



Center for Connected
Health Policy

THE NATIONAL
TELEHEALTH POLICY
RESOURCE CENTER

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Billing for Telehealth Encounters

AN INTRODUCTORY
GUIDE ON
FEE-FOR-SERVICE





Introduction

The COVID-19 federal Public Health Emergency (PHE) ended on May 11, 2023 moving telehealth policy in Medicare into its next, but still temporary phase. In preparation for the end of the PHE, the months leading up to May 11, 2023 included a flurry of federal policy activity both on the Legislative and Administrative levels, all intended to answer the question of “what happens after the PHE is over?” The fates of the multitude of federal waivers impacting telehealth vary depending on what they were. Some pandemic-era waivers will remain in place through December 31, 2023, others to December 31, 2024 and some have expired. Many of the major temporary policies will at least remain through the end of 2024 due to the “Consolidated Appropriations Act of 2023 (CAA 2023), Sec. 4113: Advancing Telehealth Beyond COVID-19”¹ and administrative actions taken by the Center for Medicare and Medicaid Services (CMS).

The Center for Connected Health Policy (CCHP) is providing this informational billing guide to assist those who have questions regarding telehealth billing in general and specifically, post-PHE. The guide is primarily about Medicare fee-for-service billing as policies vary from state-to-state for Medicaid and commercial payers. It is not meant to be a guarantee of reimbursement for services rendered via telehealth, but to act as a guide to clarify certain policies related to:

- telehealth billing and reimbursement
- requirements applicable during 2023 (in the post-PHE environment)
- permanent telehealth billing requirements past the temporary grace period post-PHE

The guide will outline the policies in place for 2023, as well as permanent Medicare policy as we currently know it. Keep in mind, policy can change rapidly and frequently.



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
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1) [Consolidated Appropriations Act of 2023](#).



Information in this guide is up to date through May 2023. It does not include any changes made after that date. Call-out boxes are used to highlight exceptions to the rule or the permanent policy that has been temporarily suspended until a future date (see Color Guide for Boxes). Every state Medicaid program's telehealth reimbursement policy is different. California is the Medicaid example used in this guide, partly because California also recently finalized most of its post-PHE telehealth policy and in some places significantly differs from Medicare. The California Medicaid example is provided to assist you in researching other state's Medicaid policies but we stress that the variations between states can be extensive. As with all policies listed in this guide, changes can be made at any time. Be sure that you check the [CCHP's Policy Finder](#) for any updated information on your state's Medicaid telehealth policies, www.cchpca.org.

Color Guide for Boxes

-  Medicare Permanent
-  Medicaid/California
-  General billing tips

The focus of this guide is on Medicare "Fee for Service" (FFS)² telehealth policy and reimbursement. The guide will not delve into specifics about commercial plan coverage, although it is important to keep in mind that some of those plans follow CMS' policies. Managed care plans, private payers and employer-based plans may also follow CMS' rules but be sure to check with the plan. Like all services, payment for telehealth encounters is not guaranteed for every visit, whether due to frequency limitations, diagnosis code or extent of coverage afforded by the plan. **Finally, please know that this CCHP resource is only a guide and should not be considered legal advice nor a guarantee of reimbursement.**

The guide has been divided into sections to provide the reader with a full understanding of the different policies that impact telehealth billing in Medicare:

- Terminology Used Related to Telehealth
- Codes
- Services
- Other Considerations
- Billing Examples

Terminology Used Related to Telehealth

It is useful to understand some of the terms used when discussing telehealth reimbursement as definitions can vary from jurisdiction-to-jurisdiction or even from one conversation to the next. Medicare may have a specific definition for one word, but your state Medicaid program may define that same word differently, which can impact how you bill in a variety of ways, such as whether the CMS 1500 (professional fee claim form) or the UB-04 (facility fee claim form) is used. These terms also dictate whether the services you provide via telehealth will be eligible for reimbursement by Medicare as they are the policies that shape what is covered and reimbursed by the program.

2) HealthCare.Gov, "[Fee for Service](#)."



ORIGINATING SITE

The originating site is where the patient is located when the telehealth encounter takes place. In permanent telehealth policy, the originating site must meet certain requirements to be eligible for coverage and reimbursement by Medicare. The requirements include where the originating site is located geographically and the type of facility/location it is. (See Call Out Box for the types of eligible facilities/locations). For 2023, geographic requirements are waived and the home is eligible to be an originating site for eligible telehealth delivered services. This temporary policy is in place until December 31, 2024.³



BILLING TIP!

When billing, you will use either the CMS-1500 form (for individual practitioners) or the UB-04 form (for facilities)



PERMANENT MEDICARE POLICY Eligible Originating Sites

- Physician and practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)
- Renal Dialysis Facilities *
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis *
- Mobile Stroke Units *
- Home of Patient receiving treatment for SUD/Opioid Abuse and co-occurring mental health disorders
- Rural Emergency Hospitals (REHs)

* Geographic limit may not apply to these facilities in specific circumstances. NOTE: Geographic limitations on originating site removed for treatment and diagnosis of acute strokes.

Medicaid Example: California

“Originating site” means the place where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates. For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited (California Welfare and Institutions Code [CA W&I Code], Section 14132.72[e]).

Source: [California Department of Health Care Services, Medi-Cal Provider Manual](#)

BILLING TIP!

Note that an originating site may bill Medicare an originating site fee using code Q3014. If the originating site is the home, no fee may be billed.

3) [Consolidated Appropriations Act of 2023](#)



DISTANT SITE

A distant site is the location of the provider (NOTE: this is different from who is an eligible provider which will be discussed later on). Medicare does not have too many policies related to distant site and telehealth, specifically. However, providers should be aware of several things that may not be telehealth-specific policies. One is regarding licensure. On this issue, Medicare defers to state law in which the patient is located. Therefore, if you are a physician and your patient is located in California at the time of the telehealth interaction, you need a California license because physicians are required to be licensed by the state when providing services to a patient within California's borders.⁴ Additionally, where the distant site provider is located will also determine the rate you will be reimbursed by Medicare as adjustments are made such as cost of living depending on location of the provider, based on "inter-jurisdictional reassignments."⁵ A common question regarding location has to do with physicians either permanently or temporarily located outside of the United States when providing



BILLING TIP!

Click on CCHP's site, [here](#), to find your state. Compare your state's policy definitions to Medicare's: What is the same? What is different?



BILLING TIP!

Since this waiver concerning home addresses may end on December 31, 2023, be sure to work with your Credentialing Staff or inform your providers on how to suppress their addresses so that they do not appear on the CMS 1500, and the group practice address will appear. Contact CMS' provider enrollment staff to assist.



BILLING TIP: MEDICARE

Current instructions with regard to the appropriate place of service (POS) codes to use indicates that providers should continue to bill as if the patient were in an in-person treatment location. Thus, non-facility locations may continue to collect reimbursement at parity for all telehealth services. However, for hospital outpatient departments (HOPDs):

Hospital Outpatient Physician Department (HOPD)

Both Provider and Patient at home: POS 19 or 22, CPT + mod 95 (CMS 1500)

- No Q3014 (originating site facility fee)

Provider on site and patient at home: POS 19 or 22, CPT + mod 95

- No G0463 (facility fee associated with evaluation and management services)

Patient on site and provider at home: POS 19 or 22, CPT + mod 95

- Q3014 on UB-04

Both Provider and Patient on site: POS 19 or 22, CPT + mod 95

- G0463 on UB-04

*Acute Hospital Care at Home for Inpatient Services**

- CMS continues to extend to a patient's home while still admitted as inpatient
- The provider may see the patient via telehealth, but this would be billed as if the patient were at the facility (still no modifier)
- RN visits to the patients' homes are part of the program

[*Consolidated Appropriations Act of 2023: Section 4140](#)

4) [Medical Board of California.](#)

5) [Medicare Online Manual, Section 10.3.1.4.3 – Additional Form CMS-855R Policies and Processing Alternatives.](#)



the telehealth services. A recent court decision, *RICU LLC v. United States Department of Health and Human Services* noted that in a review of the case, the Acting Director of CMS' Chronic Care Policy Group wrote that Medicare cannot reimburse any telehealth services by medical providers outside of the United States because of the Medicare Act's ban on foreign payments.⁶

One temporary policy that has been extended during this grace period post-PHE relates to provider location. During the pandemic, providers were allowed to use their work addresses when they enrolled even if they were providing services via telehealth from their homes. This has been a long-standing concern for providers in Medicare because their home addresses may be publicly accessible. CMS will continue this exception through the end of 2023.⁷ Therefore, while there might not be an expansive list or requirements for eligible distant sites like there is for originating sites, there are policies that impact the provider based upon location.

