



Physician Services Version

KEY CONCEPTS OUTLINE

Module 13: Telehealth and Virtual Services

- I. Telehealth vs. Communications Based Technology Services
 - A. Telehealth Services are a Medicare benefit payable under Medicare Part B (Supplementary Medical Insurance).
 - 1. Background:
 - a. Medicare's coverage for telehealth for home- and community-based care, was first introduced the 1997 Budget Balanced Act and then implemented in the 2001 Medicare Physician Fee Schedule.
 - (i) Originally limited in scope, the types of services payable as a telehealth benefit, have incrementally expanded since inception.
 - 2. Approved telehealth services can be found on the CMS website at the following:
 - a. <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
 - b. Telehealth services are generally added on annual basis.
 - (i) Note: However, during the Public Health Emergency, services were added or expanded to meet the healthcare needs during the PHE. For the duration for the PHE, checking the list on a frequent basis is recommended.
 - (ii) Note: Services that are temporarily included on the Medicare Telehealth Services List during the PHE, but aren't included on a Category I, II, or III basis for a period of 151 days following the end of

the PHE, in alignment with the Consolidated Appropriations Act, 2022 (CAA, 2022). < See *MLN Matters* MM12982 >

- c. Changes to the list of Medicare telehealth services are made using the annual physician fee schedule proposed rule published in the summer and the final rule published by November 1st each year.
 - (i) A regulatory process was established for adding services to the Medicare telehealth service list. <67 FR 79988>
 - (a) This process provides the public with an ongoing opportunity to submit requests for adding services. The services are reviewed and assigned to one of following three categories:
 - (1) Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list.
 - (2) Category 2: Services that are not similar to those on the current Medicare telehealth services list.
 - (ii) To meet the needs of the PHE, a third temporary category was finalized in the 2021 Medicare Physician Fee Schedule Final Rule
 - (1) Category 3: Services added to the Medicare telehealth list during the PHE for the COVID-19 pandemic (COVID-19 PHE) that will remain on the list through the calendar year in which the PHE ends.
- d. Delivery of Telehealth Services
- e. Telehealth services must be provided via an interactive audio and video telecommunications system that allows for real-time communication between the provider and the beneficiary.
 - (i) Exception: Asynchronous technology, the transmission of medical information to the distant site and reviewed later by the physician or practitioner, is permitted in federal telemedicine demonstration programs.
 - (a) Applicable states are Alaska and Hawaii.
 - (ii) COVID Exception

(a) CMS indicated that the 151-day extension of Medicare Telehealth flexibilities in the Consolidated Appropriations Act, 2022 (CAA). The extension includes allowing certain services to be provided via audio-only.

(b)

3. Eligibility:

a. Based on location (outside of the COVID PHE). Telehealth services can be provided when the following conditions are met:

b. Location:

(i) Rural health professional shortage areas (HPSA); or

(ii) counties not classified as a metropolitan statistical areas (MSA).
<Medicare Claims Processing Manual, Pub 100-04, Chapter 12 §190.1>

(iii)Exception:

(a) Entities participating in a federal telemedicine demonstration project that were approved by or were receiving funding from the Secretary of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. Such entities are not required to be in a rural HPSA or non-MSA<Medicare Claims Processing Manual, Pub 100-04, Chapter 12 §190.2.2>

(iv)COVID 19

(a) CMS indicated that the 151-day extension of Medicare Telehealth flexibilities in the Consolidated Appropriations Act, 2022 (CAA). The extension includes allowing telehealth services to be provided in any geographic area.

4. Originating Site

(i) The location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system takes place.
<Medicare Claims Processing Manual, Pub 100-04, Chapter 12 §190.2.3>

(a) Authorized Originating Sites:

- (1) Physician and practitioner offices;
- (2) Hospitals;
- (3) Critical Access Hospitals (CAHs);
- (4) Rural Health Clinics;
- (5) Federally Qualified Health Centers;
- (6) Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- (7) Skilled Nursing Facilities (SNFs);
- (8) Community Mental Health Centers (CMHCs);
- (9) Renal Dialysis Facilities;
- (10) Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis; and
- (11) Mobile Stroke Units

(b) COVID-19 CMS indicated that the 151-day extension of Medicare Telehealth flexibilities in the Consolidated Appropriations Act, 2022 (CAA). The extension includes the originating site flexibility, including the patients home.

(ii)

5. Distant Site

- a. The location of the provider delivering the service.
- b. Eligible distant site providers:
 - (i) Physicians
 - (ii) Nurse practitioners
 - (iii) Physician assistants
 - (iv) Nurse-midwives
 - (v) Clinical nurse specialists

- (vi) Certified registered nurse anesthetists
- (vii) Clinical psychologists and clinical social workers (may not bill for psychiatric diagnostic interviews or E/M services)
- (viii) Registered dietitians or nutrition professionals

6. Telehealth Billing and Coding

a. Distant Site Billing

- (i) Submit the appropriate HCPCS or CPT code identifying the telehealth service.

(ii) Place of Service

- (a) To indicate the service was provided as a professional telehealth service from a distant site, an appropriate place of service code (POS) must be reported.
- (b) The POS workgroup has revised the current telehealth POS code and created a new POS code, effective January 1, 2022, <MLN Matters MM12427>

(1) POS 02: Telehealth Provided Other than in Patient's Home

- a. Descriptor: 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.

(2) POS 10 – Telehealth Provided in a Patient's Home

- a. Descriptor: 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

(iii) Modifiers

- (a) GT - Service provided via synchronous telecommunication.

(1) Indicates that the service has been provided in accordance with this CMS requirements of two-way audio/video communications.

(b) GQ – Service delivered via asynchronous telecommunications.

(1) Note: Asynchronous “store and forward” technology is permitted only in Federal telemedicine demonstration programs in Alaska or Hawaii.

