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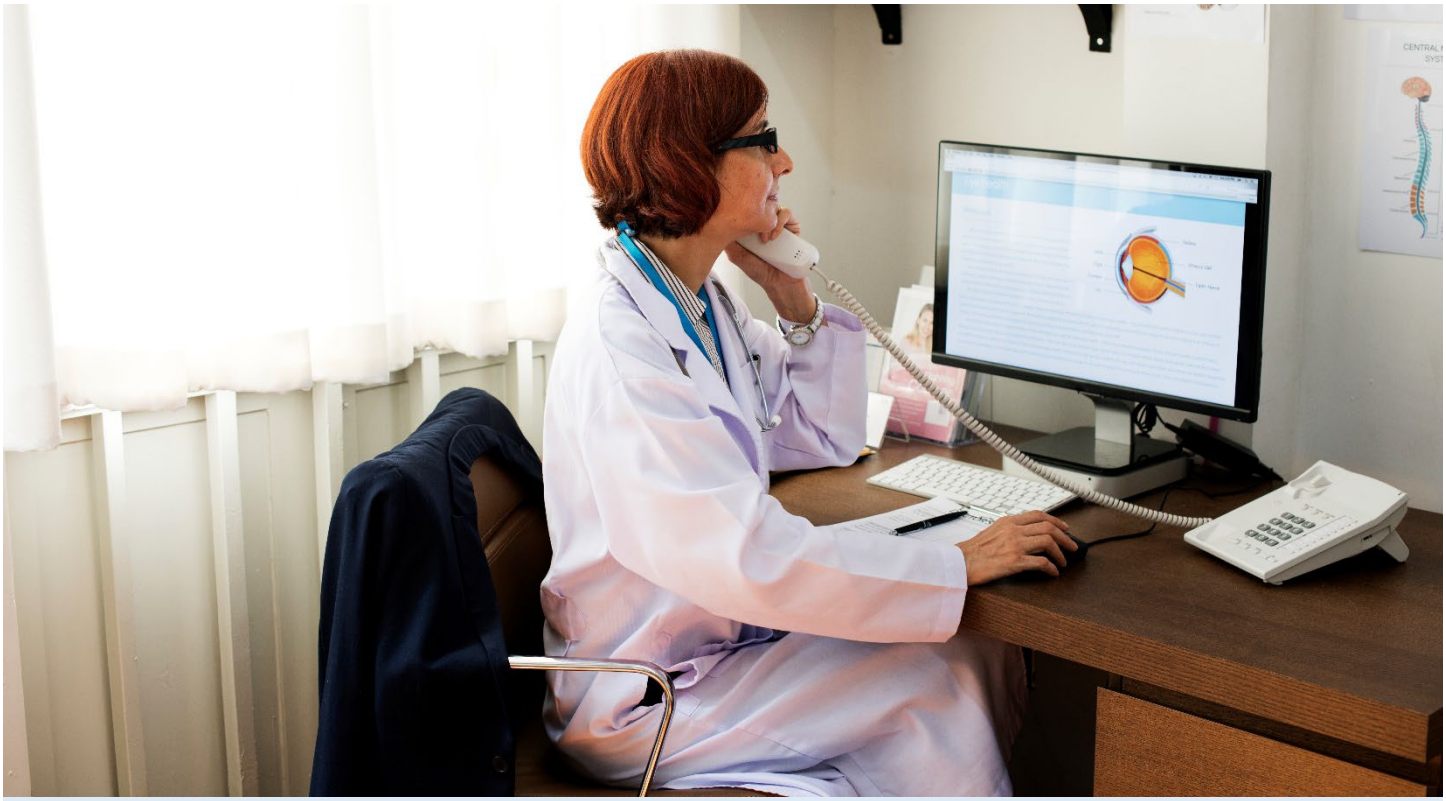

Medicare Telehealth, Remote Patient Monitoring (RPM) & Covid-19

Coding & Billing Summary

Medicare will continue emergency telehealth rules through the Covid-19 Public /Health Emergency (PHE) ends, so at least through 7/11/2022.