ELIGIBLE PROVIDERS

Under permanent Medicare telehealth policy, only a specific list of providers are eligible for reimbursement when using the technology to provide services. However, during the PHE the list was expanded to include all eligible Medicare providers. CMS has said it will continue the COVID-19 policies on the expanded list of eligible providers through December 31, 2024.⁸ These providers can continue to bill from non-facility as well as facility hospital outpatient department (HOPD) locations through the end of 2024. Per the End of PHE FAQs, "The services included a subset of hospital outpatient therapy, counseling, and educational services, beyond just mental/behavioral health services."⁹



PERMANENT MEDICARE POLICY Eligible Providers

This is the permanent list of eligible providers who may use telehealth to deliver services and be reimbursed by the Medicare program. Until December 31, 2024, this limited list has been waived and all Medicare providers are eligible.

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs)
- Registered dietitians or nutrition professionals

Medicaid Example: California

"Medi-Cal defines the "distant site" as "... a site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location." This allows the practitioner to be in a location suitable to telehealth encounters, but not necessarily in a clinic or facility themselves.

Source: [California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth](#)



6) [RICU LLC v. United States Department of Health and Human Services.](#)
7) [CMS: Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19](#)
8) [CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19](#)
9) [FAQs: CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency, pg. 8](#)



Medicaid Example: California

Medi-Cal does not limit the type of provider who may provide services via telehealth. Recently Medi-Cal added to its permanent policy douglas, community health workers (CHWs) and unlicensed asthma preventive service providers in its January 2023 updated telehealth provider manual.

Source: [California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth](#)

Also included in this list of temporarily eligible telehealth providers are FQHCs and RHCs. However, while the other health professionals who are temporarily added to the eligible provider list will receive the same reimbursement for services delivered via telehealth that would have been paid if the service was delivered in-person, FQHCs and RHCs will receive a flat rate which in 2023 is approximately \$99.

Additionally, telehealth policy was expanded to include medical trainees during the PHE and although the ability to virtually supervise trainees had been rescinded at the end of the PHE, on May 12, 2023, CMS updated its policies as follows:

Will teaching physicians be allowed to use virtual presence and bill for services involving residents in residency training sites outside of a MSA after the PHE ends?

CMS is exercising enforcement discretion to allow teaching physicians in all teaching settings to be present virtually, through audio/video real-time communications technology, for purposes of billing under the PFS for services they furnish involving resident physicians. We are exercising this enforcement discretion through December 31, 2023, as we anticipate considering our policy for services involving teaching physicians and residents further through our rulemaking process.¹⁰

There was dismay over the end of audio-video trainee supervision for telehealth services at the end of the PHE and the ensuing advocacy efforts of the Association of American Medical Colleges (AAMC) and others may have influenced CMS to extend virtual trainee supervision.¹¹ Note that general supervision (of clinical staff) remains through December 31, 2023, as well.

Codes

A brief overview of Common Procedural Terminology (CPT) codes will help novices understand how Medicare, Medicaid, other payers, coders and billers discuss coverage. Note that CPTs can go on the CMS 1500 or the UB-04. A CPT code is defined by the American Medical Association (AMA) as follows¹²:

[A] uniform language for coding medical services and procedures ... All CPT codes are five-digits and can be either numeric or alphanumeric, depending on the category.

Category I: *These codes have descriptors that correspond to a procedure or service. Codes range from 00100–99499 and are generally ordered into sub-categories based on procedure/service type and anatomy.*

10) CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency FAQs, Pg 10.

11) Virtual trainee Supervision, see pg. 9.

12) American Medical Association, "CPT overview and code approval."



Category II: These alphanumeric tracking codes are supplemental codes used for performance measurement. Using them is optional and not required for correct coding.

Category III: These are temporary alphanumeric codes for new and developing technology, procedures and services. They were created for data collection, assessment and in some instances, payment of new services and procedures that currently don't meet the criteria for a Category I code.

CMS groups CPT codes for different programs and this is how CMS categorizes eligible services that may be provided via telehealth. CMS maintains a permanent Telehealth CPT Code list¹³ which grew from 103 CPT codes at the start of 2020 to 266 at current count, however not all of the additional codes are on the permanent list. On the current telehealth available services list are notations of what can also be provided via “audio only” and what services at this time are only available through the end of 2024. Finally, list updates can occur with little notice and it is only by reviewing the list every so often that one can catch changes that may be applicable to your program.

PERMANENT MEDICARE POLICY

Outpatient Prospective Payment System (OPPS)



Three codes were added to the CMS Telehealth List on May 9, 2023 and are discussed below.

Since the PHE allowed Partial Hospitalization and Intensive Outpatient Program services to take place in a patient's home via telehealth, the following occurred:

In the CY 2023 Outpatient Prospective Payment System final rule, CMS established a policy that allows clinical staff of hospitals to provide certain mental health services via a telecommunications system to patients in their homes after the PHE. They established 3 new codes and code descriptors (C7900-C7902) for these remote mental health services furnished by hospital outpatient department (HOPD) staff. Because HCPCS codes C7900 – C7902 describe remote mental health services furnished by hospital staff to a patient in their home, and the statute prohibits Partial Hospitalization Program (PHP) services from being furnished in an individual's home, these are not considered PHP services, and CMHCs can't furnish these remote services. However, patients receiving PHP services from a CMHC or hospital-based PHP could receive the remote mental health services from clinical staff of a HOPD. The policy discussion starts at 87 FR 72014.

The code definitions are as follows:

- **C7900** - Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 15-29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service
- **C7901** - Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 30-60 minutes, provided remotely by hospital staff who are licensed to provided mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service
- **C7902** - Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable state law(s), when the patient is in their home, and there is no associated professional service (list separately in addition to code for primary service)

13) Center for Medicare and Medicaid Services, [“List of Telehealth Services.”](#)



Medicaid Example: California



Medi-Cal covered benefits or services, identified by CPT or HCPCS codes and subject to all existing Medi-Cal coverage and reimbursement policies, including any Treatment Authorization Request (TAR) requirements, may be provided via a telehealth modality as outlined in this section only if all of the following are satisfied:

- The treating health care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices to be delivered via telehealth.
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT or HCPCS code(s), as defined by the American Medical Association (AMA), associated with the Medi-Cal covered service or benefit, as well as any extended guidelines as described in this section of the Medi-Cal provider manual.
- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to his or her medical information.

Source: [California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth](#)

Adding Services for Medicare Telehealth CPT List



To add services to the approved telehealth CPT list in Medicare, the service must fit into one of three "categories"¹:

- **Category 1:** Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services.
- **Category 2:** Services that are not similar to the current list of telehealth services. Review of these requests will include an assessment of whether the service is accurately described by the corresponding code when delivered via telehealth and whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient.
- **Category 3:** A temporary holding place for some codes approved for reimbursement during the pandemic. These codes will remain available for reimbursement if provided via telehealth until December 31, 2023.

