VIRTUAL VISITS

Service Category	CPT® Code	CPT® Code Description	CMS National NON- Facility MPFS	CMS National Facility MPFS	wRVU	*Additional AMA CPT® Guidance	Patient Consent Required	New Patient	Established Patient	No EM Within Previous 7 days	No EM or Service in next 24 hours	Operational Examples
Virtual Visit "Check In" (CMS Services)	G2012	Brief communication technology-based service, e.g., **virtual check-in**, by a physician or other qualified health care professional; **5-10 minutes of medical discussion**	$ 14.80	$ 13.35	0.25	May be "phone only" or other telecommunication device. No frequency limits. Telephone calls that involve only clinical staff cannot be billed.	X	N/A	X	X	X	Verbal patient consent obtained and documented. A physician or QHCP (APP, NP, PA, etc.) returns a call to a patient lasting 5-10 minutes. Documentation by the physician or QHCP supports time, context and is authenticated by the provider. Intent - "check-ins" that do not last more than a few minutes.
Virtual Visit Services (Commercial - no CMS)	99441	Telephone E&M service by a physician or other qualified health care professional provided to an established patient, parent, or guardian; 5-10 minutes of medical discussion	$ 13.35	$ 14.44	0.25							
	99442	11-20 minutes of medical discussion	$ 26.71	$ 28.15	0.5							
	99443	21-30 minutes of medical discussion	$ 39.70	$ 41.14	0.75							
Online Digital Evaluation, "e-consults, portal visits" (CMS & Commercial)	99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; **5-10 minutes**	$ 15.52	$ 13.35	0.25	**Pt. Initiated.** Document cumulative time spent over a 7-day period- not resulting from an E&M. Digital evaluation performed with separately reportable E&M services during same time frame for new or established patient. Billable with INR Monitoring (93793). INR monitoring and EMs excluded. 99421-99423 are reserved for physicians and other healthcare practitioners that can directly bill Medicare E/M codes G2061, G2062, and G2063 for non-physician practitioners who are unable to bill E/M services.	*** See Additional Guidance**	X	X	*** See Additional Guidance**	*** See Additional Guidance**	99421-23 - Example - A 75-year-old female with chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF) submits an online query through her physician's EHR portal about worsening shortness of breath and mild weight gain. Provider reviews the initial patient inquiry, medical history, documents sent by the patient and/or obtained by clinical staff. Assess medical condition described in the patient query. Formulate and sends response (eg, a diagnosis and treatment plan and/or request for additional information). Review test results and other reports. Email prescriptions. Conduct follow-up communication with the patient. Interact with clinical staff to order diagnostic tests, coordinate care, and implement the care plan. Complete medical record documentation of all communications and time. Provides necessary care coordination, etc.
	99422	**11-20 minutes**	$ 31.04	$ 27.43	0.5							
	99423	**21 or more minutes**	$ 50.16	$ 43.67	0.8							
	G2061	**Qualified nonphysician health care professional online assessment**, for an established patient, for up to 7 days, cumulative time during the 7 days; **5-10 minutes**	$ 12.27	$ 12.27	0.25							
	G2062	**11-20 minutes**	$ 21.65	$ 21.65	0.44							
	G2063	**21 or more minutes**	$ 33.92	$ 33.56	0.69							