What happens for Medicare telehealth after the PHE? - see page 16

Updated 4.20.2022

This information was prepared as a service to the public and is not intended to grant rights or impose obligations. This information may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

Check for updates. View our website for the latest version: https://healthcentricadvisors.org/medicare-telehealth-and-remote-patient-monitoring-rpm-services/

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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
- Behavioral Health Specialists
    - Clinical psychologists (CPs)
    - Clinical social workers (CSWs)

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 (Also see CS modifier)
- 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. Do not bill coinsurance or deductible to patients for testing –related services.
Modifier CR – ***Catastrophe-related service*** Informational on claims relevant to the PHE; eVisits, and on-line assessments. Not for use on claims for telehealth (audio-visual) services, or those services allowed prior to the Covid-19 public health emergency (PHE). See more on page 6.
Modifier 95 – Telemedicine modifier Add to all telehealth (audio and/or visual) services on the CMS list (see resources)

Services Definition & Codes	Notes / Medicare Billing
Evaluation and Management Visits • 99202 – 99205 office visits, new patient • 99211 – Nurse/ MA visit • 99212 – 99215 office visit established 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 ***updated for 2022*** https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	• Use any private platform (i.e. Skype, FaceTime, Zoom) • New patient's encounters are allowed via telehealth • During the PHE bill with usual designated location, i.e. office or clinic POS 11 • POS 02 paid at the facility rate. POS where services are usually rendered will be paid at the full non-facility rate during the PHE. • Modifier 95 (Modifier GT for CAH II, Modifier G0 for acute stroke services). Do not report the telehealth modifier for through-window services. • May add non-Face-to-Face prolonged services to telehealth E&Ms. Billing guidance. https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-03-31-mlnc-se
Behavioral Health - *May be rendered audio-only (phone or on-line without video). Bill with regular codes. (Check full list)* • 90791 – Psychiatric evaluation • 90792 – Psych evaluation with med services • 90832 – 90838 psychiatric treatment w patient • 90839 – 90840 – Crisis treatment • 90845 – Psychoanalysis	• POS where services are usually rendered • If treatment rendered are by telephone, bill the regular CPT service code, not the telephone codes. • Add 95 modifier when audio/visual **or** audio only ***New for 2022*** Modifiers • FQ - A telehealth service was furnished audio-only (document reason)

Services Definition & Codes	Notes / Medicare Billing
• 90847 – 90847 Family therapy w or w/o patient • 90853 – Group therapy	• FR - A supervising practitioner was present through a real-time two-way, audio/video communication technology After the PHE ends, the patient must have an in-person visit within 6 months
Virtual Check-Ins https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf *CMS removed phone as a modality for G2012 June 2020* Brief communication service with practitioners via a number of communication technology modalities (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	• 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. • **PT/OT/SPL may bill (with GN, GO, or GP modifier)** • Place of service (POS) is where physician usually provides services i.e. office • No modifier needed because these are, by nature, telehealth services and are not on Medicare's telehealth exception list.
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	• Billed every 7 days • Place of service (POS) is where physician usually provides services i.e. office • Add CR modifier. No modifier 95 needed.
Telephone Services Physician (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	*Physician telephone services may be billed to Medicare Part B when rendered to patients in a Part A covered SNF stay. 8/3/2020.* • Established patient rule waived for COVID-19 • E&M Billing provider only may use these codes • Place of service (POS) is where physician usually provides services i.e. office • Add modifier 95 • May add non-face-to-face prolonged service codes. • Frequency limits removed for the PHE 6/16/2020 *one service billable per day until the PHE ends.* ***98966 – 98968 are not included in frequency limit removal.***