(iv) COVID-19 Billing

- (a) Services are reported with modifier 95 and the POS , that the service would normally be furnished.
- (b) For 2023, CMS guidance indicates telehealth claims should continue to be billed with the place of service indicator you would bill for an in-person visit.
- (c) You must use modifier 95 to identify them as telehealth services through the end of CY 2023 or the end of the year in which the PHE ends. <See *MLN Matters* MM12982>

b. Originating Site

- (i) HCPCS code Q3014 describes the Medicare telehealth originating site facility fee.
 - (a) Separately billable
 - (b) CY 2023 Payment - \$28.64

c. Mobile Stroke

- (i) There are no geographic limitations for the originating site of telehealth services furnished on or after January 1, 2019 for the purpose of diagnosis, evaluation, or treatment of symptoms of an acute stroke <2018 Bipartisan Budget Act, see *MLN Matters* 10883>
 - (a) Modifier G0 is appended to the HCPCS/CPT code when reported for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
 - (b) Valid for the following:

- (1) Telehealth distant site codes billed with Place of Service (POS) code 02 or Critical Access Hospitals, CAH method II (revenue codes 096X, 097X, or 098X); or
- (2) Telehealth originating site facility fee, billed with HCPCS code Q3014.

B. Communications Based Technology Services

1. Services that are furnished via telecommunications technology; but are not considered Medicare telehealth services. Therefore, it would not be appropriate to report POS 02 or telehealth modifiers.
 - a. Types of services that are not ordinarily furnished in person <2019 MPFS Final Rule>
2. Virtual Check-Ins – HCPCS Codes G2010-G2012 and G2250-G2251
 - a. To be used by providers who can bill evaluation and management services:
 - (i) G2010 - Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment.
 - (ii) 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.
 - b. For use by nonphysician qualified health care professionals who cannot bill evaluation and management (E/M) codes:
 - (i) G2250 - Remote assessment 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 service provided within the previous 7

days nor leading to a service or procedure within the next 24 hours or soonest available appointment.

- (ii) G2251 - Brief communication technology-based service, e.g., virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of clinical discussion.

- c. Covered in all areas - not limited to rural geographic locations.
- d. Normally limited to established patients; however, during the PHE the services can be furnished to new or established patients.
- e. Correct Reporting
 - (i) initiated by an established patient,
 - (ii) Unrelated to a previous evaluation or treatment session provided within the last seven days,
 - (iii) Conducted through a HIPAA-compliant platform, and
 - (iv) Medically necessary (requires clinical decision making and is not for administrative or scheduling purposes).

3. E -Visits – Online Assessments

- a. E-visits or online assessment and management services are covered in all areas (not just rural), including the patient's home.
- b. CMS clarified that certain clinicians who may not independently bill for E/M visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists, clinical social workers) can also provide these e-visits as professional services only.
- c. CMS expects e-visit services to be initiated by the patient; however, practitioners can educate patients on the availability of the service.
- d. No limitation to location of practitioner/clinician to location of the patient
- e. CPT codes for Practitioners

- (i) 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- (ii) 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
- (iii) 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

f. CPT Codes for Other Clinicians

Examples of qualified nonphysician health care professionals include registered dietitian, physical therapist, occupational therapist, and speech-language pathologist.

- (i) 98970 - Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- (ii) 98971 - Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
- (iii) 98972 - Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
- (iv) Correct Reporting:
 - (a) Initiated by an established patient,
 - (b) unrelated to a previous evaluation or treatment session provided within the last seven days,
 - (c) conducted through a HIPAA-compliant platform, and
 - (d) medically necessary (requires clinical decision making and is not for administrative or scheduling purposes).
 - (e) The established patient and HIPAA requirements may be waived by some payers during the public health emergency.

- (f) Documentation of clinical decision-making and storage of the exchange are required.

C. Communications Based Technology Services and Telehealth During the COVID PHE

1. Telehealth Services

a. CMS Medicare Instructions during the COVID PHE:

- (i) Report the appropriate CPT /HCPCS code, with modifier 95 and the place of service, the service would normally take place, if provided in person.

- (a) Provider may still report POS 02; but reporting in this manner will result in a change in payment.

D. Virtual Services

1. Telephone services, previously not recognized by CMS, but due to PHE and possible unavailability of audio/visual technology CMS believes that the existing telephone E/M codes, in both description and valuation, are the best way to recognize the relative resource costs of these kinds of services.
 - a. Reported with 98966–98968 and 99441-99443 for telephone assessment and management by qualified healthcare staff and physicians and practitioners, respectively.
 - b. CPT codes 98966-98968 describe assessment and management services performed by practitioners who cannot separately bill for E/Ms. We are noting that these services may be furnished by, among others, LCSWs, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists when the visit pertains to a service that falls within the benefit category of those practitioners.
 - c. These services are extended to both new and established patients.

E. Virtual Check- Ins or E-visits

1. CMS expects e-visit services to be initiated by the patient; however, practitioners can educate patients on the availability of the service.

2. CMS has waived the established patient requirement for virtual visits during the COVID PHE.

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Medicare Physician Fee Schedule Final Rule Summary: CY 2023

MLN Matters Number: MM12982

Related Change Request (CR) Number: 12982

Related CR Release Date: November 17, 2022 Effective Date: January 1, 2023

Related CR Transmittal Number: R11708CP Implementation Date: January 3, 2023

Related CR Title: Summary of Policies in the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

Provider Types Affected

This MLN Matters Article is for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about the following CY 2023 MPFS updates:

- Telehealth originating site facility fee payment amount
- Expansion of coverage for colorectal cancer screening
- Coverage of Audiology services
- Other covered services

Background

This Article gives a summary of the policies in the CY 2023 MPFS. CMS issued the [2023 Physician Fee Schedule](#) final rule updating payment policies and Medicare payment rates for services we pay providers under the MPFS in CY 2023. The final rule also addresses public comments on Medicare payment policies proposed earlier this year. We summarize the payment policies under the MPFS in CY 2023 in this Article.

