

Navigating Digital Medicine Coding and Payment



INTRODUCTION

Determining whether there is coverage and payment for digital medicine services and technologies that you want incorporated into your practice will require research and a plan.

This resource is designed to highlight several digital medicine services covered and paid separately by Medicare on the Physician Fee Schedule (Medicare Part B) beginning January 1, 2019. Commercial health insurers and government health care programs may have very different coverage policies as well as different payment amounts. However, both commercial and state Medicaid programs are influenced by Medicare's policies, so it is anticipated that other health insurers will expand coverage as well.

AMA DIGITAL MEDICINE PAYMENT ADVISORY GROUP

The Digital Medicine Payment Advisory Group (DMPAG), convened by the AMA, includes a diverse cross-section of leading experts who identify barriers to digital medicine adoption and propose comprehensive solutions for coding, payment, and coverage while also identifying clinical validation literature and evidence. While payment for digital medicine is a work in progress, significant gains have been made in 2018 as Congress and the Centers for Medicare & Medicaid Services (CMS) have authorized coverage of a number of digital medicine services and modalities beginning January 1, 2019.

OVERVIEW DIGITAL MEDICINE SERVICES AND PAYMENT

This resource will provide information on the digital medicine services summarized below, which are covered by Medicare regardless of location. Effective January 1, 2019, physicians are able to offer the following covered services in their practice:

- Chronic care remote physiologic monitoring (CPT codes 99453, 99454, and 99457)
- Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012)
- Remote evaluation of pre-recorded patient information (HCPCS code G2010)
- Interprofessional internet consultations (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449)

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REMOTE PATIENT MONITORING (RPM)

Effective January 1, 2019, a combination of RPM codes will be covered by Medicare on the Physician Fee Schedule¹. The RPM codes may also be used in combination with other service codes as detailed below.

CPT CODE 99091

Effective January 1, 2018, Medicare began coverage and payment for the collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional.

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| CPT CODE 99091 | Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days) |
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ADDITIONAL COVERAGE REQUIREMENTS FOR THE USE OF CPT CODE 99091 INCLUDE:

- Advance patient consent: practitioners must obtain advanced consent for the service and document in the patient's record.
- In-person visit prior to service: for new patients or patients not seen within the year by billing practitioner, service must be initiated during an in-person visit.
 - Includes evaluation/management services (levels 2-5), preventative physical exam, translational care management.
 - Does not include virtual face-to-face visit utilizing other online or telehealth modality.
- 30-day reporting period: billing limited to once in a 30-day period.
 - Use with other services: billing is permitted for the same service period as chronic care management (CCM) (CPT codes 99487-99490), transitional care management (TCM) (CPT codes 99495-99496) and behavioral health integration (BHI) (CPT codes 99484, 99492-99494).

¹ When remote patient monitoring services are offered by a home health agency, the Medicare payment differs. If offered by a home health agency, remote patient monitoring is defined as the collection of physiologic data (for example, ECG, blood pressure, or glucose monitoring) digitally stored and transmitted by the patient or caregiver or both to the home health agency. If remote patient monitoring is used by the home health agency to augment the care planning process, the costs of the equipment, set-up, and service related to this system are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the remote patient monitoring equipment, without the provision of a skilled service are not separately bill. These services cannot be included as an allowable cost under the Medicare home health prospective payment system and the Medicare Physician Fee Schedule for the same Medicare beneficiary for the same services rendered.

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CPT CODES 99453, 99454, 99457

The AMA's CPT Editorial Panel created three additional remote chronic care management codes, which effective January 1, 2019, are included for coverage and payment by Medicare. These codes represent modern practices and account for both the professional service, clinical staff time, and practice expenses.

The codes are described below:

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| 99453 | Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment. (Initial set-up and patient education of monitoring equipment) |
| 99454 | Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient) |
| 99457 | Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month. (Interpretation of the received data and interaction with patient on a treatment plan by a clinician) |

ADDITIONAL COVERAGE REQUIREMENTS FOR THE USE OF THESE CPT CODES INCLUDE:

- Advance patient consent: practitioners must obtain advanced consent for the service and document in the patient's record.
- 30-day reporting period: billing limited to once in a 30-day period.
- Use with other services: billing is permitted for the same service period as chronic care management (CCM) (CPT codes 99487-99490), transitional care management (TCM) (CPT codes 99495-99496), and behavioral health integration (BHI) (CPT codes 99484, 99492-99494).
- The Medicare program will be issuing additional guidance on the type of remote patient monitoring technology that will be permitted under 99454.
- CPT code 99457 and 99091 may not be billed together for same billing period and beneficiary.

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VIRTUAL CHECK-IN

CMS has created a new service code to support virtual check-ins by patients with their existing physician or other qualified health care professional (HCPCS code G2012).

These services are the kind of brief check-in services furnished using communication technology that are employed to evaluate whether or not an office visit or other service is warranted. When the check-in services are furnished prior to an office visit, then the Medicare program considers them to be bundled into the payment for the resulting visit, such as through an evaluation and management (E/M) visit code. However, in cases where the check-in service does not lead to an office visit, then there is no office visit with which the check-in service can be bundled. Therefore, Medicare will cover and pay for such services to the extent these are medically necessary and reasonable.

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| HCPCS 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 |
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ADDITIONAL COVERAGE REQUIREMENTS FOR USE OF THIS CODE INCLUDE:

- Advance patient consent: practitioners must obtain advanced consent for the service and document in the patient's record.
- This service is only covered for established patients.
- The technology that can be used by the patient includes real-time audio-only telephone interactions and synchronous, two-way audio interactions that are enhanced with the video or other kinds of data transmission.
- There are no frequency limitations.
- Telephone calls that involve only clinical staff cannot be billed using this code.

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REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION

CMS has created a new service code to support remote evaluation of recorded video and/or images submitted by an established patient.

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| HCPCS 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 |
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ADDITIONAL COVERAGE REQUIREMENTS FOR USE OF THIS CODE INCLUDE:

- Advance patient content: practitioners must obtain advanced consent for the service and document in the patient's record.
- This service is only covered for established patients.
- Services may involve pre-recorded patient-generated still or video images and used to determine whether or not an office visit or other service is warranted.
- Follow-up with the patient could take place via phone call, audio/visual communication, secure text messaging, email, or patient portal communication and must be compliant with HIPAA.
- Service is distinct from the virtual check-in service in that this service involves the practitioner's evaluation of a patient-generated still or video image transmitted by the patient, and the subsequent communication of the practitioner's response to the patient.

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INTERPROFESSIONAL INTERNET CONSULTATION

Interprofessional Internet Consultation codes have the potential to enhance quality and coordination of care while overcoming the persistent shortages of medical specialists. Medicare provides coverage and payment for the following codes:

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| CPT CODE 99446 | Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review |
| CPT CODE 99447 | Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review |
| CPT CODE 99448 | Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review |
| CPT CODE 99449 | Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review |
| CPT CODE 99452 | Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes). |

ADDITIONAL COVERAGE REQUIREMENTS FOR USE OF THIS CODE INCLUDE:

- Advance patient consent: practitioners must obtain advanced consent for the service and document in the patient's record.

**This guide will be updated over time to reflect changes in additional guidance that CMS is expected to provide for these highlighted services. All questions concerning CMS requirements, should be addressed to the relevant Medicare contractor in your region. In addition to this guide, consider reviewing the National Consortium of Telehealth Resource Centers and the utilizing resources from the Telehealth Resource Center in your region.*