Services Definition & Codes	Notes / Medicare Billing
Telephone Services Non-Physician (non-face-to-face) NP, PA, CNS, CNM, Psychologist, Physical/Occupational/Speech Therapists, Optometry (OD), LCSW. ***Update 11/11/2020*** *Registered Dietitians / Nutrition Professionals may bill these codes, or nutrition services codes whichever is applicable.* • 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	• Billed every 7 days. Add all phone call time together for each patient and bill weekly. • 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-physician billing provider service • Place of service (POS) is where clinician usually provides services i.e. office • Add modifier CR (no modifier 95) • May add non-face-to-face prolonged service codes. • PT/OT/SPL bill with modifier GN, GO or GP
++ 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 minutes or more	• Use non face-to-face prolonged service codes for extended telephone time over the day or 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*	Perform the usual AWV components Vital signs optional for PHE Send copy of care plan to patient *Add modifier 95 and use usual POS until PHE ends.* May perform (audio/visual) acute visit if needed (add modifier 25 & 95).
Usual telehealth (audio/visual) consults codes available ○ G0425 – G0427 – 1st ED or inpatient consult ○ G0406 – G0408 – subsequent inpatient consult ○ G0508 - G0509 – critical care consult	*May be audio only.* *No modifier needed.*
Neurostimulators & Analysis/Programming Procedures • 95970 - Analysis of implanted neurostimulator pulse generator/ transmitter, without programming • 95971 - Analysis of implanted neurostimulator pulse generator/ transmitter, with programming • 95972 - Analysis of implanted neurostimulator pulse generator/transmitter; with complex spinal cord or peripheral nerve (eg sacral nerve) programming • 95983 - Alys brn npgt prgrmg 15 min • + 95984 - Alys brn npgt prgrmg addl 15	*Temporary addition for the PHE only*

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

Services Definition & Codes	Notes / Medicare Billing
Therapy Services *(available at least through 12/31/2023)* • *PT/OT Evaluations 97161- 97168* • *PT/OT Therapy 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761* • *SPL 92521- 92524, 92507* • *Pulmonary Rehab 94625 & 94626*	• Add modifier 95 until end of PHE • POS usually customary until PHE ends. • **PT/OT/SPL add GN, GO, or GP modifier** • *See new Remote Treatment Monitoring (RTM) services, page 15*
Intensive Cardiac Rehabilitation Services *(available through 12/31/2023)* • *93797 out-patient cardiac rehab, without continuous ECG monitoring (per session)* • *93798 out-patient cardiac rehab, with continuous ECG monitoring (per session)* • *93750 Interrogation of ventricular assist device (VAD), in person* • *G0422 Intensive cardiac rehab, with or without continuous ECG monitoring; with exercise, per session* • *G0423 Intensive cardiac rehab, with or without continuous ECG monitoring; without exercise, per session*	• must be audio and visual

Facility Billing

Facility Fee – Q3014 Billable by a facility where the patient is located. ***2022 reimbursement $27.59***	***Provider-based Hospital*** • CMS has said that a provider-based hospital may bill a facility fee for registered outpatients who receive services from home via telehealth. ***Use CR or DR modifier.*** ***Nursing Homes*** • A staff member will need to facilitate the telemedicine experience between the patient and clinician by managing the technology onsite at the nursing home. • Nursing homes do not need to apply for a waiver to use telehealth and telemedicine services. • Q3014 is not allowed in Skilled Nursing Facility type of bill 21X • Q3014 is allowed on type of bill 22X or 23X – SNF Part B stay • https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c07.pdf

