Medicare Billing for Telehealth Encounters

AN INTRODUCTORY GUIDE FOR FEE-FOR-SERVICE

SEPTEMBER 2024

Center for Connected Health Policy

THE NATIONAL TELEHEALTH POLICY RESOURCE CENTER

Introduction

The post-COVID-19 Public Health Emergency (PHE) temporary waivers enacted by Congress via the Consolidated Appropriations Act of 2023 for Medicare encounters remain in place through December 31, 2024. Although there are multiple pieces of legislation[1] moving through Congress to either make permanent certain aspects or extend these waivers through 2026, at the time of this billing manual's publication, no legislation has been passed. Should any of these bills be enacted, it is possible that some currently existing policies may be changed.

This billing guide covers what is in effect through the end of 2024. While this update comes late in 2024, there have been several updates, clarifications and refinements to federal telehealth policy that would have rendered information in any document published earlier in the year outdated or inaccurate. The first section contains an overview of Medicare telehealth permanent policy to contrast it with the temporary COVID policy that generally allows for broader telehealth reimbursement and/or waives certain permanent policy provisions. Depending on when you may be reading the manual, important information affecting reimbursement may have changed. The Center for Connected Health Policy (CCHP) suggests if you are uncertain whether new or updated policies have been enacted that you:

- Contact CCHP;
- Contact your regional telehealth resource center;[2] or
- Contact your Medicare Administrative Contractor (MAC)[3] for more information.

Ultimately, this guide is for Medicare. Medicaid and commercial payers have different policies regarding what they will reimburse for covered telehealth services. In some instances, we will include examples of what other payers may require (which also can frequently change). If you are billing a payer other than

TOPICS COVERED IN THIS DOCUMENT

1. CCHP Pending Legislation: Federal *(Accessed August 10, 2024)*
2. National Consortium of Telehealth Resource Centers. *(Accessed Aug. 14, 2024)*.
3. Center for Medicare and Medicaid Services, What Is A MAC? *(Accessed Aug. 14, 2024)*.

© Public Health Institute/Center for Connected Health Policy 2024

Medicare, you will need to refer to their policies, although Medicare sometimes is the basis upon which a payer's coverage is developed.

CCHP has updated the format of this guide to help make it more easily navigable. The contents of the guide include:

- **Medicare Basics: Telehealth Policy**
  - o Permanent Medicare Telehealth Policy
  - o Current/Temporary Medicare Telehealth Policy
  - o What a distant site practitioner needs to know
  - o What the originating site needs to know
  - o What a hospital/facility needs to know

- **Communication Technology Based Services (CTBS)**
  - o Remote Evaluation and Virtual Check-In
  - o Remote Physiological or Patient Monitoring (RPM)
  - o Remote Therapeutic Monitoring (RTM)
  - o eConsult or Interprofessional Consultation Codes & eVisit
  - o Chronic Care Management, Transitional Care Management and Principal Care Management

Finally, this guide is not "general billing 101" and we assume the reader has a basic understanding of claims billing in order to focus upon virtual care caveats and nuances. Please keep in mind that this guide is provided strictly for informational and educational purposes. CCHP makes no guarantee on reimbursement and as noted above, information can change from what is currently in this guide.

Medicare Basics: Telehealth Policy

Permanent Medicare Telehealth Policy

In order for a practitioner to be reimbursed by Medicare for a telehealth service, certain conditions are required:

1. The patient must be located in a specific type of originating site, both geographically (rural area) and in a specific type of health facility/building with some exceptions.
2. The telehealth service practitioner (or distant site practitioner) must be an eligible provider.
3. The service provided must be on the Medicare List of Telehealth Services (indicating the service meets applicable policy).
4. The modality used to provide the service must qualify based upon medical necessity, patient preference and/or ability (available broadband, etc.).[4]

4) Social Security Act Section 1834(m)(m).