Medicare Telehealth Services

For CY 2023, we're adding new HCPCS codes to the list of Medicare telehealth services on a Category 1 basis, specifically HCPCS codes G0316, G0317, G0318, G3002, and G3003. We're keeping many services that are temporarily available as telehealth services for the duration of

the COVID-19 Public Health Emergency (PHE) on a Category 3 basis through CY 2023; including: CPT codes 90875, 90901, 92012, 92014, 92550, 92552, 92553, 92555-92557, 92563, 92567, 92568, 92570, 92587, 92588, 92601, 92625-92627, 94005, 95970, 95983, 95984, 96105, 96110, 96112, 96113, 96127, 96170, 96171, 97129, 97130, 97150-97158, 97530, 97537, 97542, 97763, 98960-98962, 99473, 0362T, and 0373T. The status of these codes on the Medicare Telehealth Services List will change to: "Available up Through December 31, 2023". We're extending the time services are temporarily included on the Medicare Telehealth Services List during the PHE, but aren't included on a Category I, II, or III basis for a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act, 2022 (CAA, 2022).

We're implementing the 151-day extensions of Medicare telehealth flexibilities in the CAA, 2022, including allowing telehealth services to be provided in any geographic area and in any originating site setting, including the patient's home, allowing certain services to be provided via audio-only telehealth, and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to provide telehealth services. The CAA, 2022 also delays the in-person visit requirements for mental health services you provide via telehealth until 152 days after the end of the PHE.

For 2023, you should continue billing telehealth claims with the place of service indicator you would bill for an in-person visit. You must use modifier 95 to identify them as telehealth services through the end of CY 2023 or the end of the year in which the PHE ends. See [list of codes added to the telehealth services list](#).

Telehealth Origination Site Facility Fee Payment Amount Update

The payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge, or \$28.64 for CY 2023 services. We base this on the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the [Social Security Act](#). The 2023 MEI increase is 3.8%. The patient is responsible for any unmet deductible amount and Medicare coinsurance.

Evaluation and Management (E/M) Visits

For CY 2023, we're finalizing changes for Other E/M visits that parallel the changes we made in recent years for office/outpatient E/M visit coding and payment.

Coding

Other E/M visits include hospital inpatient, hospital observation, emergency department, nursing facility, home services, residence services, and cognitive impairment assessment visits. For 2023, we're adopting the revised CPT codes for Other E/M visits (except for prolonged services). This includes:

- Merger of hospital inpatient and observation visits into a single code set, and merger of domiciliary, rest home (for example, boarding home), or custodial care and home visits

- into a single code set.
- Choice of medical decision making or time to select visit level (except for visits that aren't timed, such as emergency department visits).
- Eliminated use of history and exam to decide visit level (instead, there's a requirement for a medically appropriate history or exam or both).
- New descriptor times (where relevant).
- Revised CPT E/M guidelines for levels of medical decision making.

We're finalizing Medicare-specific coding for prolonged Other E/M services and creating 3 new G codes (one per E/M family). These are:

- G0316 for reporting prolonged hospital inpatient or observation services
- G0317 for prolonged nursing facility services
- G0318 for prolonged home or residence services

Report prolonged cognitive impairment assessment services using G2212, the Medicare-specific code for prolonged office/outpatient services. Don't use CPT codes to report these services.

Split (or Shared) Visits

We're delaying for another year our CY 2022 final policy defining the substantive portion of a split (or shared) visit as more than half of the total practitioner time. For CY 2023, as in CY 2022, the substantive portion can be 1 of the following:

- History
- Physical exam
- Medical decision making
- More than half of the total practitioner time

Critical Care

We issued a technical correction clarifying that the reporting threshold time for the add-on code for critical care services is the same for split (or shared) critical care as for critical care that isn't split (or shared). Use CPT Code 99292 to report additional, complete 30-minute time increments provided to the same patient, therefore it isn't reported until at least 104 minutes are spent (74 + 30 = 104 minutes).

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

For CY 2023, we're modifying our policies to expand coverage of colorectal cancer (CRC) screening in 2 ways:

- First, we're modifying coverage and payment requirements for certain CRC screening tests to start when the individual is 45 years of age or older, including Blood-based Biomarker Tests, The Cologuard™ – Multi-target Stool DNA (sDNA) Test, Immunoassay-based Fecal Occult Blood Test (iFOBT), Guaiac-based Fecal Occult Blood Test (gFOBT),

Barium Enema Test, and Flexible Sigmoidoscopy Test. Screening Colonoscopy will continue with no minimum age limitation. We aren't modifying existing maximum age limitations.

- Second, we're expanding the regulatory definition of CRC screening tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based CRC screening test returns a positive result. We added the regulatory definition to [42 CFR 410.37](#).

See MLN Matters Article [MM12656](#) for more information.

Audiology Services

For CY 2023, we're finalizing a policy to allow patients direct access to an audiologist for certain diagnostic tests for non-acute hearing conditions without an order from a treating physician or NPP, including nurse practitioners, clinical nurse specialists, and physician assistants. The finalized policy requires the use of the new AB modifier. This is instead of using HCPCS code GAUDX (that encompassed a list of 36 CPT codes) as we proposed.

Services billed with modifier AB, with any of those on the finalized list of 36 CPT codes, would include those the audiologist personally:

- Provided by the audiologist on a single treatment day to allow patients to get care for non-acute hearing assessments (gradual loss of hearing, typically in both ears)
- Related to implanted auditory prosthetic devices (including cochlear, osseointegrated, and auditory brainstem implants) unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids.