Modifier CR

Waiver/ Flexibility	Summary
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	When DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable, allow the DME Medicare Administrative Contractors (MACs) to have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician's order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable or unavailable as a result of the emergency. **Add modifier CR to HCPC**
Modification of 60- Day Limit for Substitute Billing Arrangements (Locum Tenens)	Modifies the 60-day limit to allow a physician or physical therapist to use the same substitute for the entire time he or she is unavailable to provide services during the COVID-19 emergency, plus an additional period of no more than 60 continuous days after the public health emergency expires. On the 61st day after the public health emergency ends (or earlier if desired), the regular physician or physical therapist must use a different substitute or return to work in his or her practice for at least one day in order to reset the 60-day clock. Physicians and eligible physical therapists must continue to use the Q5 or Q6 modifier (as applicable) and **do not need to begin including the CR modifier until the 61st continuous day.**
Waivers of certain hospital and Community Mental Health Center (CMHC) Conditions of Participation and provider-based rules	Allows a hospital or Community Mental Health Center (CMHC) to consider temporary expansion locations, **including the patient's home**, to be a provider-based department of the hospital or extension of the CMHC, which **allows institutional billing for certain outpatient services furnished in such temporary expansion locations**. If the entire claim falls under the waiver, the provider will only use the DR condition code. If some claim lines fall under this waiver and others do not, then the provider would only append the CR modifier to the particular line(s) that falls under the waiver.
Billing Procedures for ESRD services when the patient is in a SNF/NF	In an effort to keep patients in their SNF/NF and decrease their risk of being exposed to COVID-19, ESRD facilities may temporarily furnish renal dialysis services to ESRD beneficiaries in the SNF/NF instead of the offsite ESRD facility. The in-center dialysis center should bill Medicare using Condition Code 71 (Full care unit. Billing for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility). The in-center dialysis center should also apply condition code DR to claims if all the treatments billed on the claim meet this condition or modifier CR on the line level to identify individual treatments meeting this condition.
Clinical Indications for Certain Respiratory, Home Anticoagulation Management, Infusion Pump and Therapeutic Continuous Glucose Monitor national and local coverage determinations	In the interim final rule with comment period (CMS-1744-IFC and CMS-5531-IFC) CMS states that clinical indications of certain national and local coverage determinations will not be enforced during the COVID-19 public health emergency. CMS will not enforce clinical indications for respiratory, oxygen, infusion pump and continuous glucose monitor national coverage determinations and local coverage determinations. Add CR modifier to these claims.

For the full listing of CR/DR modifier usage, click here https://www.cms.gov/files/document/se20011.pdf

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; *through the end of the Public Health Emergency (PHE).*

Services Definition & Codes	Notes / Medicare Billing
RHC/ FQHC Billing during the Covid-19 PHE https://www.cms.gov/files/document/se20016-new-expanded-flexibilities-rhcs-fqhcs-during-covid-19-phe.pdf Any health care practitioner working for you within your scope of practice can provide distant site telehealth services. Practitioners can provide distant site telehealth services (approved by Medicare as a distant site telehealth service under the Physician Fee Schedule) from any location, including their home, during the time that they're working for you. A list of these services is available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes **Behavioral Health/ Substance Use Services (FQHC)** Beginning January 1, 2022, FQHC mental health visits will include visits furnished using interactive, real-time telecommunications technology. There must be an in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service and that in general, there must be an in-person mental health service (without the use of telecommunications technology) must be provided at least every 12 months while the beneficiary is receiving services furnished via telecommunications technology for diagnosis, evaluation, or treatment of mental health disorders. However, **exceptions to the in-person visit requirement may be made** based on beneficiary circumstances (with the reason documented in the patient's medical record) and more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.	**All medical visits done by telehealth are billed with G2025** ***(As of 7/1/2020)*** FQHC • G2025 (no modifier) RHC • G2025 (No CG modifier, 95 modifier optional) FQHC & RHC - Add a CS modifier on the service line for COVID-19 testing related services **and for preventive services provided via telehealth such as AWV** (co-insurance and deductible waived). AWV by telehealth billing example: G2025 CS • UB04 or 837I • rev code 0521, 0781 • Payment for G2025 will be the AIR/PPS rate for 2022 $97.24 **All behavioral health or substance use services done by telehealth in FQHC:** To bill for mental health visits furnished via telecommunications for dates of service on or after January 1, 2022, FQHCs should bill • Revenue code 0900 • with the applicable FQHC Specific Payment Code (G0469 or G0470) • and the FQHC PPS Qualifying Payment code for mental health visits (ie.90834) Use modifier on your specific payment code. For example G0469 FQ or G0470 95 • 95 for services furnished via audio and video telecommunications • FQ modifier for services that were furnished audio-only For additional information on payment, billing, and claims processing, see https://www.cms.gov/files/document/se20016.pdf (PDF)

Services Definition & Codes	Notes / Medicare Billing
FQHC/RHC: virtual check-in or digital eVisit: G0071 – virtual check-in or remote evaluation of recorded images, 5 minutes or more. *2022 pay rate is $23.88* Initiation by the patient; however, practitioners may need to educate beneficiaries that services are available.	▪ 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