© Public Health Institute/Center for Connected Health Policy 2024

Under permanent Medicare policy, the chart below illustrates the current permanent policy for the above four requirements[5]:

PERMANENT TELEHEALTH POLICY FOR MEDICARE			
Site – Geographic	**Site – Facility/Place (Originating Site)**	**Telehealth/ Distant Site Provider**	**Modality**
An area that is designated as a rural health professional shortage area;[6] a county that is not included in a Metropolitan Statistical Area OR an entity participating in a federal telehealth demonstration project. Certain exemptions are made in specific cases such as for treatment of stroke.	• 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)	• 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 • Marriage and Family Therapists and Counselors	• Live Audio & Video • Store & Forward (only for telehealth demonstration programs in Alaska & Hawaii) • Audio-Only (only for certain mental/behavioral services if certain conditions met)

** Geographic limit may not apply to these facilities in specific circumstances such as the geographic limitations on originating site are removed for treatment and diagnosis of acute strokes. Additionally, the provision of mental health services via telehealth without meeting the geographical or site requirements is also allowed if certain additional requirements are met such as a prior in-person visit with the telehealth provider six months before the delivery of services via telehealth, and annually thereafter.[7] Additionally, through the 2022 Physician Fee Schedule, CMS changed the definition of a "mental health visit" for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to include use of live video and audio-only to provide those services. However, as this was a regulatory change to the definition of what is a mental health visit for these organizations, it was not regarded as telehealth. Therefore, this policy applying to FQHCs and RHCs is not addressed in this manual.[8]*

Medicare List of Telehealth Services

CMS has a specific list of services that may be provided via telehealth. During the PHE, certain services were temporarily added to this list. Between the years of 2020 and 2024, some of these temporary additions were either made permanent or taken off the list. Additionally, only certain services may be provided via audio-only. Some services still retain a temporary status through the end of 2024. You can find the current list of eligible services on CMS' website.[9]

5) Ibid.
6) HRSA Telehealth Site Eligibility Analyzer (Accessed Aug 8, 2024).
7) Consolidated Appropriations Act of 2021. (Accessed Aug. 14, 2024).
8) Federal Register, 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-Payment Medical Review Requirements, Vol, 86, No. 221 (Nov. 19, 2021), p. 213. (Accessed Aug 14, 2024).
9) Center for Medicare and Medicaid Services, List of Telehealth Services. (Accessed Aug. 19, 2024).

© Public Health Institute/Center for Connected Health Policy 2024

Current/Temporary Medicare Telehealth Policy

Because of the continuation of certain COVID-19 waivers through the end of 2024, the current conditions differ from the permanent ones set out above:[10]

CURRENT TELEHEALTH POLICY IN MEDICARE (WITH TEMPORARY WAIVERS APPLIED)			
Site – Geographic	**Site – Facility/Place**	**Provider**	**Modality**
Geographic requirement/ restrictions waived until the end of 2024.	Site location waived until the end of 2024.	All providers eligible to provide services under the Medicare program and can appropriately provide the eligible services (including FQHCs/RHCs)	• Live Audio & Video • Audio-Only (only for certain specific codes, see CMS service list)

As an example of how payer policies can differ, below is an example of California's Medicaid program.[11]

CALIFORNIA CURRENT MEDICAID POLICY			
Site – Geographic	**Site – Facility/Place**	**Provider**	**Modality**
N/A	N/A	All providers eligible to provide services in Medicaid and can appropriately provide the service being billed	• Live Video • Store-and-Forward • Audio-Only • RPM (Limited)* • eConsult (Limited)*

**For Medicare, RPM and eConsult services come under Communication Technology Based Services (CTBS). See that section for more information.*

California Medicaid unlike CMS does not have a specific list of telehealth services, though other state Medicaid programs may also use a specific list of covered services similar to Medicare. Instead, California's Medicaid policy allows the provider to decide on the appropriate modality (live video, store-and-forward, or audio-only) as long as the service is medically appropriate (for example, not requiring an in-person element). California Medicaid's allowance of store-and-forward and audio-only has a few more conditions that must be met to be allowed in providing the service (for instance, limitations to established patients). You can check CCHP's Policy Finder for more information.

What a distant site practitioner needs to know

If you belong to a medical group contracted to perform work in a facility or own your own business, you bill for a telehealth-delivered service just as you would if the service had been provided in-person, entered on the professional fee invoice known as the CMS-1500. The mechanics of billing are the same for the most basic and straightforward telehealth interactions, although some of the information that's requested is different.

10) Center for Medicare and Medicaid Services MLN Fact Sheet, Telehealth Services (April 2024). (Accessed Aug. 14, 2024).
11) California Department of Health Care Services Medi-Cal Program, Provider Manual: Medicine: Telehealth (March 2024). (Accessed Aug. 14, 2024).