MODIFIERS

Modifiers help CMS identify how the service was delivered to an enrollee. Billing examples showing how they are used are located at the end of the guide.

According to Noridian, the Jurisdiction E Medicare Administrative Carrier (MAC), modifiers¹⁴ are:

- *two-digit numbers, two-character modifiers, or alpha-numeric indicators. Modifiers provide additional information to payers to make sure your provider gets paid correctly for services rendered.*
- *more than one modifier may be used with a single procedure code; however, they are not applicable for every category of the CPT codes. Some modifiers can only be used with a particular category and some are not compatible with others.*

14) [Noridian Health Care Solutions, Modifiers.](#)



For Medicare FFS and other programs' telehealth claims (including for FQHCs and RHCs¹⁵), the CPT modifiers listed below are used for particular situations:

- **G0:** (zero): Used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
- **GQ:** (not used unless you are in Alaska or Hawaii): asynchronous telehealth service.
- **GT:** Critical Access Hospital distant site providers billing under CAH Optional Method II. This goes on an institutional claim and pays 80% of the Professional Fee Service rate.
- **GY:** Notice of Liability Not Issued, Not Required Under Payer Policy. Used to report that an Advanced Beneficiary Notice (ABN) was not issued because item or service is statutorily excluded or does not meet definition of any Medicare benefit. (Note: only to be used when the patient is not at an eligible originating site.)
- **FR:** Supervising practitioner present through two-way, audio and video communication.
- **FQ:** A telehealth service was furnished using real-time audio-only communication technology.
- **93:** Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system.
- **95:** Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.

While FQ and 93 may appear to be the same, CMS clarified in the 2023 Medicare Physician Fee Schedule (MPFS)¹⁶ that 93 is to be used for mental health claims:

Additionally, effective on and after January 1, 2023, CPT modifier "93" can be appended to claim lines, as appropriate, for services furnished using audio-only communications technology in accordance with our regulation at § 410.78(a) (3). All providers, including RHCs, FQHCs, and OTPs must append Medicare modifier "FQ" (Medicare telehealth service was furnished using audio-only communication technology) for allowable audio-only services furnished in those settings. However, consistent with our proposal for audio-only services furnished under the PFS, we are also finalizing to require all providers including RHCs, FQHCs, and OTPs to use modifier "93" when billing for eligible mental health services furnished via audio-only telecommunications technology. Providers have the option to use the "FQ" or the 93" modifiers or both where appropriate and true, since they are identical in meaning.

Medicaid Example: Audio-Only Specific Modifiers

- FQ: audio only. Some states are requiring the use of the FQ modifier already, such as the [Washington State Health Authority](#).
- UD: audio only. This is the modifier required by [Arizona Medicaid](#).
- 93: audio only, as can be found in the California Medicaid program's [Telehealth manual](#).



15) [MLN Matters updated May 23, 2023.](#)

16) [CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies \(November 18, 2022\).](#)



Until December 31, 2023, the CPT codes representing telehealth services require a modifier 95 (telehealth) to be placed on the CMS 1500 in order to differentiate between telehealth and on-site services.¹⁷

Managed care and private plan policies vary on what modifier they require in order to bill for telehealth (i.e., GT or 95). Always check with the plan to see what is required for your billing.



Medicaid Example: California

For Medi-Cal, the modifiers for telehealth are as follows:

Synchronous, Interactive Audio and Telecommunication Systems: Modifier 95

Modifier 95 must be used for Medi-Cal covered benefits or services delivered via synchronous, interactive audio/visual telecommunications systems. Only the portion(s) of the telehealth service rendered at the distant site are billed with modifier 95. The use of modifier 95 does not alter reimbursement for the CPT or HCPCS code.

Synchronous, Telephone or Other Interactive Audio-only Telecommunications Systems: Modifier 93

Modifier 93 must be used for Medi-Cal covered benefits or services delivered via synchronous, telephone or other interactive audio-only telecommunications systems. Only the portion(s) of the telehealth service rendered at the distant site are billed with modifier 93. The use of modifier 93 does not alter reimbursement for the CPT or HCPCS code.

Asynchronous Store-and-Forward Telecommunication Systems: Modifier GQ

Modifier GQ must be used for Medi-Cal covered benefits or services including, but not limited to, teleophthalmology, teledermatology, teledentistry and teleradiology, delivered via asynchronous store-and-forward telecommunications systems, including e-consult (CPT 99451). Only the service(s) rendered from the distant site must be billed with modifier GQ. The use of modifier GQ does not alter reimbursement for the CPT or HCPCS code billed.

Source: [California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth](#)

PLACE OF SERVICE CODES

CMS publishes a Place of Service (POS) code list¹⁸ that tells CMS via the CMS-1500 where the provider and patient are located during a health encounter. The treatment location affects reimbursement, the CPT code categories, and sometimes the modifiers to use with the CPT codes. What follows in this guide are codes specific to telehealth services.

As noted above, however, when providing telehealth services to patients in their homes through the end of 2023¹⁹, clinics and facilities should indicate the POS that the patient would have utilized had they come to an encounter in-person, and then also putting a modifier 93 or 95 on the CPT code for a service. Payment parity will be maintained for non-facility places of service through 2023, but beyond that is a question mark, as CMS may make changes to the PFS for 2024.

18) [Center for Medicare and Medicaid Services, Place of Service Code Set.](#)

19) [CMS Fact Sheets After the PHE.](#)



[W]e are finalizing that we will continue to allow for payment be made for Medicare telehealth services at the place of service for telehealth services that ordinarily would have been paid under the PFS, if the services were furnished in-person, through the latter of the end of the of CY 2023 or the end of the calendar year in which the PHE ends. For those services furnished in a facility as an originating site, POS 02 may be used, and the corresponding facility fee can be billed, per pre-PHE.²⁰

For example:

- **11** – Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
- **19** – A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **22** – A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

SYNCHRONOUS SERVICES POS CODE

For Medicare synchronous telehealth services, a POS 02 (telehealth) is required for use on the billing form CMS 1500 or POS 10 (home telehealth). These code definitions are:

- **02** – Telehealth Provided Other than in Patient’s Home. The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. (Effective January 1, 2017) (Description change effective January 1, 2022, and applicable for Medicare April 1, 2022.)
- **10** – Telehealth Provided in Patient’s Home. The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. (This code is effective January 1, 2022, and available to Medicare April 1, 2022.)

Due to the CAA of 2023, CMS is paying providers the fee they would have received had their patients physically come into a non-facility/provider-based clinic. Note that prior to the PHE, non-facility clinics received only the facility-based reimbursement for its distant site provider services (the originating site bills Q3014 and receives \$27).

Through the end of 2024, non-facility clinics may indicate POS 11 (using a modifier 95 on the CPT billed) and receive 100% reimbursement.

²⁰ [CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies \(November 18, 2022\), p.63.](#)



However, while CMS is also instructing facility-based clinics to use POS 19 or 22 (with a modifier 95 on the CPT billed), they will receive the facility-based fee professional fee, which is lower than the non-facility reimbursement.²¹

Medicaid Example: California



Medi-Cal's address requirement for telehealth claims: "The distant site for purposes of telehealth can be different from the administrative location." An interpretation of this statement, based on the above discussion, would indicate that under POS 02, the address for Box 32 means the practitioner's "usual" place of business.

Source: [California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth](#)

THE REST OF THE POS CODES

Place of Services (POS) codes are two-digit numbers that describe the practice billing and where the service took place. During this grace period post-PHE, CMS has instructed providers to use the POS that would have been used had the service would have taken place in-person. Some of the more commonly used codes can be found in Figure 1.