Documentation

- Document (annually) the patient's consent to telehealth visits. Any staff member may obtain consent.
- Document the technology modality used (i.e. Skype, Zoom, Google Hangouts, EHR), and whether the visit is audio/visual or audio only for telemedicine. If audio-only, document the reason the patient is not on video (lack of technical capacity, or lack of patient consent).
- Document the type of service; for example, office visit, PT session, on-line assessment, psychotherapy, annual wellness visit, virtual check-in, telephone call
- Document the location (exact address in case of emergency) of the patient, along with any others present and their role in the visit.
- Document time if coding by time (do not include tech set-up time). Select E&M code level based on criteria or time.
- Self-reported exam components are acceptable.
- Real-time video storage is not required.
- Scribes may participate in the telehealth visit.
- Document content of discussion, care plan changes, necessary follow-up and time spent for time-based codes. Start/ stop times acceptable.

COVID-19 Coding ICD-10, HCPC, CPT

Diagnosing COVID-19 - *effective 2022*

- **U07.1** COVID-19 with positive test result

Post-covid condition: For sequela, assign a code for the specific condition related to a previous Covid-19 infection, then add

- **U09.9** post-covid condition, unspecified

- Use additional code to identify other manifestations, such as *pneumonia due to covid (J12.82)*
- For unconfirmed cases, code signs and symptoms
- U07.2 COVID-19 has been deleted

Diagnosing COVID-19 - *effective 2022*

Exposure or Screening:

Z20.822 – Contact with and expected exposure to Covid-19

New ICD-10 Guidance
https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines-updated-02012022.pdf

- Do not use Z11.52 – *Encounter for screening for Covid* during the pandemic (public health emergency).
- Use Z20.822 for pre-operative testing, or other screening for Covid during the PHE

Specimen Collection *effective March 1, 2020 – update 2022*

Labs or Home Health Agency

- **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

Hospital Outpatient Department

- **C9803 -** Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [COVID-19]), any specimen source

Physician Office

- bill as **99211** – nurse visit
- FQHC/ RHC may not bill for specimen collection

Testing, Vaccines & Treatment for COVID-19

Testing

A lab ordered is needed (does not need to be treating physician).
May be written or verbal. If verbal, NPI is not required on the claim.

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 QW -** 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets)

All Covid-19 Testing Codes updated *Feb 2022*
https://www.ama-assn.org/system/files/coronavirus-long-descriptors.pdf

Rapid testing
87811 – QW Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) *Use for BinaxNow (Abbott) or iHealth*

Vaccines

Vaccine codes
https://www.ama-assn.org/find-covid-19-vaccine-codes

Treatment

Antiviral Drug Coding

Remdesivir (VEKLURYTM) in the Outpatient Setting – *authorized by FDA January 21, 2022*
On January 21, 2022, the FDA updated the approval of VEKLURYTM (remdesivir) and authorized its use in the outpatient setting. The federal government isn't purchasing remdesivir. Medicare Part B will provide payment for the drug and its administration. In most cases, your patient's yearly Part B deductible and 20% co-insurance apply.

J0248 1mg - report units to reflect the dosage you administered for each patient

Testing, Vaccines & Treatment for COVID-19

Monoclonal Antibodies Coding

Sotrovimab

Q0247 Injection, 500 mg
M0247 Intravenous infusion, sotrovimab, includes infusion and post administration monitoring

For the full monoclonal antibody code list, scroll to the coding section at this site https://www.cms.gov/monoclonal

Other Resources for Covid-19 Billing

Visit the Medicare Part B Drug Average Sales Price webpage

Medicare FFS Covid-19 Billing FAQ - 2022
https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

United Healthcare Covid-19 Billing Guide
https://www.uhcprovider.com/content/dam/provider/docs/public/resources/news/2020/covid19/UHC-COVID-19-Provider-Billing-Guidance.pdf