© Public Health Institute/Center for Connected Health Policy 2024

1. What service did you provide?

Once you have determined what CPT[12] code describes the telehealth service you have provided, look for it on the Medicare List of Telehealth Services. If the code does not appear on that list, it is not eligible for reimbursement. If it is, enter it into the CMS-1500, as you would any other service.

2. What modality did you use to provide the service?

If you provided a service via live video and it is on the Medicare List of Telehealth Services, you can proceed to invoice creation and submission. If you plan to perform the service via audio-only, you also need to check the list to see if it was audio-only eligible. Services provided via store-and-forward are only reimbursed in telehealth demonstration programs ongoing in the states of Alaska and Hawaii. If you are not a demonstration program in Alaska or Hawaii and you provided a service asynchronously, you will not be reimbursed under existing (permanent and temporary) telehealth rules. (However, you may still be eligible for reimbursement through CMS' Communication Technology Based Services (CTBS) policy, see below.)

The type of modality used (live video or audio-only) is indicated by affixing a modifier on the CPT code when filling out the CMS 1500:

- **GQ** (not used unless you are in an Alaska or Hawaii telehealth demonstration project): asynchronous telehealth service.
- **GT:** Critical Access Hospital distant site providers billing under CAH Optional Method II.
- **FQ:** A Medicare 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.*

Other modifiers that may be used when billing for telehealth:

- **G0** (zero): Used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
- **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.

3. What type of provider are you?

Under permanent Medicare telehealth policy, there is a specific list of practitioners who are eligible to provide services and be reimbursed by the program (see Permanent Telehealth section). However, under the temporary telehealth waivers, all Medicare eligible billing providers can be reimbursed for providing eligible services via telehealth. Note, the waiver has allowed certain providers such as physical and occupational therapists as well as FQHCs and RHCs to provide services via telehealth during this temporary waiver period, otherwise they would not qualify as an eligible telehealth provider as was noted earlier.

12) AMA Current Procedural Terminology definition (accessed August 10, 2024)

© Public Health Institute/Center for Connected Health Policy 2024

4. Where was the patient located at the time of the telehealth interaction?

Due to the temporary waivers in Medicare telehealth policy, the geographic and specific site limitations have been waived through the end of 2024. Therefore, currently where the patient is located does not impact reimbursement eligibility. However, you will still need to supply information about the patient's location at the time of the telehealth interaction by using a place of service (POS) code placed on the CMS 1500 to let the Medicare Administrative Contractor (MAC) know where the patient was at the time of the encounter.

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.

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. CMS has also indicated that other locations maybe considered the home such as if the patient needs to travel a short distance to access connectivity.[13]

5. Is the practitioner's location important?

The practitioner's location, or distant site, during the telehealth interaction does not affect eligibility of the service being covered, but it is important for calculating the amount the practitioner is paid by the MAC for the service provided. 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."[14] For instance, if a practitioner is located and also licensed in Florida, but provides a service to a patient located in California, that practitioner's home address is reported to the MAC in Florida. The CMS 1500 is also submitted to the MAC covering Florida (which at this time is First Coast Services Options, Inc.) to achieve the cost-of-living appropriate payment. In this example, the practitioner will also have to be enrolled with two MACs as California and Florida are covered by different MACs.

PECOS: Medicare's Provider, Enrollment, Chain and Ownership System is where a provider will update their location and enroll with the different Medicare Administrative Contractors. Doing so will allow different MACS to reimburse one provider, since a provider can enroll in multiple jurisdictions.

Source: Medicare Enrollment for Providers

While the Social Security Act (SSA) section specifies payment parity, the amount is dependent upon where the provider practices. Under permanent telehealth policy, Medicare pays the "facility" professional fee rate, which is lower than the non-facility rate. The professional fee facility rate is lower because the patient is in an originating site facility during the telehealth interaction. Some of the costs are reimbursed to that originating site via HCPCS[15] Q3014[16] and thus the telehealth provider experiences less costs, and earns a lower amount. For example, formerly under permanent Medicare policy if the patient is at home, POS 10 would result in the practitioner reimbursement at the facility rate (lower amount). However, in the Physician Fee Schedule for 2024, CMS noted that it will pay the non-facility rate even when the patient is at home and even though the permanent policy would indicate that the facility rate would be paid. CMS stated in

13) Federal Register, 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-Payment Medical Review Requirements, Vol, 86, No. 221 (Nov. 19, 2021), p. 55. (Accessed Aug 14, 2024).
14) Medicare Online Manual, Section 10.3.1.4.3 – Additional Form CMS-855R Policies and Processing Alternatives.
15) Healthcare Common Procedure Coding System (accessed August 9, 2024).
16) Medicare Telehealth Originating Site Facility Fee (Accessed Aug 14, 2024).