As proposed, we're finalizing to permit audiologists to bill for this direct access (without an order) once every 12 months, per patient, effective January 1, 2023.

We show the permissible use of the AB modifier on the list of Audiology Services on the [PFS website](#), as follows:

- Must be used alongside any of the codes on the finalized list of 36 CPT codes, but only when the patient has directly accessed the audiologist (that's, without a physician or NPP order). Although there'll be times that audiologists will bill for these services, as appropriate, when the patient presents with an order/referral from a physician or NPP that won't have the modifier appended.
- Isn't applicable to the remainder of the codes on the Audiology Services code list – 14 CPT codes for vestibular function tests – for which codes billed with the AB modifier won't be payable.

For each patient, we allow only 1 visit to an audiologist without a physician or NPP order every 12 months. Audiologists may bill using modifier AB once every 12 months – regardless of the number of applicable CPT codes billed with the modifier on that date of service. For example, if you bill 1 CPT code with the AB modifier on a certain date, none of the codes on the list of 36

applicable CPT codes will be payable under the PFS for another 12 months without a qualifying order.

Behavioral Health

We're finalizing a proposal to create a new HCPCS code (G0323) describing General Behavioral Health Integration performed by clinical psychologists (CP) or clinical social workers (CSW) to account for monthly care integration where the mental health services provided by a CP or CSW are serving as the focal point of care integration.

Chronic Pain Management

We're finalizing a CY 2023 proposal to create 2 new G codes (G3002 and G3003) performed by physicians and other qualified health professionals, describing monthly CPM for payment starting January 1, 2023.

Opioid Treatment Programs (OTPs)

To stabilize methadone pricing for CY 2023 and subsequent years, we're finalizing our proposal to revise our method for pricing the drug component of the methadone weekly bundle and the add-on code for take-home supplies of methadone. As proposed, we'll base the payment amount for the drug component of HCPCS codes G2067 and G2078 for CY 2023 and subsequent years on the payment amount for methadone in CY 2021 and update this amount annually to account for inflation using the Producer Price Index for Pharmaceuticals for Human Use (Prescription).

Also, based on the severity of needs of the patient population diagnosed with opioid use disorder (OUD) and getting services in the OTP setting, we're finalizing our proposal to modify the payment rate for the non-drug component of the bundled payments for episodes of care. We're basing the rate for individual therapy on a crosswalk code describing a 45-minute session, rather than the current crosswalk to a code describing a 30-minute session. This will increase overall payments for medication-assisted treatment and other treatments for OUD, recognizing the longer therapy sessions that are usually required.

We're also finalizing our proposal to allow the OTP intake add-on code you provide via 2-way, interactive, audio-video technology when you bill for the initiation of treatment with buprenorphine using audio-video technology to start treatment with buprenorphine as authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) at the time you provide the service. We're also finalizing our proposal to permit the use of 2-way, interactive, audio-only technology to start treatment with buprenorphine in cases where audio-video technology isn't available to the patient and all other applicable requirements are met.

Also in CY 2023, we're:

- Allowing you to provide periodic assessments with audio-only when video isn't available for the duration of CY 2023, when SAMHSA and DEA authorizes it at the time you provide the service.
- Clarifying that OTPs can bill Medicare for medically reasonable and necessary services provided via mobile units in accordance with SAMHSA and DEA guidance. We'll apply locality adjustments for services you provide via mobile units as if you provided the service at the physical location of the OTP registered with DEA and certified by SAMHSA.

Dental and Oral Health Services

Medicare currently pays for dental services in a limited number of circumstances, such as when that service is an integral part of specific treatment of a patient's primary medical condition. Some examples include:

- Reconstruction of the jaw following accidental injury
- Tooth extractions done in preparation for radiation treatment for cancer involving the jaw
- Oral exams preceding kidney transplantation.

We proposed to clarify and codify certain aspects of our current Medicare Fee-for-Service (FFS) payment policies for dental services. We also proposed and sought comment on payment for other dental services, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures that may be inseparably linked to the clinical success of an otherwise covered medical service.

Effective for CY 2023, we're finalizing both policies as proposed and finalizing a process to review public submissions of other potentially analogous medical services where dental services are inseparably linked. Lastly, starting in CY 2024, we're finalizing Medicare FFS payment for dental services, such as dental exams and necessary treatments prior to the treatment for head and neck cancers.

Skin Substitutes

We proposed several changes to the policies for skin substitute products to streamline the coding, billing, and payment rules and to establish consistency with these products across the various settings. Specifically, we proposed to change the terminology of skin substitutes to 'wound care management products', and to treat and pay for these products as incident to supplies under the MPFS starting on January 1, 2024. We plan to conduct a Town Hall in early CY 2023 with interested parties to address commenters' concerns as well as discuss potential approaches to the method for payment of skin substitute products under the MPFS.

FY Modifier Reduction Changes from 7% to 10%

As required by Medicare law, effective January 1, 2018, a payment reduction of 7% applies to imaging services that are X-rays taken using computed radiography (including the X-ray

component of a packaged service). The payment reduction increases to 10% in 2023 and subsequent years. (See [CR 10188](#) for more information.)

More Information

We issued [CR 12982](#) to your MAC as the official instruction for this change.

For more information, [find your MAC's website](#).

Document History

Date of Change	Description
November 17, 2022	Initial article released.

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New/Modifications to the Place of Service (POS) Codes for Telehealth

MLN Matters Number: MM12427

Related Change Request (CR) Number: 12427

Related CR Release Date: October 13, 2021

Effective Date: January 1, 2022

Related CR Transmittal Number: R11045CP

Implementation Date: April 4, 2022

Provider Types Affected

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for telehealth services they provide to Medicare patients.