REVENUE CODES

Facilities utilize revenue codes to indicate the type of service provided by the facility. It describes a category of service and is entered on the UB-04. The codes are 4-digit codes "that are descriptions and dollar amounts charged for hospital services provided to a patient. The revenue code tells an insurance company whether the procedure was performed in the emergency room, operating room or another department."²²

Revenue Code 780 is used for telemedicine institutional claims billed both to Medicare and Medicaid²³. Examples will be provided below when this is appropriate to submit on a UB-04.



PERMANENT MEDICARE POLICY

Due to the policies around mental health that CMS has implemented for 2022, audio-only can be used to deliver mental health services when the patient is in the home, if certain conditions are met. While POS 10 can be reported, it is still expected that providers use 11, 19 or 22 and modifier 93 or 95. In addition, the physician clinic location must go onto the CMS 1500 as well. The address lets the MACs know what conversion factor to use based on the geographic factor payment rate to calculate accurate reimbursement. Noridian stated that when a provider assigns their enrollment rights to a group or facility, then the group address is what is indicated on the CMS 1500, with the practitioner's address known to CMS (if working a large portion of time at home), but billed through the group entity.¹

Note that this requirement was waived during the PHE due to the vast majority of telehealth visits being conducted from providers' homes. Requiring these updates would have been overwhelming to both providers and to CMS. Therefore, now that the PHE is over, this requirement will not be instituted until January 1, 2024.



BILLING TIP!

If a provider or a facility staff member provides a telehealth visit to a Medicare beneficiary that did not meet the statutory guidelines (ineligible originating site, for example), put a GY modifier on the CPT (on either the CMS 1500 or UB-04) to indicate that you provided an excluded service.

21) [CMS FAQ After the PHE, pg. 7.](#)

22) [Value Healthcare Services Understanding Hospital Revenue Codes.](#)

23) [Noridian Healthcare Solutions, Revenue Codes.](#)



FIGURE 1: Different Types of Facilities and Their POS Codes

- **Independent Clinic (POS 49):** a clinic that is not part of a hospital and is for outpatient treatment. The employees in this type of practice will be able to act under general or direct supervision of the treating practitioner who is managing patient care. This means incident-to billing can occur, which has an impact on the remote patient monitoring (RPM) codes. This also affects whether or not certain Chronic Care Management (CCM) services can be billed. [\(Ref 1\)](#) This can be an originating site for Medicare services if eligible under HRSA guidelines, as well as a distant site. Note that Remote Physiological Monitoring and CCM do not fall under geographic restrictions, as they are not “telehealth.”
- **Off Campus Outpatient Hospital Clinic (POS 19):** this type of clinic employs staff who do not have a direct employment relationship with the ordering physicians. Thus, any activities performed under the direct or general supervision of the physician are bundled with the facility services on the UB-04 and cannot be reported on the CMS 1500 or billed under the physician’s NPI. [\(Ref 2\)](#)

A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016.) [\(Ref 3\)](#)

POS 19 can be an originating site for Medicare services if eligible under geographic requirements, as well as serve as a distant site location for a provider.

- **Inpatient service (POS 21):** This can be an originating site for Medicare services if eligible under requirements, as well as a distant site. Refer to the List of Telehealth Services for Healthcare Common Procedure Coding System (HCPCS) codes applicable to Medicare-only billing. The usual inpatient codes apply to Medi-Cal and other payers for reimbursement.
- **Emergency Room – Hospital (POS 23):** This is a great place to use the modifier applicable to stroke intervention – G0 (zero) – for remote neurologists, as geographic restrictions do not apply for Medicare beneficiaries. Other services are billable with the geographic limitation caveat and there are specific HCPCS codes applicable to the ER setting. You can find these codes on the Medicare Telehealth List that can be downloaded with the Physician Fee Schedule related materials.
- **On-Campus, Facility-Based Hospital Clinic (POS 22):** A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization can serve as an originating site, as well as a distant site. As with the other identified sites, services will be billed out using POS 02.
- **Federally Qualified Health Center (FQHC) (POS 50):** Authorized to serve as an originating site for telehealth services if the FQHC is located in a qualifying area. An originating site is the location of an eligible Medicare patient at the time the service being furnished via a telecommunications system occurs. FQHCs that serve as an originating site for telehealth services are paid an originating site facility fee.
- **Rural Health Clinic (POS 72):** A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician. May serve as an originating site in Medicare.

Indian Health Services (IHS): multiple places of service fall under the jurisdiction of Indian Health. They are:

- **Funding:** Federally funded.
- **Location:** Both on and off of surrounding reservations.
- **Customer:** Federally recognized Tribal Members from surrounding areas.

The POS codes for such entities are:

- **Tribal 638 Agreement Free-standing Facility (POS 07).**
- **Tribal 638 Agreement Provider-based Facility (POS 08).**
 - o Funding: The Tribe self-administers the funding and Health Services.
 - o Location: Tribal Reservations (Federal Trust Land).
 - o Customer: Tribal Members only.



Services

Now that we have covered Terminology and the Codes, you **may be** wondering if you can bill, yet. **Almost!** Next, we have to look at what constitutes a ‘telehealth service’.

EVALUATION AND MANAGEMENT CPT CODES

This category of CPT codes, primarily outpatient ‘office visit’, are used for telehealth, as opposed to having a separate code solely describing a telehealth E/M service (although this may change in 2025, per the AMA)²⁴. Additionally, telephone evaluation and management codes 99441, 99442 and 99443 are listed as being deleted effective January 2025. Many providers have become accustomed to billing these codes for their telephone visits during the PHE. The AMA CPT Editorial Panel’s removal of 99441-99443 may leave providers uncertain about audio-only reimbursement, requiring payers to effectively communicate how to proceed without the codes.

In an earlier version of this guide, the 2021 E&M revisions were covered. In January 2023, the guidance was updated again to encompass inpatient, observation and other sites of care, including prolonged care in these non-outpatient settings.²⁵ Briefly,

Time Component: total non-face-to-face (F2F) and F2F time per patient, per 24-hour day.

Time Documentation should include:

- Reason for visit
- Medically appropriate physical exam
- Assessment and plan
- The precise total number of minutes spent on patient care
 - o Note the time parameters that the total time falls into
 - o A description of how that time was accrued

Medical Decision Making (MDM) Component per the AMA:

- The number and complexity of problems addressed in the encounter
- The amount or complexity of data to be reviewed and analyzed. This reduces cut-and-paste note bloat by not requiring physicians to enter “voluminous,” repetitive test data that is irrelevant or ancillary to the purpose of the visit.
- Risk of complications or morbidity of patient management. This can now include social determinants of health and reasons behind decisions not to admit a patient or intervene in some way.²⁶

Note that CMS has a different code for prolonged care based on the maximum time reached (past 99205 or 99215) – G2212. Commercial payers will need to be consulted, although it is anticipated they will follow AMA CPT which is 99417, and the time is accrued from the minimum time of the level 5 time-durations.

24) [AMA CPT Editorial Summary of Panel Actions \(Feb. 2023\)](#).

25) [CPT® Evaluation and Management \(E/M\) Code and Guideline Changes](#).

26) Robeznieks, Andis, American Medical Association, “[How 2021 E/M coding changes will reshape the physician note.](#)” (November 6, 2020).



G2212:

Prolonged office or other outpatient evaluation and management service(s) **beyond the maximum required time** of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPG codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes).

99417:

Prolonged office or other outpatient evaluation and management service(s) **beyond the minimum required time of the primary** procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services.)

OTHER E/M SERVICES

As discussed above in the CPT section, CMS' list of approved telehealth codes can be found on its site. Categories of services include behavioral health, inpatient E/M, emergency department and others.