Provider to Provider e-Consults	99451	Interprofessional telephone/Internet/electronic health record assessment and management service **provided by a consultative physician**, including a written report to the patient's treating/requesting physician or other qualified health care professional, **5 minutes or more of medical consultative time**	$ 37.53	$ 37.53	0.7	New or established pt with new problem or exacerbation of existing problem and not seen within the last 14 days. Require written report to treating/requesting provider. The written or verbal request for by the treating/requesting provider should be documented. Code 99452 is reported for 16-30 minutes in a service day preparing for the referral and/or communicating with the consultant.	X	X	X	*** See Additional Guidance**	*** See Additional Guidance**	99451 - Example - A 75-year-old female with dyspnea on exertion has been evaluated by her primary physician abnormal echocardiogram. The referring clinician asks a Cardiologist (via shared electronic record, telephone, etc.) for advice on management of the patient. The intraservice period includes clarifying the nature of patient's problem; obtaining and reviewing data or relevant information; presenting an analysis of patient's problem, including likely diagnosis and suggested management; responding to questions to clarify diagnostic and treatment approach. Documentation to support time, context, requesting physician and report to requesting physician.
	99452	Interprofessional telephone/Internet/electronic health record referral service(s) **provided by a treating/requesting physician or other qualified health care professional, 30 minutes**	$ 37.53	$ 37.53	0.7							
Remote Patient Monitoring Services	99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), **initial; set-up and patient education on use of equipment.**	$ 18.77	$ 18.77	0	30-day reporting period for 99454. Calendar Month reporting for 99457. 99453 reportable only once. Device used must be a medical device as defined by the FDA. Use with other services: billing is permitted for the same service period as CCM and TCM. CPT code 99457 and 99091 may not be billed together for same billing period and beneficiary	X	N/A	X	*** See Additional Guidance**	*** See Additional Guidance**	99457-58 - Example - The provider or clinical staff utilizes the results obtained from an FDA-defined RPM device to oversee the patient's treatment plan. The device is ordered by a physician or other qualified health care provider and used by the patient for the purposes of collecting, monitoring, and reporting health-related data, including, but not limited to, weight, blood pressure, or pulse oximetry. This technology allows for the gathering of health data from the patient in one location and the electronic transmission of that data to a provider in a different location for review and subsequent recommendations, particularly in patients with ongoing and/or chronic disease processes. Documentation supports time, context and provider authentication.
	99454	**Device(s) supply** with daily recording(s) or programmed alert(s) transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient)	$ 62.44	$ 62.44	0							
	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**	$ 51.61	$ 32.84	0.61							
	99458	**+ each additional 20 minutes** (List separately in addition to code for primary procedure)	$ 42.22	$ 32.84	0.61							
	G2010	Remote evaluation of **recorded video and/or images** submitted by an established patient (e.g., store and forward) by a physician or other qualified health care professional	$ 12.27	$ 9.38	0.18	Follow-up with the patient could take place via phone call, audio/visual communication, secure text messaging, email, or patient portal communication and must be compliant with HIPAA.. Services may involve pre-recorded patient-generated still or video images. Follow-up with the patient within 24 business hours.	X	N/A	X	X	X	Verbal patient consent obtained and documented. Physicians or QHCP (APP, NP, PA, etc.) reviews photos or video information submitted by the patient to determine if a visit is required. Provider follows up with the patient within 24 hours with a 5-10 minutes discussion. Documentation of images/video and encounter are stored.

