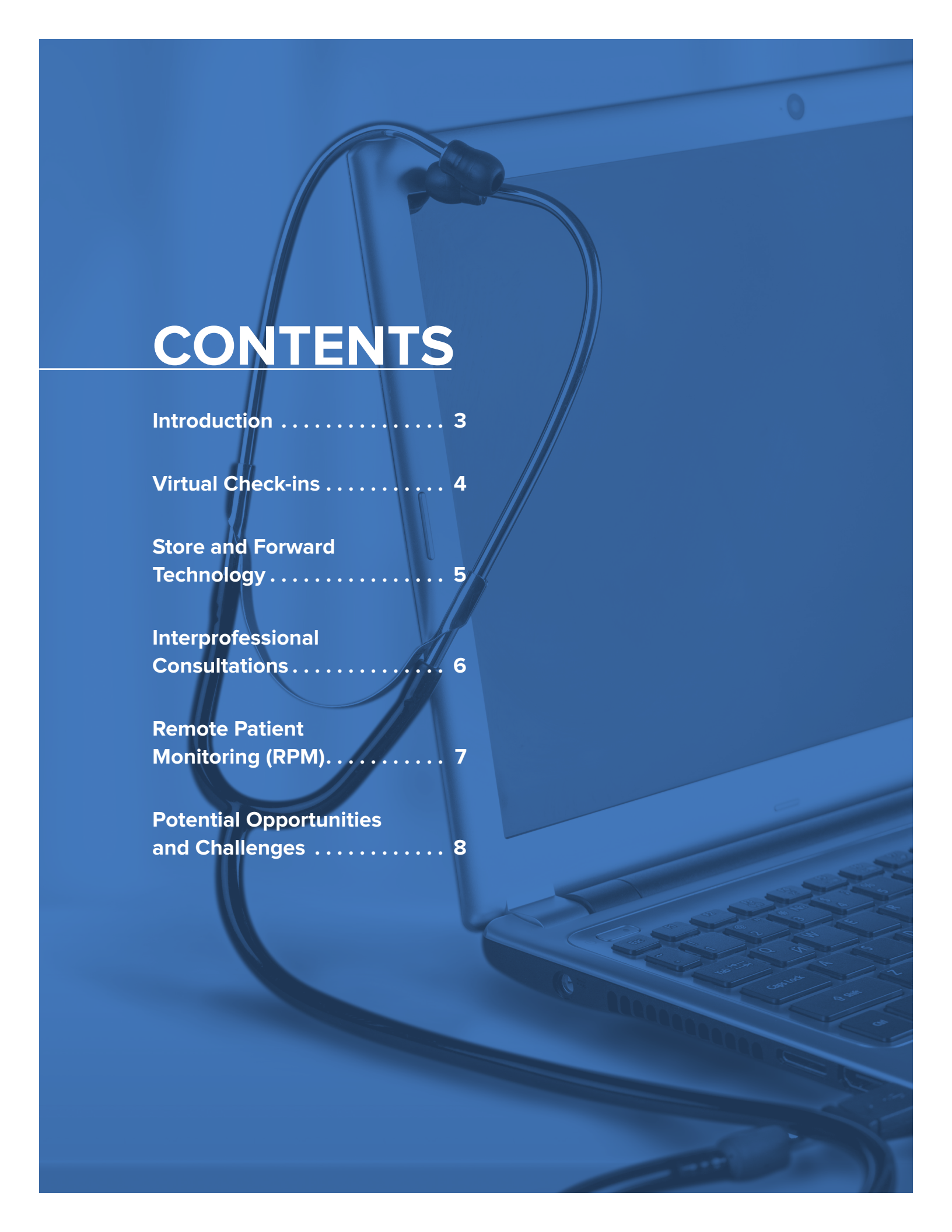




MEDICARE COMMUNICATIONS-BASED TECHNOLOGY CODES

MGMA MEMBER-EXCLUSIVE ANALYSIS

MGMA
Medical Group Management Association®



CONTENTS

Introduction 3

Virtual Check-ins 4

Store and Forward
Technology 5

Interprofessional
Consultations 6

Remote Patient
Monitoring (RPM)..... 7

Potential Opportunities
and Challenges 8

INTRODUCTION

The Centers for Medicare & Medicaid Services (CMS) took steps to modernize the Medicare program by expanding reimbursement opportunities for communications-based services, including telephone interactions, patient-submitted photos, and interprofessional consultations effective Jan. 1, 2019. CMS determined these services are not considered to be Medicare telehealth services, which means they are not subject to the statutory restrictions providing originating site limitations and rural geographic requirements. As such, new communications-based services can be furnished even when a patient is in their home. Additionally, billing guidance for telehealth services, including use of telehealth place of service codes and modifiers, should not be used for these codes.

In order to be reimbursed for [Medicare telehealth services](#), all statutory billing requirements (including geographic limitations, technology requirements, and originating site restrictions) must be met. Guidelines on Medicare telehealth services are beyond the scope of this resource.

This resource provides an overview of the new services and billing requirements. Members who have questions regarding any of these policies should contact MGMA Government Affairs staff at 202-293-3450 or govaff@mgma.org.

VIRTUAL CHECK-INS

CMS finalized payment for a newly defined physician service (G2012) to describe a remote communication service furnished to evaluate whether or not an in-office visit is necessary.