COMMUNICATION TECHNOLOGY BASED SERVICES (CTBS) - NON-TELEHEALTH TECHNOLOGY SERVICES

CTBS are represented by CPTs that describe technology-based services but are not labeled "telehealth" by CMS. Because of this, providers may bill and get reimbursed for them even if they do not meet the requirements that telehealth services must under the Medicare program. Therefore, services that take place when the patient is at home or if they live in a city could be reimbursable. During the PHE, CMS did not create many waivers involving CTBS but did allow some CTBS services to be furnished to new patients. However, post-PHE these services will only be for established patients.²⁷

The CTBS CPT codes do not require a modifier and the POS should reflect the location of where the provider normally practices medicine or provides patient care during the provision of the service. There is also no originating site facility fee for CTBS encounters since they aren't considered telehealth services.



BILLING TIP!

Can your practice bill incident-to services? Do you employ the RNs and other clinical staff? Do you work at an off-campus (physician based) facility outpatient clinic? Part B outpatient services for Professional fees are submitted on the CMS 1500 and the Facility Fee portion is submitted on the UB-04.



BILLING TIP!

Recall that a new patient visit is an allowed service for non-CTBS visits. The Telehealth CPT List has always included CPTs 99202-99205 (new patient E/M visits).

27) [CMS Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19 \(May 10, 2023\)](#)



REMOTE EVALUATION AND VIRTUAL CHECK-IN

These CTBS codes were introduced in 2019 in order to reimburse providers for a review of an image or for a brief conversation with their patients. Following that introduction, CMS noted in the 2020 final rule that the CTBS should be patient-initiated (e.g., the patient calls in and the provider calls them back)²⁸.

The definitions are:

- **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.
- **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 7 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.
- **G2252** - 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 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 11–20 minutes of medical discussion.

For providers who cannot bill independently (utilizing appropriate incident-to guidelines), the codes G2250 and G2251 are available. The service definitions are almost the same but are to be done by non-qualified health professionals.

CARE MANAGEMENT (CM) CODES

This category of CPT codes relates to services that do not involve direct or face-to-face (F2F) patient discussion or care but are important in caring for simple or complex medical conditions.



BILLING TIP!

INCIDENT-TO

Can be done when there is a direct contractual relationship between the provider and staff. Incident-to is prohibited at facilities.



MEDICARE:

FQHC'S AND RHC'S may provide virtual check-in services but the correct HCPCS is G0071 if the service is provided.

Source: Center for Medicare and Medicaid Services, "Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Question," December 2018.

28) [Federal Register, Vol 85, No 248, December 28, 2020.](#)



REMOTE PHYSIOLOGICAL OR PATIENT MONITORING (RPM)

RPM is a subset of CM codes for patients who require chronic, post-discharge or senior care. By connecting high-risk patients with remote monitoring, it can notify healthcare organizations of potential health issues or keep track of patient data between visits.²⁹ These services are again only available for established patients in a practice; although if RPM began prior to the PHE, the RPM may continue even if the patient was “new” (not seen within the practice in the past three years).³⁰

Non-Facility Sites of Service

RPM may be done under general supervision and billed by staff under an NPI-holding practitioner. You must follow the incident-to rules for different types of practices. Note that the uploading and transmission of data must be automated and cannot be billed if the data is entered manually.

- **99453:** Staff service: initial set up of device; bill after 16 days of monitoring.
- **99454:** Staff or facility service: covers initial device payment; bill after 16 days of receipt of and monitoring readings, bill every 30 days.
- **99457:** QHP service; 20 minutes of Non F2F and F2F time spent in analysis and via synchronous communication with patient the findings or care plan.
- **99458:** Add-on code; full additional 20 minutes for services described in 99457.

Facility Sites of Service

CPT codes 99453 and 99454 are found on the Outpatient Prospective Payment System (OPPS) fee schedule, Addendum B.³¹ In a facility, when a provider places the order for RPM, facility staff perform 99453 and 99454, as these cannot be billed under the ordering provider’s NPI: incident-to cannot be performed at a facility. The reimbursement figures are significantly different. Additionally, the time-based activities contributing to the 20-minute increments for 99457 and 99458 must only be performed by the provider billing under their own NPI.

Because of these limitations, facilities may choose to outsource RPM activities to a vendor. The California TRC has a toolkit to assist in choosing a vendor and could prove useful to your practice.³²

Devices

Your next question may be “what device qualifies for remote monitoring?” According to the FDA:

- The device “must be a medical device as defined by the FDA”; and
- The service must be ordered by a physician or other qualified health care professional.



BILLING TIP!

Collect 16 days of data before you bill either 99453 or 99454.

29) [US Health and Human Services: Telehealth and remote patient monitoring.](#)

30) [FAQs: CMS Waivers . . . , page 10.](#)

31) [CMS 2023 OPPS Addendum.](#)

32) [The California Telehealth Resource Center Vendor Selection Toolkit.](#)



The FDA outlines its medical device guidelines, [here](#), depending on the context of how and what you are monitoring. Here are a few examples, as outlined in a recent article by *Tech Target*:

- Glucose meters for patients with diabetes.
- Heart rate or blood pressure monitors.
- Continuous surveillance monitors that can locate patients with conditions like dementia and alert healthcare professionals of an event like a fall.
- Remote infertility treatment and monitoring.
- At-home tests that can keep substance abuse patients accountable for and on track with their goals.
- Caloric intake or diet logging programs.



BILLING TIP!

WHAT IF MY PATIENT OWNS THEIR OWN DEVICE?

Bill 99457 and 99458 only as there will be no practice expenses incurred.

Recent clarification to include omitted verbiage and update intent concerning RPM by CMS was published in the Federal Register in January 2021³³:

We also note that when a more specific code is available to describe a service, CPT indicates that the more specific code should be billed. We believe that there are additional, more specific codes available for billing that allow remote monitoring (for example, CPT code 95250 for continuous glucose monitoring and CPT codes 99473 and 99474 for self-measured blood pressure monitoring). In summary, we are clarifying that CPT codes 99453 and 99454 should be reported only once during a 30-day period; that even when multiple medical devices are provided to a patient, the services associated with all the medical devices can be billed by only one practitioner, only once per patient, per 30-day period, and only when at least 16 days of data have been collected; and that the services must be reasonable and necessary.

Figure 2 - FDA Device Definition

“Medical devices range from simple tongue depressors and bedpans to complex programmable pacemakers with micro-chip technology and laser surgical devices. In addition, medical devices include in vitro diagnostic products, such as general-purpose lab equipment, reagents, and test kits, which may include monoclonal antibody technology. Certain electronic radiation emitting products with medical application and claims meet the definition of medical device. Examples include diagnostic ultrasound products, x-ray machines, and medical lasers.”

For more information, see the FDA link at: <https://www.fda.gov/medical-devices>



33) [Federal Register, Final Rule and Interim Final Rule; Correction](#)



Finally, note that for 99457 and 99458 one interactive communication event must take place. As defined by CMS, “interactive communication” is a conversation that occurs in real-time and includes synchronous, two-way interactions that can be enhanced with video or other kinds of data as described by HCPCS code G2012. ***“We further clarified that the 20-minutes of time required to bill for the services of CPT codes 99457 and 99458 can include time for furnishing care management services as well as for the required interactive communication.”***



MEDICARE:

Do not bill RPM at the following:

- FQHCs
- RHCs
- Home Health Agencies

(However, all can claim as an expense)

REMOTE THERAPEUTIC MONITORING (RTM)

Unlike RPM, RTM does not monitor physiological vital signs but the progression of therapies performed by the patient based on a plan. In the 2022 Federal Register reporting the Medicare Physician Fee Schedule³⁴, CMS clarified that in addition to MDs and Advanced Practice Providers (APPs), physical therapists and occupational therapists can be considered a service provider as the codes are currently specific to respiratory and musculoskeletal therapies. In 2023, an additional code was added for cognitive behavioral therapy (CBT):

98975	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment
98976	Device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
98977	Device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
98978	30-day device supply with scheduled recording and/or programmed alert transmission to monitor CBT
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
98981	Each additional 20 minutes (List separately in addition to code for primary procedure)

Similar to the 99453, 98975 represents the education and set up of the device with the patient. The next two codes are specific to the body areas monitored and finally, 98980 and 98981 are similar to 99457 and 99458.

