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Medicare Telehealth and Remote Patient Monitoring (RPM) Services

Coding & Billing Summary

COVID-19 Response

Medicare will continue emergency telehealth rules through the end of the year in which the COVID-19 Public Health Emergency (PHE) ends, so at least through 12/31/2021.

Updated 1.7.2021

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Check for updates on our website: https://qi.ipro.org/2020/05/04/telehealth-rpm-guide/

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- 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. 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; 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). 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 2021** 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 • 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. May reopen claims to reprocess for increased payment. • Modifier 95 (Modifier GT for CAH II, Modifier G0 for acute stroke services). Do not report 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 • 90847 – 90847 Family therapy w or w/o patient • 90853 – Group therapy	• 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

Services Definition & Codes	Notes / Medicare Billing
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
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
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	***NEW*** *– Physician telephone services may be billed to Medicare Part B when rendered to patients in a Part A covered SNF stay. 8/3/2020. MACs will reprocess claims for CPT codes 99441, 99442 & 99443 back to 3/1/2020, that were denied due to SNF CB edits. If you already received payment from the SNF for these physician services, return that payment to the SNF once the MAC reprocesses your claim.* • 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.* ***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 – *May now be rendered audio-only. Bill as AWV G0438 or G0439.* • G0438 – Annual Wellness Visit – *initial* • G0439 – Annual Wellness Visit – *subsequent* • G0444 – Annual depression screening *May not perform the initial IPPE via telehealth*	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. Perform the usual AWV components Vital signs optional for PHE Send copy of care plan to patient ***Add modifier 95*** May perform (audio/visual) acute visit if needed (add modifier 25 & 95).
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 ○ G0425 – G0427 – 1st ED or inpatient consult ○ G0406 – G0408 – subsequent inpatient consult ○ G0508 - G0509 – critical care consult

Services Definition & Codes	Notes / Medicare Billing
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	Added 10/14/2020 Please see CPT code manual for full descriptions

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

Services Definition & Codes	Notes / Medicare Billing
Therapy Services, Physical and Occupational Therapy, All levels bill CPT codes • PT/OT Evaluations 97161- 97168 • PT/OT Therapy 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761 • SPL 92521- 92524, 92507	• Add modifier 95 • POS usually customary • **PT/OT/SPL add GN, GO, or GP modifier**
*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	• May not include new patients • Bill cumulative time every 7 days • **PT/OT/SPL add GN, GO, or GP modifier**
Cardiac Rehabilitation Services (added 10/14/2020) • 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	• must be audio and visual
Intensive Cardiac Rehabilitation Services (added 10/14/2020) • 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 • G0424 Pulmonary rehab with exercise (and monitoring), one hour, per session, up to two sessions per day	• must be audio and visual

Facility Billing

Facility Fee – Q3014 Billable by a facility where the patient is located.	***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 would 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.

Waiver/ Flexibility	Summary
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;

Services Definition & Codes	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 Billing Guidance SE20016	**Through 6/30/2020** FQHC • Encounter G code ie. G046/67/69/70 • telehealth list CPT code with 95 modifier • G2025 95 modifier RHC • telehealth list CPT code with CG and 95 modifier • G2025 CG modifier **As of 7/1/2020** FQHC • G2025 (no modifier), RHC • G2025 (No CG modifier, 95 modifier optional)

Services Definition & Codes	Notes / Medicare Billing
https://www.cms.gov/files/document/se20016.pdf	FQHC & RHC - Add a CS modifier on the service line for COVID-19 testing related services and ***(NEW)*** **for preventive services such as AWV** (co-insurance and deductible waived). AWV by telehealth billing example: G2025 CS • 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.	▪ 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

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.
- 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) 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 code level based on E&M criteria or time.
- Self-reported exam components are acceptable. Also document that exam is limited by telehealth for full credit.
- 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 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 **(now covered by CMS even for pre-op screening; NGS mass claims adjustment in process.)**

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

- **B34.2** Coronavirus, unspecified

New ICD-10 Guidance
https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf

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

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; effective March 1, 2020. OPPS claims received on or after May 1, 2020, with Coronavirus Specimen Collection HCPCS Codes G2023 and G2024 will be returned to you with edit W7062. Resubmit returned claims as a packaged service to include Code C9803, when appropriate.

Physician Office

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

Testing for COVID-19

- *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.*

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 QW** (eff 3/20 must re-open claims to add)- 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 QW** (eff 3/20 must re-open claims to add) **–** 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
3. Antibody testing codes**:** *eff 4/8/2020 included in July 2020 release. Hold claims or will be held by NGS*
   - **86328 – QW** Immunoassay for infectious agent antibody(ies), qualitative or semi quantitative, single-step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).
     If more than one reagent strip is used, modifier 59 (distinct procedural service) should be appended to the code for the second reagent strip assay to identify two distinct analyses were performed.
   - **86769 – QW** Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).
     Used for antibody tests with multi-step methods. When two distinct analyses are performed (e.g, IgG and IgM), 86769 is reported on two claim lines with modifier 59 (distinct procedural service) appended to 86769 on the second claim line.
4. **New rapid testing code**
   - **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)*

New testing codes for covid-19 & influenza A&B available. Please see the following American Medical Association documents for all codes and guidelines: coronavirus-long-descriptors.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

Vaccine and Administration codes for Covid-19

Please see the AMA website for complete information:

CODES:
https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes

Coding GUIDANCE:
https://www.ama-assn.org/system/files/2020-11/cpt-assistant-guide-covid-vaccine-coding-2020.pdf

Remote Patient Monitoring – *not billable 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 ***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 • May be reported for less than 16 days during the public health emergency to monitor infectious disease. 8/20/2020
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* ✓ *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 ○ 99326 – 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***

CPT Code	Definition	Notes
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 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 (not staff 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. *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*
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*	• 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

CPT Code	Definition	Notes
	✓ *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*	• 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 & CY2021 Physician Fee Schedule Final Rules, and AMA CPT Assistant Jan 2019

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
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https://www.youtube.com/watch?v=Bsp5tIFnYHk&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/