Billing Requirements

1. **Billing practitioner.** Billing is limited to practitioners who can independently bill Medicare for E/M services. To be reimbursed, the interaction must be between the patient and the billing practitioner, not clinical staff
2. **Patient consent and documentation.** Practitioners must document patient consent in the medical record for each consultation, which includes informing the patient of any cost-sharing obligations. Verbal consent is permitted. There are no service-specific documentation requirements.
3. **Established patients.** Virtual check-ins may only be furnished to established patients, defined as patients who have received professional services within the past three years from the physician or qualified healthcare professional (QHP) or physician/QHP of the exact same specialty and sub-specialty in the same group practice.
4. **Timing of in-person visit.** If the virtual check-in (i) takes place within seven days after a related in-person E/M service, or (ii) triggers an in-person office visit within 24 hours (or the soonest available appointment), the service is not separately billable, as payment would be considered bundled into the relevant in-office E/M code.
5. **Qualifying technology.** CMS does not intend to be overly prescriptive in describing the types of technology that qualify for the virtual check-in. CMS describes qualifying technology as including audio-only devices such as a telephone or two-way audio enhanced with video or other data transmissions.
6. **Place of service.** The billing practitioner should report the place of service (POS) code for the location where he or she would ordinarily provide face-to-face care to the beneficiary. For example, if they are in a physician's office, they would use POS 11.

HCPCS code G2012 –
Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

STORE AND FORWARD TECHNOLOGY

CMS finalized payment for the remote evaluation of patient-submitted technology, such as a picture or a video using G-code G2010.

Billing Requirements

1. The billing requirements for **billing practitioner type, patient consent and documentation, established patients, timing limitations, and POS code** for G2010 are the same as G2012, explained previously.
2. **Qualifying technology.** The agency does not specify how the initial image or video must be transmitted but does make clear the interaction cannot be based solely on non-image data. After the practitioner reviews and interprets the image, they must follow-up with the patient within 24 hours. The patient follow-up may occur via telephone call, secure text message, or patient portal message.

HCPCS code G2010 - Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment).

INTERPROFESSIONAL CONSULTATIONS

CMS finalized codes for interprofessional telecommunications consultations that were previously bundled. These codes are intended to describe assessment and management services conducted through phone, internet, or EHR consultation furnished when a patient's treating physician or QHP requests the opinion or treatment advice of a consulting physician or QHP with specific expertise to assist with diagnosis or care management without the need for the patient to be present.

Billing Requirements

1. **Billing practitioner.** Like G2010 and G2012, billing is limited to those practitioners that can independently bill Medicare for E/M services.
2. **Consent and documentation.** Consent must be documented in the medical record by the treating practitioner and must include that the patient is aware of any cost-sharing obligations, similar to the conditions of payment for separately billable care management services. Practices may document that verbal consent was received.
3. **Benefit of the patient.** To be separately payable, consultations must be for the benefit of the patient, as CMS explains this reimbursement is not intended for activities undertaken for the benefit of the practitioner, such as a professional courtesy or as continuing education.

CPT codes 99446-99449 –

Interprofessional telephone/ internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review. Additional time may be billed using 99447 (11-20 minutes), 99448 (21-30 minutes), 99449 (31 minutes or more).

CPT code 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 or more minutes of medical consultative time.

CPT code 99452 –

Interprofessional telephone/ Internet/electronic health record referral service(s) provided by a treating/ requesting physician or qualified health care professional, 30 minutes.

REMOTE PATIENT MONITORING (RPM)

New RPM CPT codes provide additional reimbursement opportunities for remote monitoring of patient health data for: (1) the initial set-up and patient education (99453); (2) initial supply of the monitoring device (99454); and (3) practice monitoring of data and interaction with patients (99457). In addition to these new codes, CMS finalized separate payment under CPT code 99091 starting Jan. 1, 2018 for RPM services and practices may continue to bill under this code as well.

Billing Requirements

1. **Billing practitioner.** CPT code 99457 can be furnished by a physician or QHP. CMS further explains that 99457 describes professional time and therefore cannot be furnished by personnel incident to a practitioner's professional services. It is based a calendar month period.
2. **Practice expense codes.** CPT codes 99453 and 99454 describe reimbursement for the practice expense associated with furnishing RPM services; no physician work is required to bill for either code.
3. **Consent and documentation.** CMS did not specifically address whether patient consent is required to bill RPM codes, however the agency did specify that cost-sharing responsibilities will apply. Given patient consent is required for 99091 and the other communications-technology services, it is possible this was an oversight and that CMS will clarify consent is required in subsequent guidance.
4. **Qualifying technology.** CMS has not yet specified the types of technology that will qualify under the new RPM CPT codes but intends to do so in sub-regulatory guidance.

CPT code 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.

CPT code 99454 –

Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.

CPT code 99457 –

Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.

POTENTIAL OPPORTUNITIES AND CHALLENGES

PROS

New virtual codes indicate CMS is finally recognizing group practices for the work they do outside of the traditional office visit.

While most codes are only reportable by physicians or qualified health professionals, CMS specifies that time spent with a nurse or clinical staff member could be counted toward other remote evaluation codes like CCM.

Providers can bill new communications-based codes the same month as CCM.

CONS

Beneficiary cost-sharing obligations may create frustrating collections situations.

The valuation of new codes is modest, and most codes exclude clinical staff time.



MEDICARE COMMUNICATIONS-BASED TECHNOLOGY CODES

MGMA
Medical Group Management Association®