Per CMS, these services must be performed by the billing providers or under direct supervision if the services are performed by a physical therapy assistant (PTA) or occupational therapy assistant (OTA). There are two modifiers required when assistants are involved (and reimbursement is reduced by 15%):

- PTA = CQ modifier
- OTA = CO modifier

³⁴) Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-P



In addition, because these are “sometimes therapy codes”, MDs and APPs can bill these codes.

With fulfilling the requirements of these codes, privacy concerns should not be ignored. Remember that virtual care technology may outpace privacy protection policies.³⁵ For instance, fitness trackers:

- If used privately, not covered by HIPAA
- If health plan provides it, it becomes covered by HIPAA

MEDICINE SERVICES AND PROCEDURES

Medicine Services and Procedure CPT codes are located in the back of the AMA CPT book. They are a series of codes that can be done by nonphysicians, as well as physicians, and the codes below can be done non-face-to-face.

ECONSULT OR INTERPROFESSIONAL CONSULTATION CODES & EVISIT

Unlike RPM, this set of care management codes are provider-to-provider based, as opposed to provider-to-patient. The ultimate hope is that Primary Care Providers (PCPs) will be educated in how to treat patients for commonly occurring, yet specialized diseases, such as diabetes, after several consults are done. For instance, when the consults are completed, the PCP will not need to ask the endocrinologist questions as frequently. The patient also must consent each time a provider-to-provider service is contemplated, to try and prevent a billing surprise for patients. The idea is also to cut down on specialist referrals to maintain access for patients with more acute conditions.

- **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.
- **99452:** Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.
- **99446-99449:** “Interprofessional telephone/Internet/electronic health record 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 minutes through and over 31 minutes).” [Bolding added for emphasis.]

At the beginning of 2023, CMS sent a letter to state Medicaid directors informing them that Medicaid programs may cover eConsult, though it was not mandated.³⁶ Therefore, you may want to check with your state Medicaid program to determine if they have taken advantage of this advisory letter. Keep in mind that reimbursement for eConsult and other CTBS codes may only appear as a reimbursed code in the fee schedule, and there may not be any other information from the Medicaid program beyond that.

35) [Standards for Privacy of Individually Identifiable Health Information](#)

36) [CMS SHO#23-001 \(January 5, 2023\)](#).



Medicaid Example: California

Medi-Cal reimburses for CPT 99451, only, for all eConsult instances. It also requires a GQ modifier.

Medi-Cal also states in its policy: 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. In accordance with the AMA requirements, CPT code 99451 is not separately reportable or reimbursable if any of the following are true:

- The distant site provider (consultant) saw the patient within the last 14 days.
- The e-consult results in a transfer of care or other face-to-face service with the distant site provider (consultant) within the next 14 days or next available appointment date of the consultant.
- The distant site provider did not spend at least five minutes of medical consultative time, and it did not result in a written report.

Source: [California Department of Health Care Services, Medi-Cal Provider Manual: Telehealth](#)

EVISIT & ONLINE DIGITAL EVALUATION/MANAGEMENT

These E/M codes were finalized for CY 2020 and were immediately useful during the PHE. The following excerpt from the Federal Register describes the use and payment for non-National Provider Identifier (NPI)³⁷ practitioner reimbursement (clinical staff can be pharmacists, medical assistants, technicians, nurses, therapists, according to Noridian):³⁸

“99421-99423 are for practitioners who can independently bill E/M services while CPT codes 98970-98972 are for practitioners who cannot independently bill E/M services.” Medicaid programs may adopt these codes, but you will need to check with your State’s Medicaid program to determine the status.”³⁹

Finally, during the PHE, licensed clinical social workers (LCSWs), clinical psychologists, PTs, OTs and SLPs were granted use of non-physician, billing practitioner CTBS “eVisit” codes.

The e-Visit CPT codes for these billing providers who cannot perform an E/M service are as follows:

- **98970** (Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes).
- **98971** (Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes); and



BILLING TIP!

In 2021, CMS granted **permanent** use of 98970-98972 and reimbursement of LCSWs, clinical psychologists, PTs, OTs and SLP services. It will consider other, proposed practitioners throughout this year.

<https://www.cms.gov/files/document/mm12126.pdf>

37) Look up NPI or National Provider Identifier at <https://npiregistry.cms.hhs.gov/>

38) <https://med.noridianmedicare.com/web/job/specialties/em/chronic-care-management-ccm#pelegibility>.

39) [Federal Register, Final Physician Fee Schedule CY 2020, page 799](#).



- **98972** (Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes).

OTHER POTENTIAL BILLING OPPORTUNITIES IN CARE MANAGEMENT

There are other ways to benefit from the use of telehealth components in bundled management of care scenarios: chronic care management⁴⁰ (CCM) and transitional care management⁴¹ (TCM).

These two programs can be billed during the same period, as they fill two distinctly different needs. Unlike the services set out above, FQHCs⁴² and RHCs⁴³ can benefit from these programs, and as of January 1, 2019, “CCM services can be billed [by FQHC and RHC] by adding the general care management G code, G0511⁴⁴. In addition, codes for “Principal Care Management (PCM)” were released for calendar year 2020: G2064 and G2065. These were replaced by 99424 through 99427 and are intended to address the care of single diagnosis chronic care situations, either post-hospitalization or episode of onset, for short periods of time (i.e., three months).⁴⁵

For CCM and Complex CCM, a patient has two or more chronic conditions monitored by a practitioner and staff. Depending on the type of clinic, these codes may be billed if the requirements are met: a plan is established, put into use, changed if needed and monitored. Note that CCM and Complex CCM may be under “general supervision,” but remember to follow the incident-to rules.

- **99490**: 20 minutes or more per month of directed staff time for two or more chronic conditions expected to last during a 12-month period or until death. This also assumes 15 minutes of the billing practitioner’s time per month.
- **99491**: 30 minutes or more of a billing provider’s time, per month.
- **99487**: “Complex” CCM, which is 60 minutes of clinical staff time as directed by a billing practitioner with the above-required elements of 99490.
- **99489**: this is an add-on code, meaning you cannot bill it without 99487. It is for 30 minutes of time in addition to the 60 minutes of recorded time billed for a 99487.



BILLING TIP!

“When billed by a private practice [or facility] PT, OT, or SLP, the codes would need to include the corresponding GO, GP, or GN therapy modifier to signify that the CTBS are furnished as therapy services furnished under an OT, PT, or SLP plan of care.”

Source: [84532 Federal Register/Vol. 85, No. 248/Monday, December 28, 2020/Rules and Regulations](#)



BILLING TIP!

ELIGIBILITY

Eligibility requirements can vary based on number of illnesses, number of meds or repeat admits or trips to the ED – check your CPT book preamble for more scenarios

40) [Center for Medicare and Medicaid Services, Details for title 2019-07.](#)

41) [Ibid](#)

42) [Noridian Health Care Solutions, Federally Qualified Health Centers \(FQHC\) Billing Guide.](#)

43) [Noridian Health Care Solutions, RHC Billing Guide.](#)

44) [Center for Medicare and Medicaid Services, “Care Management Services in Rural Health Clinics \(RHCs\) and Federally Qualified Health Centers \(FQHCs\). Frequently Asked Questions, December 2019.”](#)

45) [2022 Medicare Physician Fee Schedule, Federal Register.](#)



Because of the 24/7 access to care requirement of CCM, a provider can use various modalities to stay in touch such as “telephone, secure messaging, secure Internet or other asynchronous non-face-to-face consultation methods (for example, email or secure electronic patient portal).”