Provider Action Needed

CR 12427 provides updates to the current POS code set by revising the description of existing POS code 02 and adding new POS code 10. Make sure your billing staff knows of the updates.

Background

The POS code set provides setting information necessary to pay claims correctly. At times, the health care industry has a greater need for specificity than Medicare. While Medicare doesn't always need this greater specificity to appropriately pay claims, it adjudicates claims with the new codes. This eases coordination of benefits and gives other payers the setting information they need. The POS Workgroup is revising the description of POS code 02 and creating a new POS code 10 to meet the overall industry needs, as follows:

1. POS 02: Telehealth Provided Other than in Patient's Home

Descriptor: 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.

2. POS 10: Telehealth Provided in Patient's Home

Descriptor: 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.

Medicare hasn't identified a need for new POS code 10. Our MACs will instruct their providers to continue to use the Medicare billing instructions for Telehealth claims in Pub. 100-04, [Medicare Claims Processing Manual, Chapter 12](#), Section 190.

More Information

We issued [CR 12427](#) to your MAC as the official instruction for this change. The CR includes the revised manual sections.

For more information, [find your MAC's website](#).

Document History

Date of Change	Description
October 14, 2021	Initial Article released.

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with comment period (76 FR 73096 through 73097), physicians and NPPs who may independently bill Medicare for their services and who are counseling individuals would generally report office or other outpatient E/M CPT codes for office visits that involve significant counseling, including genetic counseling, and these office visit CPT codes are already on the Medicare telehealth services list. CPT code 96040 would only be reported by genetic counselors for genetic counseling services. Genetic counselors are not among the practitioners who can bill Medicare directly for their professional services, and they are also not practitioners who can furnish telehealth services as specified in section 1834(m)(4)(E) of the Act. As such, we noted that we do not believe that it would be necessary or appropriate to add CPT code 96040 to the Medicare telehealth services list.

HCPSC code S0265 is a Medication, Supplies, and Services code. There is no separate payment under the PFS for this category of codes. Therefore, we did not propose to add this service to the Medicare telehealth services list.

We received public comments on the requests to add services to the Medicare telehealth services list for CY 2021. The following is a summary of the comments we received and our responses.

Comment: Commenters broadly supported our proposal to add HCPCS codes and CPT codes 90853, 96121, G2212, 99483, 99334, 99335, 99347, and 99348 to the Medicare telehealth list on a Category 1 basis.

Response: We thank the commenters for their support and feedback.

Comment: One commenter opposed the addition of G2211 to the Medicare telehealth list on the basis they do not agree the creation of the code.

Response: We thank the commenter for their feedback and refer them to section II.F.2.c. of this final rule for further discussion of payment policies for HCPCS code G2211. We note that HCPCS codes G2211 and G2212 replace GPC1X and 99XXX respectively, please see section II.F.2.c in this final rule.

Comment: One commenter requested clarification on the addition of CPT codes 99347 and 99348 (*Home visit for the evaluation and management of an established patient*). Specifically, the commenter requested clarification from CMS on the situations in which a home visit after the end of the PHE for COVID-19 would be allowed via telehealth.

Response: While the patient's home cannot serve as an originating site (where the patient is located) for purposes of most Medicare telehealth

services, the SUPPORT for Patients and Communities Act amended section 1834(m)(4)(C) of the Act and added a new paragraph at section 1834(m)(7) of the Act to remove geographic limitations and authorize the patient's home to serve as a telehealth originating site for purposes of treatment of a SUD or a co-occurring mental health disorder, furnished on or after July 1, 2019, to an individual with a SUD diagnosis. These domiciliary/home visits contain the same elements and similar descriptors to the O/O E/M visits, and therefore, we believe there is sufficient justification to add them to the Medicare telehealth services list on a Category 1 basis. We are adding these to the telehealth services list because an office/outpatient visit might not always most accurately or specifically describe the type of visit furnished to treat an individual in their home for an SUD or co-occurring mental health disorder; and that sometimes one of the domiciliary/home visit codes would more accurately describe the service.

Comment: One commenter stated that Assessment and Care Planning for Patients with Cognitive Impairment (CPT Code 99483) should not be added at this time until more study can be done to assess the appropriateness of this service being delivered in the telehealth context given that many cognitive impairments and symptoms may require in-person assessment.

Response: We continue to believe that CPT code 99483 is sufficiently similar to an office visit to warrant addition to the Medicare telehealth list on a permanent basis in that it involves evaluating and managing a patient's cognitive impairment in an office/outpatient setting. When the AMA CPT Editorial Panel created this code, they assumed that the work associated with assessment and care planning for patients with cognitive impairment had been reported with CPT code 99215 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family*), which is currently on the Medicare telehealth list.

After considering the public comments received, we are finalizing our proposal and adding HCPCS codes G2211 and CPT codes 90853, 96121, G2212, 99483, 99334, 99335, 99347, and 99348 to the Medicare telehealth list for CY 2021.

Comment: Commenters expressed opposition to CMS' decision not to propose to add Medical Genetics services (CPT code 96040) to the Medicare telehealth services list.