© Public Health Institute/Center for Connected Health Policy 2024

their reasoning for this 2024 decision that they believed telehealth practitioners would still be incurring costs though some patients would not be on the practitioner's premises. A recent CMS notice[17] issued in July 2024 indicated that "the payment rate for POS 10 is the non-facility rate (NF). Use of audio-only (93) or audio-video (95) does not change rate of payment, only the POS code determines the non-facility or facility payment rate."

Another issue practitioners should be aware of are licensure requirements of the state the patient is located in during the telehealth interaction. CMS has noted that it defers to the state's policy on licensure. However, one largely consistent fact for CMS billing is that the provider must have a license in two locations: the state where the patient is located and another for the state in which the provider is located.[18]

One area where a practitioner's location can specifically impact whether they are reimbursed by CMS or not, is if the practitioner is located outside of the United States or its territories during the telehealth interaction. *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.[19]

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 extended this exception through the end of 2024.[20] The proposed fee schedule for 2025 is seeking to extend the delay for an additional year. Additionally, in a new notice from CMS this year, they clarified that while the Agency will still require the provider location address, it will allow for that to be either a post office box or personal mailbox offered by a private delivery service if the provider's NPI is entity type code = 1 and does not have a physical location other than their home.[21]

The practitioner now has the information needed to bill Medicare.

EXAMPLE

The practitioner documented a synchronous live audio-video visit, with an established, follow-up patient located in their home, aged 65, total time spent non-face-to-face and face-to-face of 25 minutes, with a diagnosis of XX. This patient's visit is covered by Medicare (for policies that last until December 31, 2024).

The result?

CPT Service Code: 99213 (2021 E/M Outpatient Guidelines time duration = 20-29 minutes) 99213 is on the Medicare eligible telehealth services list.

POS 10.

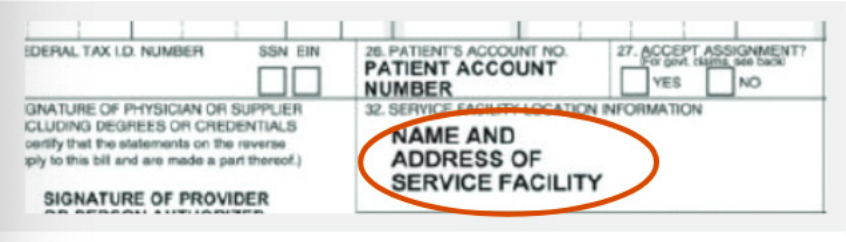
The service was provided via synchronous live video. Modifier 95.

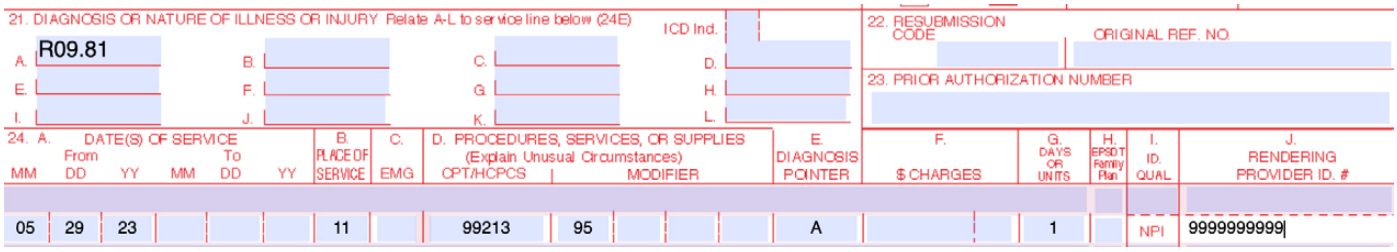
There is no need to check the patient's originating site clinic address on the HRSA site, as the patient may be at home or in any geographic location until December 31, 2024.