The intent of transitional care management (TCM) is to manage post-inpatient-admission patients after they are discharged to ensure continuity of care within a 30-day period (the first day is date of discharge + 29 days). It can be performed by the discharging service or the PCP who is accepting care of the patient back into their community. There are two types of urgency:

- **Moderate/99495:** contact patient within 2 days after discharge, modality (telephone, electronic) or direct contact. A follow-up visit must occur face-to-face within 14 calendar days of discharge.
- **High/99496:** contact patient within 2 days after discharge, modality (telephone, electronic) or direct contact. A follow-up visit must occur face-to-face within 7 calendar days of discharge.

The in-person or face-to-face encounter may be conducted via telehealth [Refer to current CMS telehealth guidelines when performing via video]. However, this can stand in for the “face-to-face” or in-person encounter, which is a great benefit to the beneficiary. TCM codes can be billed during the same time period as CCM codes.

Other Considerations

You are almost ready to bill your telehealth encounters – but just a few more things to keep in mind!!

CO-PAYS & CONSENT

Medicare requires cost-sharing for all services so consent must be obtained but can be done by staff and at a non-specific time (not necessary at time service performed). Since the provider work is done either via audio or not necessarily face-to-face with the patient, it’s a good idea for either you or your staff to educate patients about the services, so they are not surprised about receiving a bill for their plan’s deductible amount or co-pay.

NON-TELEHEALTH SPECIFIC FACTORS

There are other policies to consider that could impact your telehealth billing as well as opportunities that may not be readily apparent because services are not called “telehealth” but utilize the technology. The following are a few things to keep in mind.



BILLING TIP!

- Are you the surgeon or provider who performed a procedure on the TCM patient?
 - o Then you cannot bill within the global period of the procedure.
- Are you the primary care physician or hospitalist who discharged the TCM patient?
 - o Then you can bill within a global period, within the 30 days of discharge



BILLING TIP!

The type of practice you work in – or where your practitioners provide services – dictates what can be billed, how the service is billed and whether or not incident-to billing can be utilized.



Patient demographics

Patient demographics are going to affect your billing workflows and choices. If located in a pediatric clinic, the focus will be on private payer policies and Medicaid. Think about where your patients are located and if your providers want to contract with FQHCs to better serve sites that lack specialty care.

Payer Mix and Billing Rules

What are the companies paying your invoices? How much of a percentage is Medicare or Medicaid?

- **Medicare Fee-for-Service:** Its rules are found in the Telehealth Guidelines previously referenced.
- **Medicare Advantage:** As of January 20, 2020, Advantage plans were allowed, but not required, to offer more extensive telehealth coverage as part of “base coverage” as they do for other excluded services, such as eyeglasses after cataract surgery. Telehealth policies will vary from plan to plan.
- **Commercial:** Be aware of the contracts in place for your insurance at work. Be cognizant that the state parity law may provide coverage security as well as advising that if a similarly covered “in-person” service at a clinic or hospital is conducted via telehealth that it should be paid the same.

Type of Care Services provided:

Hospice care

Telehealth can be used to conduct recertification of eligibility for hospice care through December 31, 2024.⁴⁶

Behavioral health

As outlined above, Medicare patients can receive telehealth services for behavioral health care in their homes and in any type of location such as in the country or in a city if certain requirements are met. This includes most behavioral health services, such as counseling, psychotherapy, and psychiatric evaluations. The in-person visit requirements before a patient may be eligible for tele behavioral health care services is delayed through December 31, 2024.⁴⁷



Medicaid Example: California

Medi-Cal: DHCS finalized its policy in 2022 and retained many of its pandemic temporary policies.

CCS-GHPP: CCS/GHPP was first in offering coverage for physical and occupational therapies, as well as other coverage for its patients.

Covered California: this group of payers available through the California Marketplace Exchange must offer basic coverages as mandated by the Affordable Care Act. In Calendar Year 2020, it is up to the insurance payers in the Exchange to determine whether telehealth will be covered as a “base.”



State Example: California

California law requires payment parity for services covered by private insurers.

See applicable statutes for details: [Health and Safety Code Section 1374.14](#) and [Insurance Code Section 10123.855](#).

46) Hospice Care, telehealth: [Consolidated Appropriations Act, 2023](#) , [Consolidated Appropriations Act, 2022](#)

47) In Person Requirement, Behavioral Health: [Consolidated Appropriations Act, 2023](#) , [Consolidated Appropriations Act, 2022](#) , [Consolidated Appropriations Act, 2021](#)



PREPARATION FOR BILLING AND WHERE TO FIND REIMBURSEMENT FIGURES

Each summer, CMS releases the proposed Physician Fee Schedule (PFS) for the following calendar year. The proposed fee schedule, as well as the finalized fee schedule, is published on the same web page, entitled “PFS Federal Regulation Notices.”⁴⁸ The proposed rule is indicated by a number ending in “P”; final in “F” and correction notes as “CN.” The finalized schedules are released in November.

There are folders at that link which provides Zip folders to download. The folders contain Excel spreadsheets with different numbers, but the two Zip files needed are the first one “Final Rule Addenda” and further down the long list: “Final Rule List of Telehealth Services.”

- **Step 1:** Download “Addendum B – Relative Value Units and Related Information Used in CY 20XX Final Rule”. This list will provide details on whether or not the non-telehealth codes are “A” active or not.
- **Step 2:** Then Download “CMS-XXXX-F List of Medicare Telehealth Services.” The second spreadsheet lists all the current, active telehealth services. Save the spreadsheets in a convenient place on your computer.
- **Step 3:** Next, go to your state’s Medicaid website or if you are coding multi-state encounters, you can easily find each state’s policies on the CCHP’s 50 state policy finder.⁴⁹ If there are specific CPT codes covered in those states, add them to your Telehealth spreadsheet and start to keep track of what you are billing, who is paying and who is denying and for what reasons the denials are applied.

Another option is the CMS Physician Fee Schedule CPT Look-Up tool.⁵⁰ You can type in individual or a series of CPT or HCPCS codes, specify the MAC jurisdiction in which your clinic or facility is located, and any calculation due to geographic practice location based on the conversion factor is automatically done for you. Under the MAC option, be sure to search under “Specific Locality” – otherwise you will get a long list of results based on jurisdiction identifiable only via the codes, such as the one seen to the left of “San Francisco” in the below example. Give it a try!

Type of Information
All

Select Healthcare Common Procedural Coding System (HCPCS) criteria.

HCPCS Criteria **HCPCS Code**
Single HCPCS Code G2012

Modifier
All Modifiers

Select Medicare Administrative Contractor (MAC) option.

MAC Option **Specific MAC Locality**
Specific Locality 0111205 SAN FRANCISCO-OAKLAND-BERKELEY (SAN FRA)

Start typing or use ARROW keys to change options, ENTER key to make a selection, ESC to dismiss.

Search fees

48) [Center for Medicare and Medicaid Services, PFS Federal Regulation Notice.](#)

49) [Center for Connected Health Policy, 50 State Current State Laws and Medicaid Policies.](#)

50) [CMS Physician Fee Schedule Look-Up tool.](#)



Conclusion

Now you are ready to fill in those billing forms. As you can see from the information provided, changes to telehealth billing can happen quickly, especially in these challenging times. We can't predict the future, but this guide should help give you a basis of understanding of how telehealth billing and reimbursement is affected, such as via outcomes of Congressional activity- and what will occur over the next two to three years.

