VIRTUAL VISITS: Revised from CMS Interim Final Rule issued April 30, 2020
Effective for Services March 1, 2020 until the end of the PHE

Service Category	CPT® Code	CPT® Code Description	CMS National NON- Facility MPFS	CMS National Facility MPFS	wRVU	AMA CPT® Guidance	Patient Consent Required ANNUALLY	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 QHP; **5-10 minutes of medical discussion**	$ 15	$ 13	0.25	Time based service. May be"phone only" or other telecommunication device. No frequency limits. Telephone calls that involve only clinical staff cannot be billed.	X	X	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.
Telephone E&M Services (Commercial/CMS) ****REVISED CMS COVERAGE - 4/30/2020**	99441	Telephone E&M service by a physician or other QHP provided to an established patient, parent, or guardian; 5-10 minutes of medical discussion	**$ 46**	**$ 26**	**0.48**	**Added to the CMS Approved Telehealth List. Reimbursement crosswalk to est. pt. visit services retroactive to 3/1/20.** Time based service. Eval and treat by a provider using audio-only. Provider time involves medical decision making/care coordination.	X	X	X	X	X	Verbal consent obtained from patient. Patient DOB verified, service provided via telephone -documentation to support reason for visit, relevant hx, results, assessment and plan. Total time spent documented for medical discussion.
	99442	11-20 minutes of medical discussion	**$ 76**	**$ 52**	**0.97**							
	99443	21-30 minutes of medical discussion	**$ 110**	**$ 80**	**1.5**							
Online Digital Evaluation, "e-consults, portal visits" (CMS & Commercial)	99421	Online digital evaluation and management service by a **physician or QHP**, for an established patient, for up to 7 days, cumulative time during the 7 days; **5-10 minutes**	$ 16	$ 13	0.25	Cumulative time spent over 7 days Billable with INR Monitoring (93793)and excludes EMs. 99421-99423 are reserved for physicians and QHPs.	X	X	X	*** See Additional CPT Guidance**	*** See Additional CPT 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 (e.g., 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 documentation of all communications and time.
	99422	**11-20 minutes**	$ 31	$ 27	0.5							
	99423	**21 or more minutes**	$ 50	$ 44	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	$ 12	0.25	G2061, G2062, and G2063 for non-physician practitioners who are unable to bill E/M services. (PT, OT, LCSW, etc.)						
	G2062	**11-20 minutes**	$ 22	$ 22	0.44							
	G2063	**21 or more minutes**	$ 34	$ 34	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**	$ 38	$ 38	0.7	Time based service. Requires 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 CPT Guidance**	*** See Additional CPT Guidance**	99451 - Example - A 75-year-old female with dyspnea on exertion has been evaluated by her primary physician abnormal echocardiogram. The referring MD 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 MD.
	99452	Interprofessional telephone/Internet/electronic health record referral service(s)**provided by a treating/requesting physician or other qualified health care professional, 30 minutes**	$ 38	$ 38	0.7							
Self Measured B/P Monitoring M**a**rch 30, 2020 may be furnished to new patients and can be used for either chronic or acute conditions.)	99473	Self-measured B/P using a device validated for clinical accuracy; patient education/training and device calibration	$ 11	$ 11	0	These codes are used to report patient measured B/P using a medically validated device. Code 99473 is used to report initial patient education and device calibration. Code 99474 is used to report each 30 days of collected data reported by the patient and an appropriate treatment plan provided to the patient. Cannot be reported in the same month with 93784, 93786, 93788, 93790, 99091, 99453, 99454, 99457, 99487, or 99489-99491.	X	X	X	***See Additional CPT Guidance**	***See Additional CPT Guidance**	A 65 year old male presents with repeated office visit measurements of B/P greater than normal or goal. Self measured BP is ordered (99473) MD reviews the clinical staff data and report with the individual and mean systolic and diastolic BPs from the recording period. Provides instructions to the clinical staff regarding care plan info to be communicated to the patient. (99474)
	99474	Self-measured B/P 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 provider, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient	$ 15	$ 9	0.18							

NOTES:
Refer to AMA CPT® Coding Guidelines for all guidance and details. This tool provides a high level overview and is not inclusive of all guidelines - details.
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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REMOTE PATIENT MONITORING SERVICES (RPM) GUIDANCE