17) US Department of Health and Human Services, CMS Manual System Pub 100-04 Medicare Claims Processing Transmittal 12671 (June 6, 2024). (Accessed Aug 14, 2024).
18) Center for Medicare and Medicaid Services, MLN MM8545 (Feb 25, 2014). (Accessed Aug. 14, 2024).
19) RICU LLC v. United States Department of Health and Human Services.
20) Center for Medicare and Medicaid Services: Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19 (Nov. 6, 2023). (Accessed Aug. 14, 2024).
21) Federal Register, National Plan and Provider Enumeration System (NPPES) Data Changes. (March 4, 2024).

© Public Health Institute/Center for Connected Health Policy 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.





What does the originating site need to know

If you are the originating site hosting the patient in its clinic space, while the telehealth encounter takes place with the distant site provider, under Medicare you are eligible to receive an originating site fee. The originating site fee is to help offset the costs incurred by the location hosting the patient. There is no originating site fee if the patient is in a non-health care setting (at home or work for example) during the telehealth interaction. However, if you are a clinic, doctor's office or nursing home, you can bill the originating site fee. You cannot bill a service unless you provided some service separate from the telehealth visit. The code used to bill the originating site fee is Q3014 and in 2024 it pays $29.96.

What a hospital/facility needs to know

Facilities billing for auxiliary staff telehealth services utilize a different invoice than providers billing for professional fee services. The form requires the use of revenue codes to indicate the type of service provided by the facility, as well as the aforementioned CPT codes. A revenue code describes a category of service and is entered on a UB-04 form. 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] There is no place to indicate place of service.

For professional fee providers who practice medicine at a facility (as opposed to a non-facility), billing is slightly more complicated. Due to the waiver policies that allow the patient to be in their home, a situation is created in deciding what POS to use to show where the service takes place. Instead of using POS 10 like a provider in a non-facility clinic, if the patient is at home, CMS instructed hospital outpatient department (HOPD) and provider-based department (PBD) clinics to use the POS that would have been used had the patient come into the clinic and appending modifier 93 or

22) Value Healthcare Services Understanding Hospital Revenue Codes. (Accessed Aug 14, 2024).

© Public Health Institute/Center for Connected Health Policy 2024

95 (depending on modality) on the relevant CPT code for the services. This payment is at the non-facility physician reimbursement rate. Depending on the situation, the form that is used to submit a claim, codes used and the amount paid can be very different. For example, if you are a practitioner billing from a facility location instead of a non-facility location:

PATIENT/PROVIDER LOCATION	POS CODE USED	ORIGINATING SITE FACILITY FEE
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	

Some of the POS codes that might be used in this situation are:

- **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.

Due to the Consolidated Appropriations Act (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.[23]

Practitioner assigns billing rights to a facility

If a practitioner is located in and assigned their billing rights to a Critical Access Hospital (CAH) and the outpatient Optional Payment Method II is selected, then the CAH and not the practitioner will bill for the service. However, the payment will be

23) Center for Medicare and Medicaid Services FAQ After the PHE (May 19, 2023), pg. 7. (Accessed Aug 14, 2024)

© Public Health Institute/Center for Connected Health Policy 2024

less than what is noted on the physician fee schedule for that service. In this scenario, the CAH will receive 80% of the PFS distant site facility amount for the service provided via telehealth.

Note however, that recently CMS finalized new regulations regarding the amount of reimbursement if a practitioner assigns their billing rights to a CAH that is participating in a Frontier Community Health Integration Project demonstration program. The new rule goes into effect on October 1, 2024. See the Federal Register notice for more details.[24]

Federally Qualified Health Centers/Rural Health Clinics

Due to the extension of the temporary waivers, FQHCs and RHCs are allowed to act as distant site telehealth providers. However, these entities will bill slightly differently. For all telehealth delivered services, FQHCs and RHCs will use G2025 or 052X for any approved telehealth service as opposed to using the specific CPT or HCPCS code on the eligible telehealth services list. FQHCs and RHCs will not receive their typical rate for telehealth delivered services, but instead a rate calculated by CMS based on the fee schedule. For 2024, this rate is $95.27.[25]

Additionally, as was noted earlier, along with the temporary waivers, a permanent change was made to the definition of a "mental health visit" for FQHCs and RHCs to include delivery of services via live video or audio-only if certain conditions have been met such as a prior in-person visit and annual in-person visits thereafter (a similar waiver was also made for other providers).[26] This 2022 change has allowed FQHCs and RHCs to provide qualifying mental health visits via live video and audio-only, however it is not regarded as a telehealth visit. Therefore, FQHCs and RHCs will not use G2025 or 052X for billing nor will they receive the telehealth calculated rate of $95.27, but their usual prospective payment or all-inclusive rate.