Response: We note that CPT code 96040 is not separately billable under the PFS; it is considered bundled into O/O E/M visits, which are already on the Medicare telehealth services list. Therefore, we believe it is unnecessary, and could potentially be confusing, to add CPT code 96040 to the list. Only codes that are separately billable can be added to the Medicare telehealth list. As we stated in the CY 2012 PFS final rule with comment period (76 FR 73096 through 73097), physicians and NPPs who furnish and bill Medicare for these services would generally report office or other outpatient E/M CPT codes for office visits that involve significant counseling, including genetic counseling; and the office visit CPT codes are already on the Medicare telehealth services list. CPT code 96040 would only be reported by genetic counselors for genetic counseling services. Genetic counselors are not among the practitioners who can bill Medicare directly for their professional services, and they are also not practitioners who can furnish telehealth services as specified in section 1834(m)(4)(E) of the Act. As such, we do not believe that it would be necessary or appropriate to add CPT code 96040 to the Medicare telehealth services list.

c. Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services From the Medicare Telehealth Services List

Legislation enacted to address the PHE for COVID-19 provided the Secretary with new authorities under section 1135(b)(8) of the Act, as added by section 102 of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. 116-123, March 6, 2020) and subsequently amended by section 6010 of the Families First Coronavirus Response Act (Pub. L. 116-127, March 18, 2020) and section 3703 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, March 27, 2020)), to waive or modify Medicare telehealth payment requirements during the PHE for COVID-19. We established several flexibilities to accommodate these

changes in the delivery of care. Through waiver authority under section 1135(b)(8) of the Act, in response to the PHE for COVID-19, we removed the geographic and site of service originating site restrictions in section 1834(m)(4)(C) of the Act, as well as the restrictions in section 1834(m)(4)(E) of the Act on the types of practitioners who may furnish telehealth services, for the duration of the PHE for COVID-19.¹ We also used waiver authority to allow certain telehealth services to be furnished via audio-only communication technology. In the March 31st COVID-19 IFC, we added 89 services to the Medicare telehealth services list on an interim basis. Through the “Medicare and Medicaid Programs; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency” interim final rule with comment period (IFC), (which was issued on May 1, 2020, and was effective upon publication in the May 8, 2020 **Federal Register** (85 FR 27550 through 27649)) (hereinafter referred to as the “May 8th COVID-19 IFC”), on an interim basis for the duration of the PHE for COVID-19, we removed the requirement in our regulations that we undertake rulemaking to add or delete services on the Medicare telehealth services list so that we could consider the addition of services on a subregulatory basis as they were recommended by the public or identified internally. On a subregulatory basis, we simultaneously added 46 more services to the Medicare telehealth services list on an interim basis when we issued the May 8th COVID-19 IFC. Finally, on October 14, 2020 we added 11 more services to the Medicare telehealth list on a subregulatory basis. For a full list of Medicare telehealth services please see the CMS website: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

At the conclusion of the PHE for COVID-19, these waivers and interim policies will expire, payment for Medicare telehealth services will once again be limited by the requirements of section 1834(m) of the Act, and we will return to the policies established through the regular notice and comment rulemaking process, including the previously established Medicare telehealth services list, as modified by subsequent changes in policies and additions to the telehealth services list adopted through rulemaking, including in this final rule. We believe that the experiences of clinicians who are

furnishing telehealth services during the PHE for COVID-19 will be useful to inform decisions about which of the services we added temporarily to the Medicare telehealth services list might be appropriate to add on a permanent basis. However, we also recognize that the annual PFS rulemaking schedule may not align perfectly with the expiration of the PHE for COVID-19, and that the clinicians providing services via telehealth during the PHE may not have the opportunity to conduct the kinds of review or develop the kind of evidence we usually consider when adding services to the Medicare telehealth services list on a permanent basis. In the event that the PHE for COVID-19 ends prior to the end of CY 2021, stakeholders might not have the opportunity to use our current consideration process for telehealth services to request permanent additions to the Medicare telehealth services list prior to those services being removed from the Medicare telehealth services list. This is especially true for those services that might need to be considered on a Category 2 basis, which involves providing supporting documentation to illustrate the clinical benefit of such services. Recognizing the extent to which practice patterns are shifting as a result of the PHE for COVID-19 from a model of care based on in-person services to one that relies on a combination of in-person services and virtual care, we noted that we believe that it would be disruptive to both clinical practice and beneficiary access to abruptly eliminate Medicare payment for these services when furnished via telehealth as soon as the PHE for COVID-19 ends without first providing an opportunity to use information developed during the PHE to support requests for permanent changes to the Medicare telehealth services list.

As previously noted, in response to the PHE for COVID-19, we added a broad range of services to the Medicare telehealth services list. Before eliminating the full range of these services from the Medicare telehealth services list and potentially jeopardizing beneficiary access to those services that have been clinically beneficial, based primarily on the timing of annual rulemaking, we noted that we believe it would be prudent to collect information from the public regarding which, where, and how various telehealth services have been in use in various communities during the COVID-19 response. Feedback from patients and clinicians is essential to helping CMS understand how the use of telehealth

services may have contributed positively to, or negatively affected, the quality of care provided to beneficiaries during the PHE for COVID-19, enabling us to better determine which services should be retained on the Medicare telehealth services list until we can give them full consideration under our established rulemaking process.

Therefore, we proposed to create a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis. This new category would describe services that would be included on the Medicare telehealth services list on a temporary basis. We would include in this category the services that were added during the PHE for COVID-19 for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. Recognizing that the services we would add on a temporary basis under Category 3 would ultimately need to meet the criteria under categories 1 or 2 in order to be permanently added to the Medicare telehealth services list, and the potential for evidence development that could continue through the Category 3 temporary addition period, we considered each of the services we added on an interim final basis during the PHE for COVID-19.

In developing the proposal to add specific services on a Category 3 basis, we conducted a clinical assessment to identify those services for which we could foresee a reasonable potential likelihood of clinical benefit when furnished via telehealth outside the circumstances of the PHE for COVID-19 and that we anticipate would be able to demonstrate that clinical benefit in such a way as to meet our Category 2 criteria in full. Any service added under the proposed Category 3 would remain on the Medicare telehealth services list through the calendar year in which the PHE for COVID-19 ends. When assessing whether there was a potential likelihood of clinical benefit for a service such that it should be added to the Medicare telehealth services list on a Category 3 basis, we considered the following factors:

- Whether, outside of the circumstances of the PHE for COVID-19, there are increased concerns for patient safety if the service is furnished as a telehealth service.
- Whether, outside of the circumstances of the PHE for COVID-19, there are concerns about whether the provision of the service via telehealth is likely to jeopardize quality of care.