Revised from CMS Interim Final Rule issued April 30, 2020 - Effective for Services March 1, 2020 until the end of the PHE

Patient Eligibility and Identification	
Provider prescription and/or order consistent with state scope of practice laws	
Consent required annually may be verbal or written	
Education on coinsurance, copay, etc. Medicare Part B services, the patient is responsible for a 20% co-payment for RPM services	
During COVID PHE	
Available for new and established patient	
Available for chronic and acute conditions – may have only 1 disease	
Equipment and Connectivity	
Device must meet the FDA's definition of medical device. **During COVID PHE - expanded use of remote patient monitoring devices by the FDA.**	
Device used for RPM must be capable of generating and transmitting recordings of the patient's physiologic data – intent is digitally connected devices to support monitoring of symptom progression, etc.	
Data must be synced where it can be evaluated. Consideration of the data collected and integration to the EMR	
If supplying device - must be supplied for at least 16 days to be applied to a billing period. **During COVID PHE - may be reported for suspected or confirmed dxs of COVID -19 for fewer than 16 days.**	
If supplying device - requirements of lease or purchase of equipment including: inventory, distribution, tracking, cleaning and calibration	
Qualified Providers	
May be performed by the physician, by a qualified healthcare professional or by clinical staff depending on the CPT code used.	
Clinical staff may include RNs and medical assistants, depending on state law.	
Regulatory and Reimbursement	
General supervision requirements must be met - effective 1/1/2020	
20 minutes or more of time is documented and spent in a month interacting, interpreting and acting on the transmitted data in relation to the patients care,	
Time spent by clinical staff may be counted toward the 20 minutes if services are performed under general supervision – Physician/QHP electronic signature required	
No previous Evaluation and Management (EM) visit in 7 days and may not lead to an EM in 24 hours or as soon as available.	
CMS does not allow reimbursement for RPM services for rural health care (RHCs) or federally qualified health centers (FQHCs)	
May be reported during the same period as TCM or CCM - but not counted as the same time.	
Coding and Billing	
Patient Set-up and Education	**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**May be used with either 99091 or 99457.
	Non Facility CMS National Reimbursement = $18.77 , Facility =$18.77, wRVU = 0
Device and Transmission of Data	**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). May be used with either 99091 or 99457.
	Non Facility CMS National Reimbursement = $62.44 , Facility =$62.44, wRVU = 0
Interpretation and Management	**99457 =** RPM 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.
	Non Facility CMS National Reimbursement = $51.61 , Facility =$32.84, wRVU = 0.61
	99458 = + each additional 20 minutes (List separately in addition to code for primary procedure)
	Non Facility CMS National Reimbursement = $42.22 , Facility =$32.84, wRVU = 0.61
	99091 = Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored59 and/or transmitted by the patient and/or caregiver to the physician or QHCP, requiring a minimum of 30 minutes of time, each 30 days. **Limited to ONLY providers (MD, APP) - not reportable for clinical staff**
	Non Facility CMS National Reimbursement = $59.19, Facility =$59.19, wRVU = 1.1
	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
	Non Facility CMS National Reimbursement = $12.27 , Facility =$9.38, wRVU = 0.18
Clinical Documentation	
Consent - consent for the use of RPM technology must be obtained and maintained. Should include provider and patient identification, full disclosure of how the	
Capturing the dates and actual time spent providing the non-face to-face services for the 30 day period	
The name of the care team member providing services (with credentials if applicable)	
A brief description of the services provided	
Data Monitoring: reviewing incoming data, discussing data with patients, flagging areas of concern, etc.	
Managing Interventions: making medical decisions based on data, reaching out in emergency situations, discussing medical changes with patients, etc.	
CMS has not defined what constitutes a "live interactive communication," we assume a face-to-face visit, an interactive video conference or a conversation by	
Attestation of the provider i.e. signature (support general supervision, review, etc.)	
Guiding Principles	
The use of RPM technologies should follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care, and positive	
The use of RPM technologies should meet or exceed applicable federal and state legal requirements of medical information privacy, including compliance with the	
Enables providers to make healthcare decisions based on meaningful and useful data, standards must be established to screen, select, and verify data communicated by RPM technologies.	
Full interoperability must be established between RPM technology, which must include the exchange of data from providers to patients and from patients to	
Resources	
Using Remote Patient Monitoring Technologies for Better Cardiovascular Disease Outcomes (AHA)	
Digital Health Implementation Playbook (AMA)	
Enforcement Policy for Non-Invasive Remote Monitoring Devices Used to Support Patient Monitoring During the Coronavirus Disease (FDA)	
Refer to AMA CPT® Coding Guidelines for additional detailed guidance This tool illustrates CMS National Reimbursement rates, remember to review your local Medicare fee schedules and contact your Commercial payers.	