The National Association of Community Health Centers has resources specifically for FQHCs in regards to billing for telehealth such as their Reimbursement Tip Sheet.

Communication Technology Based Services (CTBS)

Under Medicare, Communication Technology Based Services (CTBS) are services that utilize technology to deliver that service, but are not regarded as telehealth-delivered services. They can be provided synchronously and asynchronously. What's the difference between CTBS and telehealth? For Medicare, services delivered via telehealth are services you will typically receive in-person. For example, you have a regular office visit with a patient. That can be done either in-person or via telehealth. However, if you were monitoring a patient over a period of days, for example their blood pressure, that patient would not typically go to their practitioner's office several times a day over a consecutive period of days to have their blood pressure taken. These types of services that aren't normally provided in-person or have no in-person equivalent, but can be provided because of technology, fall under the category of CTBS. Under CTBS is where you will see remote monitoring services, and where it was noted earlier that asynchronous services may also take place without meeting the statutory requirements telehealth services face. Note, this is Medicare's policy and it is not necessarily replicated in state Medicaid programs or commercial payers. Therefore, it is always wise to check with the payer in question on what services are covered and reimbursed if technology is used.

24) Federal Register, Medicare and Medicaid Programs and the Children's Health Insurance Program: Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Progams Requirements; and Other Policy Changes. (Accessed Aug 19, 2024).
25) Telehealth.hhs.gov, Billing Medicare as a safety-net provider. (Accessed Aug 14, 2024).
26) Center for Medicare and Medicaid Services Medicare Learning Network, MLN 006397 (Jan 2024). (Accessed Aug 14, 2024).

© Public Health Institute/Center for Connected Health Policy 2024

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.

The following are the categories of technology-enabled services that fall under CTBS and are covered by Medicare.

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 PFS final rule that the CTBS should be patient-initiated (e.g., the patient calls in and the provider calls them back)[27].

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. (NOTE: A proposal has been made by CMS to eliminate this code and replace it with another for 2025).
- **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.

You will note that G2010's definition is for asynchronous services and is the store-and-forward option for providers that was mentioned earlier. 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 patient discussion or care but are important in caring for simple or complex medical conditions.

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.[28] 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).[29]

27) Federal Register, Vol 85, No 248. December 28, 2020. (Accessed Aug 14, 2024).
28) Telehealth.HHS. Gov, US Health and Human Services: Telehealth and remote patient monitoring. (Accessed Aug 14, 2024).
29) Center for Medicare and Medicaid Services, FAQs: CMS Waivers (May 9, 2023), page 10. (Accessed Aug 14, 2024).

© Public Health Institute/Center for Connected Health Policy 2024

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.

Remote physiological monitoring codes include:

- **99091:** The provider interprets medical information, such as ECG recordings, blood pressure records, and home glucose monitoring results, received in digital form from a patient or his caregiver requiring at least 30 minutes of the provider's time. A physician or other qualified healthcare professional may report this code once each 30–day period. (But not at the same time as any of the following CPT codes).
- **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 face to face and face to face 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.[30] 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.

To bill for these facility RPM services to Medicare, the UB-04 form is used. Although the below example states "Month", RPM is every 30 days so the billing staff would indicate "July 1-July 30", with a description of 16 days' data collection completed, list the procedure code, unit of 1, and the charge.[31] The second example demonstrates how the 99453 would be billed, as it is a one-time code, although only billable after 16 days' of data is collected.

Medicaid Example: California

Medi-Cal pays for RPM for patients 21 years of age and up. The Evaluation and Management Provider Manual was updated in December 2021 to include Remote Physiological Monitoring. Review the CCHP website to check your state's reimbursement of these services.

30) Center for Medicare and Medicaid Services 2023 OPPS Addendum. (Accessed Aug 14, 2024).
31) UB-04 Special Billing Instructions for Outpatients example from California Medicaid Manual.

© Public Health Institute/Center for Connected Health Policy 2024

Unit Type as "Month"

Procedure codes with a unit type of "Month" must be billed using the "from-through" method. *Figure 1*, below, is an example of "From-Through" billing.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1		SERVICES FOR JULY		070307		
2		7/3, 7/7, 7/13, 7/19, 7/24, 7/31	Procedure code	073107	6	129000
3						
4						

Figure 1: "From-Through" Billing Example.

