



Medicare Telehealth and Remote Patient Monitoring (RPM) Services

Coding & Guidelines Summary COVID-19 Response

Updated 6/10/2020

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.

This material was prepared by the IPRO QIN-QIO, a collaboration of Healthcentric Advisors, Qlarant and IPRO, serving as the Medicare Quality Innovation Network-Quality Improvement Organization for the New England states, NY, NJ, OH, DE, MD, and the District of Columbia, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents do not necessarily reflect CMS policy. 12SOW-IPRO-QIN-TA-AA-20-41

Table of Contents

| | |
|---|----|
| Table of Contents..... | 2 |
| Who May Render or Bill for Telehealth? | 2 |
| Physician Office Telehealth Services (non-FQHC/RHC) | 3 |
| Physical, Occupational, Speech Therapy Telehealth Services (non-FQHC/RHC) | 6 |
| Modifier CR | 6 |
| Facility Billing | 7 |
| Telehealth in FQHC/RHC for Medicare Beneficiaries | 8 |
| Remote Patient Monitoring | 11 |
| Resources | 13 |

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 (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 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 | Documentation | Notes / Medicare Billing |
|---|---|--|
| <p>Evaluation and Management Visits – All Settings</p> <ul style="list-style-type: none"> • 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 <p>Full list of telehealth CPT codes https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes <i>Several codes added, and several codes allowed for audio-only interactions as of 4.30.2020</i></p> | <ul style="list-style-type: none"> ▪ 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 (do not include tech set-up 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. | <ul style="list-style-type: none"> • 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. • May add non Face-to-Face prolonged services to telehealth E&Ms. <p>Billing guidance. https://www.cms.gov/outreach-and-education/outreachffsprovpartprogprovider-partnership-email-archive/2020-03-31-mlnc-se</p> |
| <p>Behavioral Health - May be rendered audio-only (phone or on-line without video). Bill with regular codes. (check full list)</p> <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> ▪ As above for E&M | <ul style="list-style-type: none"> • POS where services are usually rendered • If rendered by telephone, bill the regular CPT service code, not the telephone codes. • Add CR modifier. • Add 95 modifier when audio/visual or audio only |

| Services Definition & Codes | Documentation | Notes / Medicare Billing |
|---|---|--|
| <p>Virtual Check-Ins (per CMS Dear Clinician Letter) https://www.cms.gov/files/document/covid-dear-clinician-letter.pdf CMS removed phone as a modality for G2012 June 2020</p> <p>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.</p> <ul style="list-style-type: none"> • G2012 – virtual check-in, 5 to 10 minutes • G2010 – remote evaluation of recorded images with interpretation and follow-up <p>Note: FQHC/RHC:</p> <ul style="list-style-type: none"> • G0071 – virtual check-in or remote evaluation of recorded images, 5 minutes or more | <p>Document patient consent to Virtual Check-in, modality used, content of discussion (changes to care plan, necessary follow-up) and time spent.</p> | <ul style="list-style-type: none"> • 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 |
| <p>eVisits – new or established patients On-line digital E&M service (via on-line patient portal)</p> <ul style="list-style-type: none"> • 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 | <p>Document that the visit was via digital technology, content of discussion changes to care plan, necessary follow-up, and time.</p> | <ul style="list-style-type: none"> • Billed every 7 days • Place of service (POS) is where physician usually provides services i.e. office • Add CR modifier. No modifier 95 |
| <p>Telephone Services (non-face-to-face) MD, DO, DPM, OD, DMD, DDS, NP, PA, CNM, CNS</p> <ul style="list-style-type: none"> • 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 | <p>Document patient consent to a telephone visit, content of discussion, follow-up plan, and time.</p> <p><i>Payment rates increased \$14-\$41 to about \$46-\$110. Effective 3/1/2020. Raise fees if necessary to capture increased payment. NGS will reprocess submitted claims but reopen processed claims via NGSConnex or LVAM to raise fee in order to capture higher reimbursement if necessary.</i></p> | <ul style="list-style-type: none"> • Billed every 7 days. Add all phone call time together for each patient and bill weekly. • not related to a medical visit (service) 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 may use these codes • Place of service (POS) is where physician usually provides services i.e. office • (No modifier 95) • May add non-face-to-face prolonged service codes. |

| Services Definition & Codes | Documentation | Notes / Medicare Billing |
|--|---|--|
| <p>Telephone Services (non-face-to-face) NP, PA, CNS, CNM, Psychologist, Physical/Occupational/Speech Therapists, Optometry (OD), LCSW, Nutrition Professionals RD (DSME bill regular dietician codes)</p> <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |
| <p>++ Telephone Services Prolonged (nonF2F):</p> <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |
| <p>Annual Wellness Visits – May now be rendered audio-only. Bill as AWV G0438 or G0439.</p> <ul style="list-style-type: none"> • G0438 – Annual Wellness Visit – <i>initial</i> • G0439 – Annual Wellness Visit – <i>subsequent</i> • G0444 – Annual depression screening <p><i>May not perform the initial IPPE via telehealth</i></p> | 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 <i>update</i> | 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). |
| <p>Consulting Physician Services Interprofessional telephone/internet/EHR assessment & management</p> <ul style="list-style-type: none"> • 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) | <p>Other consultative services:</p> <ul style="list-style-type: none"> • 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 |