TELEHEALTH CHEAT SHEET

CMS TELEHEALTH SERVICES: Revised from CMS Interim Final Rule issued April 30, 2020

Originating Site	Rural or Critical Access Areas
	CMS Waiver = All places of service including patients home
Common Telehealth Services ****Temporary Additions for the COVID-19 Pandemic - CMS 4/30/2020** (This is 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
	Initial hospital care (H/P) 99221-99223
	Critical Care services 99291-99292
	Observation and Emergency Room visits (99281-99285)
	Hospital Discharge 99238-99239
	Smoking cessation services - G0436, G0437, 99406, 99407
	Transitional care management services with moderate/high medical decision complexity - 99495-99496
	Telephone E&M Services (99441-99443) - Increased Reimbursement and May be Audio Only for Telehealth.
	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
	Expansion to PT, OT and Speech Therapists, etc.
Eligible Beneficiary	Benefit eligible established patient
	CMS Waiver = policy enforcement discretion
Equipment & Communication	Audio and Visual Interactive Telecommunication Systems - **REMAINS A REQUIREMENT**
	CMS Waiver = authorize use of telephones that have audio and video capabilities.
	CMS Waiver = enforcement discretion with HIPAA
Coding, Billing and Reimbursement ****REVISED CMS 3/30/2020**	Professional Services billed with CPT or HCPCS codes and modifier 95 on all claim lines.
	Place of Service = reported as would have been reported had the service been furnished in person. (11, 22, 19, etc.)
	Frequency limitations on subsequent inpatient visits, nursing facility visits, and critical care consultations are eliminated
	Facility originating site billed with Q3014 - does not apply to patients home.
	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- Example
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 *****CMS Re-Clarification in 4/30/2020**	Same as a face-to-face encounter based on CPT/HCPCS coding requirements.
	Telehealth can be based on medical decision making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter.
	The current definition of MDM applies.
	Practitioners must document E/M visits as necessary to ensure quality and continuity of care. Requirements regarding documentation of history and/or physical exam in the medical record are waived.
	Verify Place of service and modifier guidance with all payers -**guidance specific to the Medicare Telehealth Program**
	Suggest documentation include a statement that the service was provided through **telehealth during the COVID-19 pandemic** both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service.
Resources	https://www.cms.gov/files/document/covid-final-ifc.pdf
	Medicare Telehealth Frequently Asked Questions
	List of Telehealth Services
	Medicare Telemedicine Health Care Provider Fact Sheet
	MLN Booklet: Telehealth Services

NOTES:

Refer to AMA CPT® Coding Guidelines for all guidance and details.