Line-Item Billing

Line-item billing is illustrated in *Figure 2* below. This method must be used for all services on the *UB-04* claim, except when using the "from-through" billing method.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1		UNLISTED THERAPEUTIC INJECT.	90772	070307	1	4000
2						
3						
4						

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

According to the Food and Drug Administration (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.

More information reqarding medical devices can be found on the FDA website[33]. A few examples of devices that are regulated are:

- 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

Patient owns their own device.

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

32) The California Telehealth Resource Center Vendor Selection Toolkit. (Accessed Aug 14, 2024).
33) US Food & Drug Administration, Overview of Device Regulation. (Accessed Aug 19, 2024).

© Public Health Institute/Center for Connected Health Policy 2024

Medicare:

Do bill RPM using HCPCS G0511 (as well as other CCM services) at the following:

- FQHCs
- RHCs
- Home Health Agencies

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."***[34] [Bolding added for emphasis.]

Remote Therapeutic Monitoring (RTM)

RTM was introduced in order to provide improved health outcomes by leveraging technology to monitor and manage patients' health remotely. It improves access to care, provides timely interventions, is cost-effective and moreover increases patient engagement in improving their health outcomes. The following codes were created based upon the RPM codes, but monitor activities as opposed to a physiological state.

- **98975** – Remote therapeutic monitoring (e.g., 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 (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
- **98977** – Device (s) supply with scheduled (e.g., 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 cognitive behavioral therapy (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. Codes 98976 and 98977 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

BILLING TIP

The CPT code is "carrier priced," per CMS. This means that you must check with your MAC to see what your clinic or facility will be reimbursed.

34) Centers for Medicare and Medicaid Services, Final Policy, Payment, and Quality Provisions Changes to Medicare Physician Fee Schedule for Calendar Year 2021 (Dec. 1, 2020).

© Public Health Institute/Center for Connected Health Policy 2024

In addition, because these are "sometimes therapy codes", MDs and NPPs can bill these codes.

With fulfilling the requirements of these codes, privacy concerns should not be ignored. In recent years, the Office of Civil Rights which oversees HIPAA has issued several guidances for practitioners and patients regarding telehealth and privacy.[35] It is important for all parties, particularly practitioners to understand what their responsibilities are regarding protection patient health information and in what situations HIPAA and other privacy rules would apply. For instance, fitness trackers:

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

eConsult or Interprofessional Consultation Codes & eVisit

eConsult/Interprofessional Consultation Codes

eConsult or Interprofessional Consultation Codes are provider-to-provider based, as opposed to provider-to-patient. 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, 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.

EXAMPLE:

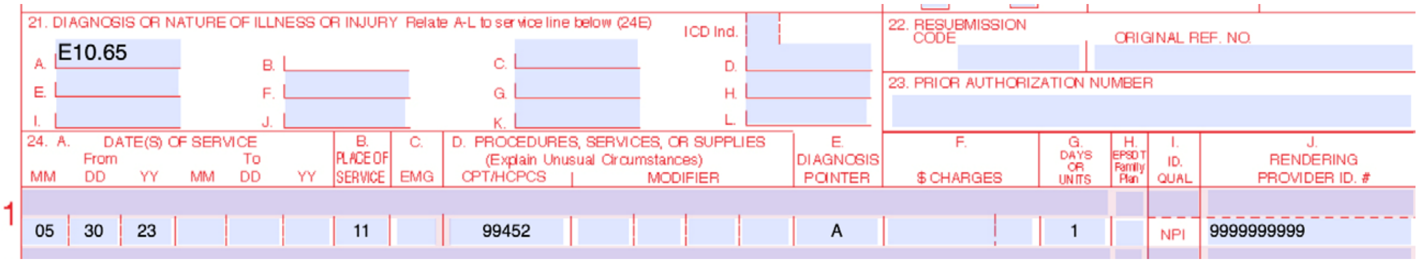
PATIENT B: 74-year-old man has consented to an eConsult, as he agrees his Primary Care Provider (PCP) should consult with an endocrinologist. The PCP prepares the clinically relevant question to the endocrinologist. The endocrinologist responds back to the PCP and PCP contacts patient to engage in care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