NOTES:
Refer to AMA CPT® Coding Guidelines for additional guidance on the existing virtual care codes.
Refer to the CMS website for additional guidance on the 1135 waiver and sign up for notifications during this dynamic time - https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit. resources/coronavirus-covid-19-partner-toolkit.
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TELEHEALTH CHEAT SHEET

CMS TELEHEALTH VISITS (AUDIO and VIDEO): EXPANSION OF TELEHEALTH WITH 1135 WAIVER, as of March 27, 2020

Originating Site	Rural or Critical Access Areas
	CMS Waiver = All places of service including patients home
Common Telehealth Services ** Not an all inclusive list	Telehealth consultations, emergency department or initial inpatient - **G0425–G0427**
	Office or other outpatient visits - **99201–99215**
	Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days - **99231–99233**
	Smoking cessation services - **G0436, G0437, 99406, 99407**
	Transitional care management services with moderate/high medical decision complexity - **99495-99496**
	Advance Care Planning - **99495-99496**
	Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth - **G0508**
	Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth - **G0509**
	Comprehensive assessment of and care planning for patients requiring chronic care management - **G0506**
Qualified Providers	Physicians
	Physician Assistants
	Nurse Practitioners
	Clinical Nurse Specialists
	Registered Dieticians
	Psychologists/Social Workers
	Nurse Anesthetists
	Nurse Midwives
Eligible Beneficiary	Benefit eligible established patient
	CMS Waiver = policy enforcement discretion
Equipment & Communication	Audio and Visual Interactive Telecommunication Systems
	CMS Waiver = authorize use of telephones that have audio and video capabilities.
	CMS Waiver = enforcement discretion with HIPAA
Coding, Billing and Reimbursement	Professional Services billed with CPT or HCPCS codes paid under MPFS at the facility fee.
	Professional Services billed place of service 02 with applicable modifiers.
	Facility originating site billed with **Q3014**
	CMS Waiver = flexibility to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Established Visit E&M Code	History	Exam	Medical Decision Making (MDM)	Average Time Spent Face to Face	CMS National Facility MPFS	CMS National NON-Facility MPFS	wRVU
99212	Brief HPI = Problem Focused	1 system = Problem Focused	1 dx addressed AND 1 self limited problem = Straightforward	10 minutes	$ 26.35	$ 46.19	0.48
99213	Brief HPI, 1 ROS = Expanded Problem Focused	2-7 systems = Expanded Problem Focused	2 dx's addressed AND 1 stable chronic illness OR 2 self limited problems = Low	15 minutes	$ 52.33	$ 76.15	0.97
99214	Extended HPI, 2-4 ROS, 1 PSFH = Detailed	2-7 systems = Detailed	3 dx's addressed or 1 dx worsening w/ 1 stable dx AND RX management or 2 or more stable chronic dx's = Moderate	25 minutes	$ 80.48	$ 110.43	1.5
99215	Extended HPI, ROS 10 Systems or pertinent +/-'s with all other negative, Complete PFSH = Comprehensive	8 or > systems = Comprehensive	4 dx's addressed or 1 dx worsening w/2 stable dx or 1 new problem w/additional workup AND Severe exacerbation of 1 or > dxs or deescalation of care, etc. = High	40 minutes	$ 113.68	$ 148.33	2.1

Based on CMS National 1995 E&M Guidelines – 2 out of 3 E&M components (History, Exam and MDM) required for Established pts.

This tool serves as an EXAMPLE only -refer to payer guidelines for further information.

Comprehensive Multi-System Visual Exam Exam
1. Constitutional = General appearance (development, grooming, nutrition, etc.)
2. Eyes = Inspection of lids and conjunctivae
3. Ears, Nose, Mouth and Throat = External Inspection of ears/nose. Inspection of mucosa, lips, gums, etc.
4. Resp = Assessment of Respiratory effort (movement, use of accessory muscles, etc.
5. CV = Exam of Ext. for edema
6. MS = Exam of gait/station or ROM
7. Skin = Inspection (ulcers, lesions, etc.)
8. Psych = Orientation x3, mode/affect

Documentation Recommendations	Same as a face-to-face encounter based on CPT/HCPCS coding requirements.
	Established patient visits (99212-99215) does not require exam elements
	Telehealth consultations, emergency department or initial inpatient G-codes are time based - must document time.
	Include history, assessment, plan, and or counseling that support the visit.
	Verify Place of service and modifier guidance with all payers.
	Suggest documentation include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service.
Resources	Medicare Telehealth Frequently Asked Questions
	List of Telehealth Services
	Medicare Telemedicine Health Care Provider Fact Sheet
	MLN Booklet: Telehealth Services

NOTES:

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CARE MANAGEMENT SERVICES

Service Category	CPT® Code	CPT® Code Description	CMS National NON-Facility MPFS	CMS National Facility MPFS	wRVU	*Additional AMA CPT® Guidance	Patient Consent Required	New Patient	Established Patient	No EM Within Previous 7 days	No EM or Service in next 24 hours
Transitional Care Management (TCM)	99495	TCM Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within **2 business days of discharge** Medical decision making of at least moderate complexity during the service period **Face-to-face visit, within 14 calendar days of discharge**	$ 187.67	$ 125.59	2.36	2 day interaction does not need to be completed by the physician; however, must be within the person's scope of work. 30 day period post discharge. ***** Refer to complete CMS and AMA CPT coding guidelines.**	N/A	N/A	X	*** See Additional Guidance**	*** See Additional Guidance**
	99496	**within 7 calendar days of discharge**	$ 247.94	$ 165.65	3.1						
Chronic Care Management (CCM)	G0506	**+Comprehensive assessment of and care planning** by the physician or other qualified health care professional for patients **requiring CCM services billed separately** from monthly care management services	$ 63.52	$ 46.56	0.87	An add-on code to be used with another E/M service for that day	X	N/A	X	*** See Additional Guidance**	*** See Additional Guidance**
	G2058	**+Chronic care management services, each additional 20 minutes** of clinical staff time directed by a physician or other qualified health care professional, per calendar month **(list separately in addition to code for primary procedure).**	$ 37.89	$ 28.57	0.54	Use G2058 in conjunction with 99490. Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491.					
	99490	Chronic care management services, **at least 20 minutes** of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with required elements	$ 42.22	$ 32.84	0.61	2 or more chronic conditions to last at least 12 months. High pt risk, w/ moderate or high complexity of care, following comprehensive care plan. 30 day Code. ***** Refer to complete CMS and AMA CPT coding guidelines.**					
	99491	**at least 30 minutes** of physician or other qualified health care professional time, per calendar month, with required elements	$ 84.09	$ 84.09	1.45						
	99487	Complex chronic care management services, with required elements, moderate or high complexity medical decision making; **60 minutes** of clinical staff time directed by a physician or other qualified health care professional, **per calendar month**	$ 92.39	$ 53.41	1.00						
	99489	+moderate or high complexity medical decision making; **each additional 30 minutes** of clinical staff time directed by a physician or other qualified health care professional, per calendar month **(List separately in addition to code for primary procedure)**	$ 44.75	$ 26.35	0.5						
Principal Care Management (PCM)	G2064	Comprehensive care management services for a single high risk disease, e.g., principal care management, at **least 30 minutes of physician or other qualified health care professional time per calendar month** with required elements	$ 92.03	$ 78.68	1.45	Disease specific care plan versus comprehensive care plan "High risk" condition per CMS: expected to last 3-12 months, or more; may have led to a recent hospitalization; patient at significant risk of death, acute exacerbation, decompensation or functional decline. ***** Refer to complete CMS and AMA CPT coding guidelines.**	X	N/A	X	*** See Additional Guidance**	*** See Additional Guidance**
	G2065	Comprehensive care management for a single high risk disease services, e.g., principal care management, at **least 30 minutes of clinical staff time** directed by a physician or other qualified health care professional, per calendar month with required elements	$ 39.70	$ 39.70	0.61						
Advanced Care Planning (ACP)	99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other QHCP; **first 30 minutes**, face-to-face with the patient, family member(s), and/or surrogate	$ 86.98	$ 80.48	1.5	There are no place-of-service limitations on ACP services. There are no limits on the number of times you can report ACP for a given patient in a given period. Time based services	N/A	N/A	X	*** See Additional Guidance**	*** See Additional Guidance**
	99498	**each additional 30 minutes** (List separately in addition to code for primary procedure)	$ 76.15	$ 75.79	1.4						

NOTES:
These codes are existing service codes available for the management of patients with chronic conditions,etc. There are no changes to these services due with the CMS waiver. Refer to AMA CPT® Coding and CMS Guidelines for additional guidance.
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TELEHEALTH VISIT FLOW