Refer to the CMS website for additional guidance 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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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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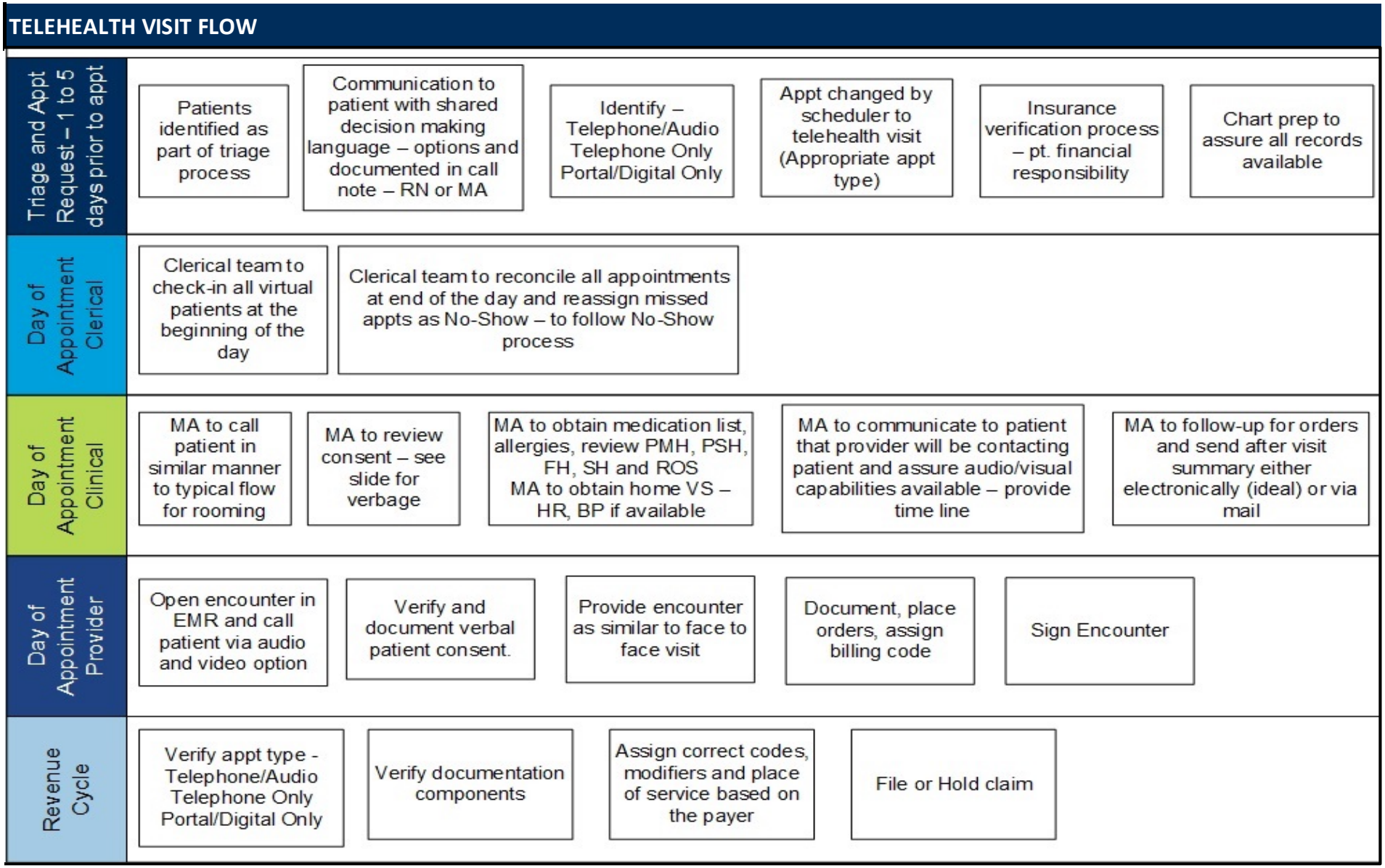
TELEHEALTH VISIT FLOW
Triage and Appt Request – 1 to 5 days prior to appt
Patients identified as part of triage process
Communication to patient with shared decision making language – options and documented in call note – RN or MA
Identify – Telephone/Audio Telephone Only Portal/Digital Only
Appt changed by scheduler to telehealth visit (Appropriate appt type)
Insurance verification process – pt. financial responsibility
Chart prep to assure all records available
Day of Appointment Clerical
Clerical team to check-in all virtual patients at the beginning of the day
Clerical team to reconcile all appointments at end of the day and reassign missed appts as No-Show – to follow No-Show process
Day of Appointment Clinical
MA to call patient in similar manner to typical flow for rooming
MA to review consent – see slide for verbage
MA to obtain medication list, allergies, review PMH, PSH, FH, SH and ROS
MA to obtain home VS – HR, BP if available
MA to communicate to patient that provider will be contacting patient and assure audio/visual capabilities available – provide time line
MA to follow-up for orders and send after visit summary either electronically (ideal) or via mail
Day of Appointment Provider
Open encounter in EMR and call patient via audio and video option
Verify and document verbal patient consent.
Provide encounter as similar to face to face visit
Document, place orders, assign billing code
Sign Encounter
Revenue Cycle
Verify appt type - Telephone/Audio Telephone Only Portal/Digital Only
Verify documentation components
Assign correct codes, modifiers and place of service based on the payer
File or Hold claim