Remote Patient Monitoring – *not billable to regular Medicare in FQHC/ RHC*

- 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	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 • *May be reported for less than 16 days until the public health emergency ends.* *Clarified in 2021 final rule. After the data collection period for CPT codes 99453 and 99454, the physiologic data that are collected and transmitted may be analyzed and interpreted as described by CPT code 99091*
99454	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* ✓ *the medical device should digitally (that is, automatically) upload patient physiologic data (that is, data are not patient self-recorded and/or self-reported).**2021 final rule***	• 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 ○ 93296 – remote pacemaker system ○ 94760 – single oximetry *99453 & 99454 can be ordered and billed only by physicians or NPPs who are eligible to bill Medicare for E/M services. **2021***
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 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 99457 (below) • Do not report with an E/M service on the same day • Do not use time reported for 99091 in time counted for other care plan oversight services: Assisted Living Oversight (99339, 99340), Care Plan Oversight (99374, 99375), Hospice Supervision (99377 to 99380); or in any care management services (99424 to 99247, 99437, 99457,99487,99491). *new 2022* • Billable for physician, Non-physician Practitioner (NPP) or Qualified Health Professional (QHP) time (not staff time)

CPT Code	Definition	Notes
	✓ *Requires a physician or NPP/ QHP prescription* ✓ *Requires FDA defined device* ✓ *May be reported with TCM 99495 – 99496* ✓ *May be reported with BHI 99484, 99492 – 99494* ✓ *May be reported with care plan oversight services if time is not counted for both services*	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.
99473	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	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 • Billed once per month • Do not report with an E/M service on the same day *new 2022* • Do not report in the same month as 93784, 93786, 93788, 93790, 99091, 99242 to 99427, 99437, 99439, 99453, 99454, 99457, 99487 to 99491.
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** ✓ *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* *"Interactive communication" for purposes of CPT codes 99457 and 99458 involves, at a minimum, a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission. 2021 Final Rule* *the medical device should digitally (that is, automatically) upload patient physiologic data (that is, data are not patient self-recorded and/or self-reported).2021 final rule*	• 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 time used with 99091 to bill this code – *new 2022* 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**	

Remote Therapeutic Monitoring (RTM) – *new for 2022*

Definition: The review and monitoring of non-physiologic data related to signs, symptoms, and functions of therapeutic response.

RTM is meant to be billable by practitioners who do not bill E&M or RPM services, such as Physical Therapist (PT), Occupational Therapist (OT), Speech and Language Therapist (SPL), Certified Respiratory Therapist (CRT) or Registered Respiratory Therapist (RRT).

- Data may be patient-reported (i.e., into an app or online platform) as well as digitally uploaded.
- The device must meet FDA definition of a device https://www.fda.gov/medical-devices/device-software-functions-including-mobile-medical-applications/examples-device-software-functions-fda-regulates
- The new codes cover only musculoskeletal or respiratory system status, therapy adherence and response.
- Services must be provided by the therapist or an assistant under direct supervision of a therapist.
- RTM are "sometimes therapy" services but should always be part of a plan of care.

CPT Code	Definition	Notes
98975	Remote therapeutic monitoring (e.g., respiratory status, therapy adherence, therapy response); *initial set-up and patient education on use of equipment*	• Use CQ or CO modifier if performed by an assistant. *De minimis* rules apply; payment will be 15% less. • Use once per episode of care.
98976	Remote therapeutic monitoring (e.g., respiratory status, therapy adherence, therapy response); device(s) *supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission* to monitor respiratory system, each 30 days	Practice/facility expense only
98977	Remote therapeutic monitoring (e.g., musculoskeletal system status, therapy adherence, therapy response); device(s) *supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission* to monitor musculoskeletal system, each 30 days	Practice/facility expense only
98980	Remote therapeutic monitoring *treatment management services*, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; *first 20 minutes*	Provided by therapist, or physician.
+98981	*…each additional 20 minutes*	Provided by therapist, or physician.
Example	*An asthmatic patient is prescribed a rescue inhaler equipped with an FDA-approved medical device that monitors the frequency and dose of inhaler use. Also noted is the patient's activity, and environmental factors such as pollen counts that affect breathing. This is non-physiologic data. The data is then used by the treating practitioner to assess the patient's therapeutic response and adherence to the asthma treatment plan.*	

What Happens to Medicare telehealth services after the Public Health Emergency (PHE) ends?