¹ <https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>.

- Whether all elements of the service could fully and effectively be performed by a remotely located clinician using two-way, audio/video telecommunications technology.

We recognized that the circumstances of the PHE for COVID-19 have provided clinicians with the opportunity to use telecommunications technology in health care delivery in a scope and manner far surpassing the telehealth services described under section 1834(m) of the Act, particularly as a result of the removal of geographic and site of service restrictions, and the addition of many services to the Medicare telehealth services list. When adding services to the Medicare telehealth services list on an interim basis during the PHE for COVID-19, we reassessed services on a Category 2 basis in the context of the widespread presence of COVID-19 in the community. We recognized that healthcare access issues could arise due to the immediate potential exposure risks to patients and healthcare workers, and that the use of telecommunication technology could mitigate risk and facilitate clinically appropriate treatment. In the context of the PHE for COVID-19, we found that all of the added services met the Category 2 criteria on the basis that there is a patient population who would otherwise not have access to clinically appropriate care (85 FR 19234). While the interim addition of a broad swath of services to the Medicare telehealth services list is responsive to critical needs during the PHE for COVID-19, the impact of adding these services to the Medicare telehealth services list on a permanent basis is currently unknown. Specifically, although it is possible to assess the uptake among health care practitioners of the added telehealth services, the extent to which service delivery via telehealth demonstrates clinical benefit outside the conditions of the PHE for COVID-19 is not known. Adding services to the Medicare telehealth services list on a Category 3 basis will give the public the opportunity to gather data and generate requests to add certain services to the Medicare telehealth services list permanently, which would be adjudicated on a Category 1 or Category 2 basis during future PFS annual rulemaking, while maintaining access to telehealth services with potential likelihood of clinical benefit. We proposed that the Category 3 criteria and the basis for considering additions to the Medicare telehealth services list would be temporary, to expire at the

end of the calendar year in which the PHE for COVID-19 expires.

We identified a number of services that we believe, based on our clinical assessment, fit the Category 3 criteria enumerated above in that we did not identify significant concerns over patient safety, quality of care, or the ability of clinicians to provide all elements of the service remotely if these services were to remain on the Medicare telehealth services list for an additional period beyond the PHE for COVID-19. Therefore, we proposed to continue including the services listed in Table 13 on the Medicare telehealth services list through the calendar year in which the PHE for COVID-19 ends. We solicited public comment on the services we identified for temporary addition to the Medicare telehealth services list through the Category 3 criteria, including whether some should not be considered as Category 3 temporary additions to the Medicare telehealth services list, or whether services currently not proposed as Category 3 additions to the Medicare telehealth services list should be considered as such. We noted that while our clinical assessment indicated that the services in Table 13 demonstrate potential likelihood of clinical benefit when furnished as telehealth services and, as such, the potential to meet the Category 1 or Category 2 criteria for permanent addition to the Medicare telehealth services list with the development of additional evidence, we solicited information from the public that would supplement our clinical assessment and assist us in consideration of our proposals regarding the Category 3 addition of services, even though we recognize that formal analyses may not yet be available. The following are examples of the types of information we sought from the public to help inform our decisions about proposed additions under Category 3:

- By whom and for whom are the services being delivered via telehealth during the PHE;
- What practical safeguards are being employed to maintain safety and clinical effectiveness of services delivered via telehealth; and how are practices quickly and efficiently transitioning patients from telehealth to in-person care as needed;
- What specific health outcomes data are being or are capable of being gathered to demonstrate clinical benefit;
- How is technology being used to facilitate the acquisition of clinical information that would otherwise be obtained by a hands-on physical examination if the service was furnished in person. Certain services on the Medicare telehealth services list prior to

the PHE, specifically the O/O E/M code set, involve a physical exam. With the telehealth expansions during the PHE, clinicians may have had valuable experience providing other telehealth services to patients in higher acuity settings of care, such as an emergency department, that involve a hands-on physical examination when furnished in person.

- Whether patient outcomes are improved by the addition of one or more services to the Medicare telehealth services list, including whether inclusion on the Medicare telehealth services list increases access, safety, patient satisfaction, and overall quality of care;

- Whether furnishing this service or services via telecommunication technology promotes prudent use of resources;

- Whether the permanent addition of specific, individual services or categories of services to the Medicare telehealth services list supports quick responses to the spread of infectious disease or other emergent circumstances that may require widespread use of telehealth; and

- What is the impact on the health care workforce of the inclusion of one or more services or categories of services on the Medicare telehealth services list (for example, whether the health care workforce and its capabilities to provide care are expanded).

In addition, we noted that CMS is committed to the following broad goals, and these weigh heavily in our decision-making around the addition, whether temporary or permanent, of a service or services to the Medicare telehealth services list. We requested that commenters consider these goals in conjunction with their comments on the proposals for the treatment of the telehealth services we added on an interim basis during the PHE for COVID-19:

- Maintaining the capacity to enable rapid assessment of patterns of care, safety, and outcomes in the Medicare, Medicaid, CHIP, and Marketplace populations;

- Establishing system safeguards to detect and avert unintended patient harms that result from policy adjustments;

- Ensuring high quality care is maintained;

- Demonstrating ongoing quality improvement efforts by Medicare participating providers, while maintaining access to necessary care;

- Establishing protections for vulnerable beneficiary populations (those with multiple chronic conditions, functional limitations, heart failure,

COPD, diabetes, dementia), and sites of heightened vulnerability (such as nursing homes, rural communities) with high risk of adverse outcomes;

- Ensuring appropriate resource utilization and supporting cost efficiency;

- Supporting emergency preparedness and maintaining capacity to surge for potential coronavirus resurgence or other healthcare issues; and

- Considering timing and pace of policy corrections in light of local and

regional variations in systems of care and the impact of the PHE for COVID-19.

