billing Medicare** COVID-19 testing: *effective 4/1/2020*
   - **U0001 -** Centers for Disease Control and Prevention (CDC) 2019 Novel Coronavirus Real Time RT-PCR Diagnostic
   - **U0002** - 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets)
2. CPT Code for **billing other payors:** *posted 3/13/2020 effective immediately*
   - **87635 –** Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique

CPT Assistant for this new code: https://www.ama-assn.org/system/files/2020-03/cpt-assistant-guide-coronavirus.pdf

Treatment for COVID-19

New injection HCPC codes for treating COVID-19 – *effective 4/1/2020*

- **C9053** – Injection, crizanlizumab-tmca, 1mg
- **C9056** – Injection, givosiran, 0.5 mg
- **C9057** – Injection, cetirizine HCl, 1mg
- **C9058** – Injection, pegfilgrastim-bmez, biosimilar, (Ziextenzo) 0.5 mg

Remote Patient Monitoring

- May be provided to new and established patients
- May be provided for acute or chronic conditions
- Can be provided for patients with just one illness, i.e., monitoring a patient's oxygen saturation levels using pulse oximetry

CPT Code	Definition	Notes
99453 ***New 2019***	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 ✓ *Report once for each episode of care (begins when initiated, ends with treatment goal target attainment)*	• Billable for set-up and patient education • Do not report for less than 16 days monitoring • **Performed by clinical staff** – no physician effort
99454 ***New 2019***	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days *Coding Tips for 99453 & 99454:* ✓ *Requires FDA defined device* ✓ *Requires physician or NPP prescription* ✓ *May not be reported with other monitoring services i.e., blood glucose monitoring 95249 - 95251*	• Billable for supplies used in 30 days • Do not report for less than 16 days monitoring • For physiologic monitoring **treatment management** use 99457 • Do not use in conjunction with codes for more specific physiologic parameters such as ○ 99326 – remote pacemaker system ○ 94760 – single oximetry
99091 ***2002***	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 healthcare professional**, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days Further definition: The physician or QHP reviews, interprets, and reports the data digitally stored and/or transmitted by the patient. At least one communication (eg, phone call or email exchange) with the patient to provide medical management and monitoring recommendations takes place. ✓ *Do not report with an E/M service on the same day* ✓ *Requires a physician or NPP/ QHP prescription* ✓ *Requires FDA defined device* ✓ *May be reported with CCM 99487 – 99490* ✓ *May be reported with TCM 99495 – 99496* ✓ *Maybe reported with BHI 99484, 99492 – 99494*	• Do not report with 99457 (below) • Do not report within 30 days of Assisted Living Oversight (99339, 99340), Care Plan Oversight (99374, 99375), Hospice Supervision (99377 to 99380) • Billable for physician, Non-physician Practitioner (NPP) or Qualified Health Professional (QHP) time Clinical Example: A 67-year-old male with labile diabetes is utilizing a home glucose-monitoring device to capture multiple glucose readings during the course of a month in association with daily data of symptoms, medication, exercise, and diet. The data are transmitted from the home computer to the physician's office by email, downloaded by the physician, and the data are reviewed.

CPT Code	Definition	Notes
99473 ***New 2020***	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration	• Billed for staff time • No further guidance available presently
99474 ***New 2020***	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	• Billed for Physician and staff time • No further guidance available presently
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** ✓ *Requires a physician or NPP prescription* ✓ *Requires FDA defined device* ✓ *May be reported with CCM 99487 – 99490* ✓ *May be reported with TCM 99495 – 99496* ✓ *Maybe reported with BHI 99484, 99492 - 99494*	• Report only once in 30 days regardless of the number of parameters monitored • When reported in the same service period as chronic care management, transitional care management, or behavioral health integration services, it is important that the time spent performing these services remains separate and that no overlapping time is reported when both services are provided in a single month • Do not report with 99091 (above) Clinical Example: 1. An 82-year-old female with systolic dysfunction heart failure is enrolled in a heart failure-management program that uses remote physiologic monitoring services. 2. Based on interpreted data, the physician or other qualified health care professional uses medical decision making to assess the patient's clinical stability, communicates the results to the patient, and oversees the management and/or coordination of services as needed, for all medical conditions
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**	

Sources: CY2020 Physician Fee Schedule Final Rule, and AMA CPT Assistant Jan 2019

Resources

Telehealth Waiver Effective 3/6/2020 and CARES ACT Bill 3548

www.congress.gov/bill/116th-congress/senate-bill/3548/text

NEW Medicare Billing Guidance 3/30/2020

www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-03-31-mlnc-se

CS Modifier 3/18/2020

Families First section in the link below.

http://view.email.ngsmedicare.com/?qs=c7306aabe2cab973ad44c2f242e674abb062f0f47566717693db23bbace1293626527a960e7ecb604cd317281a4ad0f4904a53daa834eddf5091ea3377d6ff66a90d3cb729d81791bb3d54033

MLN SE20016 4/30/2020

https://www.cms.gov/files/document/se20016.pdf

CMS FAQs 5/1/2020

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

CMS Video - Medicare Coverage and Payment of Virtual Services

https://www.youtube.com/watch?v=bdb9NKtybzo&feature=youtu.be

CMS Provider Enrollment FAQs

National Government Services Hotline 1-888-802-3898

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Health & Human Services Telehealth site for providers and patients

https://telehealth.hhs.gov/

What will Medicare pay?

Find out at the Medicare Fee Look-up Tool: https://www.cms.gov/apps/physician-fee-schedule/overview.aspx