After the PHE ends, Medicare beneficiaries are eligible for telehealth services that are permanently on the telehealth list. Office Visits via telehealth may only be rendered if the Medicare patient is in an originating site located in

- a rural health professional shortage area (HPSA) located either outside of a metropolitan statistical area (MSA) or in a rural census tract; or
- a county outside of an MSA.

  How do I know? Enter your patient's address at this website https://data.hrsa.gov/tools/shortage-area/by-address

Authorized originating sites within these areas are; physician office, hospital, critical access hospital (CAH), rural health center (RHC), federally qualified health center (FQHC), hospital-based renal dialysis center, skilled nursing facility (SNF), community mental health center (CMHC), and those sites participating in the Comprehensive ESRD Care model, specifically the home of beneficiaries receiving ESRD dialysis.

Stroke Services: Geographic HPSA restrictions for approved originating sites (now including mobile stroke units) have been removed. Use modifier G0 when billing for telehealth stroke services.

Billing Originating Site Services: The place where the patient is located to receive telehealth services is billable. Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014. When billing for the originating site, the POS is 11 and the location address is where the beneficiary was located. ***2022 reimbursement $27.59***

Exception Behavioral Health and/or Substance Use Services.

- Geographic restrictions do not apply to behavioral health or substance use services rendered to Medicare beneficiaries via telehealth.
- Audio-only services are allowed when the patient does not have video connection and is receiving services from their home. (Please see the *Audio-Only* column on the telehealth list.) Patients in another medical facility, must have video connection. The provider must document the reason that the visit is taking place audio-only.
- You may use the patient's home as the place of service even if they are in another location, such as a parking lot, or a friend's home.
- After the PHE ends, the patient must receive an in-person visit with the practitioner within 6 months of the initiation of care.

What telehealth services are allowed temporarily or permanently by Medicare? Check the listing at this website. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

How to read the list?

- Those temporarily available for the PHE are noted and will no longer be covered after the PHE ends, such as initial observation admissions, or telephone E/M services (99441- 99443).
- Services expected to be permanently allowed are given an end date of December 31, 2023, when they will be reviewed.
- Services without dates are covered indefinitely if the patient resides in a HPSA or MSA location, or if the service is a behavioral health service.

99213	Office/outpatient visit est	
99214	Office/outpatient visit est	
99215	Office/outpatient visit est	
99217	Observation care discharge	Available up Through December 31, 2023
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99219	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic

		LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2022 - updated January 5, 2022	
Code	**Short Descriptor**	**Status**	**Can Audio-only Interaction Meet the Requirements**
0362T	Bhv id suprt assmt ea 15 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	
0373T	Adapt bhv tx ea 15 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	
77427	Radiation tx management x5	Temporary Addition for the PHE for the COVID-19 Pandemic	
90785	Psytx complex interactive		Yes
90791	Psych diagnostic evaluation		Yes
90792	Psych diag eval w/med srvcs		Yes
90832	Psytx w pt 30 minutes		Yes
90833	Psytx w pt w e/m 30 min		Yes

Place of Service: Place of service will revert to POS 02 (not the clinic POS 11 that was used during the public health emergency.) Modifier 95 will no longer be necessary.

Resources

Final Rule Fact Sheet 2021
https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1

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

MM11765 4.24.2020 QW Modifier
https://www.cms.gov/files/document/mm11765.pdf

MLN SE20016 1/13/2022
https://www.cms.gov/files/document/se20016.pdf

MLN SE20017 5/8/2020 – Pharmacies Enroll as Laboratories for COVID-19 Testing
https://www.cms.gov/files/document/se20017.pdf

CMS FAQs 2/28/2022
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=Bsp5tIFnYHk&feature=youtu.be

CMS Provider Enrollment FAQs – December 2021
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/

National Government Services Hotline 1-888-802-3898