Examples



PATIENT 1: The practitioner documented a synchronous telehealth visit, with an established, follow-up patient, aged 65, total time spent non-F2F and F2F of 25 minutes, with a diagnosis of XX.
Insurance: Medicare (for policies that last until December 31, 2024)

CODE IT:⁵²

- Pro Fee: 99213 (2021 E/M Outpatient Guidelines time duration = 20-29 minutes)
- Then- check the CMS Telehealth Services List.
 - CPT codes are listed in the first column, headed "Code."
 - 99213 is on the list
 - Then following interim guidelines, use POS 11, modifier 95

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated May 9, 2023			
Code	Short Descriptor	Can Audio-only Interaction Meet the Requirements?	Medicare Payment Limitations
99212	Office/outpatient visit est		
99213	Office/outpatient visit est		
99214	Office/outpatient visit est		

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE		ORIGINAL REF. NO.					
A. R09.81		B.		C.		D.		E.		23. PRIOR AUTHORIZATION NUMBER									
E.		F.		G.		H.		I.		J.									
I.		J.		K.		L.													
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. REPORT RATE		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY														
05	29	23				11	99213	95	A			1			NPI	9999999999			

There is no need to check the patient's originating site clinic address on the HRSA site, as the patient may be at home or in any geographic location until December 31, 2024.

Put the address of the distant site provider (the person performing the service) in Box 32. Note that this is the address of the "usual" clinic address or if the majority of telehealth services are done in the provider's home, suppress the address via PECOS, as set out above.

52) You may refer to the [List of Medicare Telehealth Services](#) or the AMA's CPT book Appendix P for the list of covered telehealth codes.



Facility Fee/HOPDs (If the patient was in a facility and not at home): For in-clinic encounters, the G0463 is billed for all outpatient evaluation and management visits. BUT

- For telehealth, CMS will not pay for distant site facility charges.
- The originating site facility can bill Q3014 (originating site facility fee) and that can be submitted on the CMS 1500 or UB-04.



PATIENT 2:

Synchronous telehealth visit, follow-up patient, aged 25, documented 99213 (25 minutes total time), analysis and interpretation of Continuous Glucose Monitoring (CGM) data (95251), diagnosis XX.

Insurance: Medi-Cal

Originating Site: Home

Distant Site: Hospital Outpatient Department

CODE IT:

Since this is Medi-Cal, its policy states that any medically necessary service that is feasible via telehealth is reimbursed, so there is no need to check any CPT Code list. The CGM interpretation is now separately reimbursable (as of May 2023) and has global days of XXX, thus no modifier 25 is required^{53,54} In addition, Medi-Cal requires a 95 modifier for the E/M encounter, so your CMS 1500 would look like this:

95251 is not a telehealth service and does not require modifier 95. However, the analysis and interpretation took place in the office, so POS 22 goes onto the same claim but as a separate line item.

Finally, bill the allowed transmission fee code T1014 x the # of minutes for the F2F portion of the encounter (15 minutes). No modifier.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.		22. RESUBMISSION CODE		ORIGINAL REF. NO.													
A	B	C	D	E	F	G	H	I	J																		
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9 PT. PROC. PLAN		I. ID. QUAL.		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY	SERVICE	EMG	CPT/HCPCS	MODIFIER																		
05	29	23				02		99213	95			A				1				NPI	999999999						
05	29	23				11		95251				A				1				NPI	999999999						
05	29	23				02		T1014				A				15				NPI	999999999						

53) [Provider Bulletin, 6](#), CPT codes 95250 and 95251 Added as a Medi-Cal Benefit.

54) Medi-Cal Modifiers: [Approved List, Updated August 2020](#).



PATIENT 3: 65-year-old patient meets with staff of an independent clinic to be fitted for/educated about a remote monitoring device with Bluetooth capabilities to keep track of her blood pressure.

The physician interprets the transmitted data for 15 minutes and has a synchronous conversation with the patient about her blood pressure for another 25 minutes.

Insurance: Medicare

CODE IT:

The codes for remote monitoring were outlined, above. As a private practice, POS 11 is used. This is not telehealth, according to Medicare, so POS 02 is not applicable in this situation.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)													22. RESUBMISSION CODE		ORIGINAL REF. NO.					
A	B	C	D	ICD Ind.									23. PRIOR AUTHORIZATION NUMBER							
R03.0																				
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #						
From	To	MM	DD	YY	MM	DD	YY	CPT/HCPCS	MODIFIER											
05	29	23			11			99453					A				1		NPI	9999999999
05	29	23			11			99454					A				1		NPI	9999999999
05	29	23			11			99457					A				1		NPI	9999999999
05	29	23			11			99458					A				1		NPI	9999999999



PATIENT 4: 45-year-old patient meets with staff of an FQHC clinic to be fitted for/educated about a remote monitoring device on the 15th of the month and undergoes monitoring that lasts through the 16th of the next month (30 days). The physician interprets the data and communicates to the patient about changing her regimen.

Insurance: Medi-Cal

CODE IT:

There is nothing to be billed with regard to RPM. The place of treatment is at an FQHC; however, the visit with the patient can be billed.



PATIENT 5: 74-year-old man has consented to an eConsult, as he agrees his Primary Care Provider (PCP) should consult with an endocrinologist. The PCP prepares the clinically relevant question to the endocrinologist. The endocrinologist responds back to the PCP and PCP contacts patient to engage in care plan per the specialist’s recommendations.

Insurance: Medicare

CODE IT:

PCP Coder: The PCP documented the question, received the information back, and communicated the findings and care plan back to the patient. The PCP documented 35 minutes of time.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.													22. RESUBMISSION CODE		ORIGINAL REF. NO			
A.	B.	C.	D.	E.	F.	G.	H.	I.	J.				23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT (Only for Minors)	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From	To	YY	MM	DD	EMG	OPT/HCP/CS	MODIFIER											
MM	DD	YY	MM	DD	YY													
E10.65																		
05	30	23				11		99452	A		1		NPI	9999999999				

Specialist Consultant Coder: the specialist, located at a tertiary care center in a facility-based clinic, documented the response and indicated at least 5 minutes of time was spent in the consideration of the reported findings and in responding to the question.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.													22. RESUBMISSION CODE		ORIGINAL REF. NO			
A.	B.	C.	D.	E.	F.	G.	H.	I.	J.				23. PRIOR AUTHORIZATION NUMBER					
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT (Only for Minors)	I. ID. QUAL.	J. RENDERING PROVIDER ID. #				
From	To	YY	MM	DD	EMG	OPT/HCP/CS	MODIFIER											
MM	DD	YY	MM	DD	YY													
E10.65																		
05	21	23				22	I	99451	A		1		NPI	9999999999				



PATIENT 6: 35-year-old man has consented to eConsult. Primary care physician (PCP) prepares question to a specialist. Specialist responds back to the PCP and PCP contacts patient to engage in care plan per the specialist’s recommendations.

Insurance: Medi-Cal

CODE IT:

PCP Coder: The coder has nothing to do. Medi-Cal only reimburses for the specialist’s activities. However, a follow-up visit might be done if there is follow-up activity advised by the specialist that the PCP can act on.

Specialist Consultant Coder: Same scenario as for Patient 5, above, but with a GQ modifier on the 99451.



PATIENT 7: 65-year-old woman discusses results of genetic testing regarding cancer diagnosis with a Genetic Counselor at a facility-based cancer center.

Insurance: Medicare

CODE IT:

Medicare does not cover genetic counseling services, as the provider type is not included on its list of eligible telehealth providers. Submit the service on the UB-04 with the GY modifier.

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / ICDPS CODE	45 SERV DATE	46 SERV UNITS	47
780	Telehealth - General	96040-GY	01/29/21	1	



PATIENT 8: 36-year-old woman discusses results of genetic testing during pregnancy with a Genetic Counselor for one hour at a facility.

Insurance: Medi-Cal

CODE IT:

Medi-Cal reimburses for genetic counselors (as does GHPP/CCS). Submit with the 96040-equivalent code – S0265, the HCPCS code billed in 30-minute increments for genetic counseling.

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / ICDPS CODE	45 SERV DATE	46 SERV UNITS	47
780	Telehealth - General	S0265-95	01/29/21	2	

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