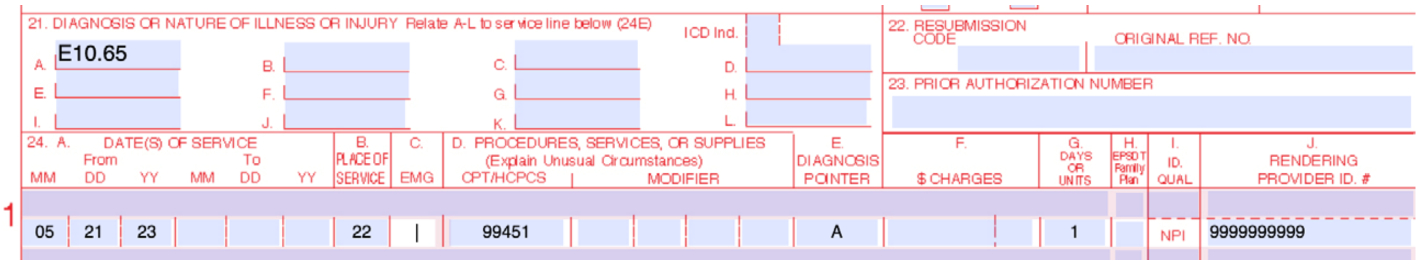
35) US Department of Health and Human Services, Office of Civil Rights, HIPAA and Telehealth (Accessed Aug. 19, 2024).
36) Center for Medicare and Medicaid Services SHO # 23-001 (January 5, 2023). (Accessed Aug 14, 2024).

© Public Health Institute/Center for Connected Health Policy 2024


21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. E10.65 B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 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.
A. E10.65 B. C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1 05	21	23				22		99451		A		1		NPI	9999999999

Medicaid Example: California

Medi-Cal reimburses for CPT 99451 and 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

There are also a set of e-Visit codes that non-physician practitioners who cannot bill independently for E/M services can use. As was noted in the Physician Fee Schedule for CY 2020:

> *"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."*[37]

37)) Federal Register, CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savins Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of Ambulance Data Collection System, Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule. P 799. (Accessed Aug 20, 2024).

© Public Health Institute/Center for Connected Health Policy 2024

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 and were granted permanent use in 2021.[38] 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
- **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).

Chronic Care Management, Transitional Care Management and Principal Care Management

Two other sets of services under CTBS are chronic care management[39] (CCM) and transitional care management[40] (TCM). These two programs can be billed during the same period, as they fill two distinctly different needs. Unlike the services set out above, FQHCs[41] and RHCs[42] 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, G0511."[43] 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).[44]

Chronic Care Management (CCM)

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.

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

38)) Center for Medicare and Medicaid Services, MLN 12126 (Dec 31, 2020). (Accessed Aug 20, 2024).
39) Center for Medicare and Medicaid Services, Details for title 2019-07. (Accessed Aug 14, 2024).
40) Ibid.
41) Noridian Health Care Solutions, Federally Qualified Health Centers (FQHC) Billing Guide. (Accessed Aug 14, 2024).
42) Noridian Health Care Solutions, RHC Billing Guide. (Accessed Aug 14, 2024).
43) 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." (Accessed Aug 14, 2024).
44) Federal Register, 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-Payment Medical Review Requirements. (Accessed Aug 14, 2024).

© Public Health Institute/Center for Connected Health Policy 2024

- **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.

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 and another asynchronous option)."

BILLING TIP - Eligibility

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

Transitional Care Management (TCM)

The intent of 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]. TCM codes can be billed during the same time period as CCM codes.

BILLING TIP

Are you the surgeon or provider who performed a procedure on the TCM patient?

- Then you cannot bill within the global period of the procedure.

Are you the primary care physician or hospitalist who discharged the TCM patient?

- Then you can bill within a global period, within the 30 days of discharge

Conclusion

Billing Medicare for telehealth delivered services can be complex and confusing. We hope this guide has helped with at least some of your questions. Policies can change or additional context provided mid-year and quite often some new policy is introduced each year. Coupled with the uncertainty of the fate of the temporary waivers, this creates an environment where it is easy to miss a change in policy. We urge the reader to make use of their regional telehealth resource centers for technical assistance and to keep abreast of any news related to telehealth policy changes.

Center for Connected Health Policy
The Federally Designated National Telehealth Policy Resource Center • info@cchpca.org • 877-707-7172
© Center for Connected Health Policy / Public Health Institute • www.cchpca.org
This fact sheet was made possible by Grant #U6743496 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.
© Public Health Institute/Center for Connected Health Policy 2024