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

| Services Definition & Codes | Documentation | Notes / Medicare Billing |
|--|--|--|
| Therapy Services, Physical and Occupational Therapy, All levels bill CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507 | Document patient consent along with usual documentation. | <ul style="list-style-type: none"> • Add modifier 95 • POS usually customary • PT/OT/SPL add GN, GO, or GP modifier |
| <p><i>PT/OT/SPL Therapists may also bill telephone services and these assessment codes to NGS:</i></p> <p>On-line assessment by qualified non-physician healthcare professional</p> <ul style="list-style-type: none"> • 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. | <ul style="list-style-type: none"> • May not include new patients • Bill cumulative time every 7 days • PT/OT/SPL add GN, GO, or GP modifier |

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. |

| | |
|--|--|
| <p>Waivers of certain hospital and Community Mental Health Center (CMHC) Conditions of Participation and provider-based rules</p> | <p>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.</p> |
| <p>Billing Procedures for ESRD services when the patient is in a SNF/NF</p> | <p>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.</p> |
| <p>Clinical Indications for Certain Respiratory, Home Anticoagulation Management, Infusion Pump and Therapeutic Continuous Glucose Monitor national and local coverage determinations</p> | <p>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.</p> |

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

Facility Billing

| Services Definition & Codes | Notes |
|--|---|
| <p>Facility Fee – Q3014 Billable by a facility where the patient is located.</p> | <ul style="list-style-type: none"> • 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. |

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 |
|--|---|--|
| <p>(F) TELEHEALTH SERVICE—</p> <p>(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.</p> <p>(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).</p> <p>Full list of telehealth CPT codes here https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes</p> | <ul style="list-style-type: none"> ▪ 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. | <p>Through 6/30/2020</p> <p>FQHC</p> <ul style="list-style-type: none"> • Encounter G code ie. G046/67/69/70 • telehealth list CPT code with 95 modifier • G2025 95 modifier <p>RHC</p> <ul style="list-style-type: none"> • telehealth list CPT code with CG and 95 modifier • G2025 CG modifier <p>As of 7/1/2020</p> <p>FQHC</p> <ul style="list-style-type: none"> • G2025 (no modifier), <p>RHC</p> <ul style="list-style-type: none"> • G2025 (No CG modifier, 95 modifier optional) <p>FQHC & RHC - Add CS modifier on the service line for Covid-19 testing related services (co-insurance and deductible waived)</p> <ul style="list-style-type: none"> • UB04 or 837I • rev code 0521, 0781 or 0900 • Payment will be AIR/PPS rate initially, then \$92.03 <i>all previous claims with 95 modifier will be reprocessed for new payment</i> |
| <p>FQHC/RHC: virtual check-in or digital eVisit:</p> <p>G0071 – virtual check-in or remote evaluation of recorded images, 5 minutes or more.</p> <p>Initiation by the patient; however, practitioners may need to educate beneficiaries that services are available.</p> | <ul style="list-style-type: none"> ▪ Document patient consent to Virtual Check-in, or digital eVisit, content of discussion, changes to care plan, necessary follow-up, and time spent. | <ul style="list-style-type: none"> ▪ Paid at new rate of \$24.90 as of 3/1/2020 to end of public health emergency (PHE). <i>NGS will reprocess claims.</i> ▪ 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 (**now covered by CMS; NGS mass claims adjustment in process.**)

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

- **B34.2** Coronavirus, unspecified

May use the screening code Z11.59 for all Covid-19 screening, including pre-op.

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. OPPTS 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

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. **New 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.

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 <i>New 2019</i> | 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 <i>✓ Report once for each episode of care (begins when initiated, ends with treatment goal target attainment)</i> | <ul style="list-style-type: none"> • Billable for set-up and patient education • Do not report for less than 16 days monitoring • Performed by clinical staff – no physician effort |
| 99454 <i>New 2019</i> | Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days <i>Coding Tips for 99453 & 99454:</i> <i>✓ Requires FDA defined device</i> <i>✓ Requires physician or NPP prescription</i> <i>✓ May not be reported with other monitoring services i.e., blood glucose monitoring 95249 - 95251</i> | <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ 99326 – remote pacemaker system ○ 94760 – single oximetry |
| 99091 <i>2002</i> | 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 <i>Further definition:</i> 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. <i>✓ Do not report with an E/M service on the same day</i> <i>✓ Requires a physician or NPP/ QHP prescription</i> <i>✓ Requires FDA defined device</i> <i>✓ May be reported with CCM 99487 – 99490</i> <i>✓ May be reported with TCM 99495 – 99496</i> <i>✓ Maybe reported with BHI 99484, 99492 – 99494</i> | <ul style="list-style-type: none"> • 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 <p>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.</p> |

| CPT Code | Definition | Notes |
|--------------------------|--|--|
| 99473 <i>New 2020</i> | Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration | <ul style="list-style-type: none"> Billed for staff time No further guidance available presently |
| 99474 <i>New 2020</i> | 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 | <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> ✓ 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 | <ul style="list-style-type: none"> 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-education/outreachffsprovpartprogprovider-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>

MM11765 4.24.2020 QW Modifier

<https://www.cms.gov/files/document/mm11765.pdf>

MLN SE20016 4/30/2020

<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 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=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/>