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Telehealth Services



The content in this Medicare Learning Network® educational product does not reflect waivers and flexibilities issued pursuant to section 1135 of the Act or short-term regulatory changes made in response to COVID-19. The Centers for Medicare & Medicaid Services (CMS) has issued blanket waivers and flexibilities and made temporary changes to its rules to prevent gaps in access to care for beneficiaries affected by the COVID-19 public health emergency. Please visit [MLN Matters® Article SE20011](#) for up-to-date information and a complete list of COVID-19 blanket waivers and flexibilities, and temporary regulatory changes.

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What's Changed?

- CMS changed frequency limitation for subsequent nursing facility visits from 30 days to 14 days

You'll find substantive content updates in dark red font.

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Introduction

Medicare pays specific Part B physician or practitioner services provided through a telecommunications system. Telehealth services substitute for an in-person visit.

Originating Sites

An originating site is the location where a Medicare patient gets physician or practitioner medical services through a telecommunications system. The patient must go to the originating site for the services located in either:

- County outside a Metropolitan Statistical Area (MSA)
- Rural [Health Professional Shortage Area](#) (HPSA) in a rural census tract

The Health Resources and Services Administration (HRSA) decides HPSAs and the Census Bureau decides MSAs. Find potential Medicare telehealth originating site payment eligibility at HRSA's [Medicare Telehealth Payment Eligibility Analyzer](#).

Regardless of location, providers qualify as originating sites if they participate in a federal telemedicine demonstration project approved by (or getting funding from) HHS.

Each December 31 of the prior Calendar Year (CY), CMS bases an originating site's geographic eligibility on the area's status. This eligibility continues for a full CY. Authorized originating sites include:

- 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
- Patients with End-Stage Renal Disease (ESRD) getting home dialysis
- Mobile Stroke Units

The [Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment \(SUPPORT\) for Patients and Communities Act](#) removed originating site geographic conditions and added an individual's home as a permissible originating telehealth services substance use disorder or co-occurring mental health treatment site.

Note: Medicare doesn't apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and patient homes when practitioners provide monthly ESRD-related medical evaluations in patient homes. Independent Renal Dialysis Facilities aren't eligible originating sites.

The 2018 Bipartisan Budget Act removed originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat acute stroke symptoms. Get more information on how to use the new billing modifier in [MLN Matters® Article MM10883](#).

Distant Site Practitioners

Distant site practitioners who can provide and get paid for covered telehealth services (subject to state law) include:

- Physicians
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Certified Nurse-Midwives (CNMs)
- Clinical Nurse Specialists (CNSs)
- Certified Registered Nurse Anesthetists (CRNAs)
- Clinical Psychologists (CPs) and Clinical Social Workers (CSWs)
 - CPs and CSWs can't bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They can't bill or get paid for CPT codes 90792, 90833, 90836, and 90838.
- Registered dietitians or nutrition professionals

Telehealth Services

You must use an interactive audio and video telecommunications system that permits real-time communication between you at the distant site and the patient at the originating site.

CMS allows sending medical information to a physician or practitioner by telehealth to review later only in Alaska or Hawaii federal telemedicine demonstration programs.

A physician, NP, PA, or CNS must provide at least 1 ESRD-related hands-on visit (not telehealth) each month to examine the patient's vascular access site.

The subsequent nursing facility services frequency limitation provided via telehealth is now 14 days, not 30 days.

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Currently Covered Telehealth Services

Find the complete [List of Telehealth Services](#) by downloading the ZIP and opening the Excel or text files.

Telehealth Services Billing & Payment

Submit professional telehealth service claims using the appropriate CPT or HCPCS code.

If you performed telehealth services through an asynchronous telecommunications system, add the telehealth GQ modifier with the professional service CPT or HCPCS code (for example, 99201 GQ). You're certifying you collected and sent the asynchronous medical file at the distant site from a federal telemedicine demonstration project conducted in Alaska or Hawaii.

Submit telehealth services claims, using Place of Service (POS) 02-Telehealth, to indicate you provided the billed service as a professional telehealth service from a distant site. Distant site practitioners billing telehealth services under the CAH Optional Payment Method II must submit institutional claims using the GT modifier.

Bill covered telehealth services to your Medicare Administrative Contractor (MAC). They pay you the appropriate telehealth services amount under the Medicare Physician Fee Schedule (PFS). If you're located in, and you reassigned your billing rights to, a CAH and elected the outpatient Optional Payment Method II, the CAH bills the MAC for telehealth services. The payment is 80% of the Medicare PFS distant site facility amount for the distant site service.

Telehealth Originating Sites Billing & Payment

HCPCS Code Q3014 describes the Medicare telehealth originating sites facility fee. Bill your MAC for the separately billable Part B originating site facility fee.

Note: The originating site facility fee doesn't count toward the number of services used to determine partial hospitalization services payment when a CMHC serves as an originating site.



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Resources

- [Health Professional Shortage Area Physician Bonus Program](#)
- [Medicare Claims Processing Manual, Chapter 12](#)
- [Physician Fee Schedule Final Rule](#)
- [Telehealth](#)

Rural Providers Helpful Websites

- [American Hospital Association Rural Health Care](#)
- [CMS Rural Health](#)
- [National Association of Rural Health Clinics](#)
- [National Rural Health Association](#)
- [Rural Health Clinics Center](#)
- [Rural Health Information Hub](#)

Regional Office Rural Health Coordinators

Get contact information for [CMS Regional Office Rural Health Coordinators](#) who offer technical, policy, and operational help on rural health issues.

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