Navigating Digital Medicine Coding & Payment

**Author's Note: The AMA is dedicated to supporting physicians and practices on the front lines as the country faces COVID-19. The resource below is based on coding and payment policies that were in place before the pandemic; however, we recognize that there has been an expansion of telemedicine coverage for Medicare, Medicaid, and commercial payers. Please visit the Telemedicine Quick Guide for the latest updates and information: https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice.*

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 planning. This resource is designed to highlight several digital medicine services covered and paid separately by Medicare on the Physician Fee Schedule (Medicare Part B). Commercial health insurers and government health care programs may have very different coverage policies as well as different payment. 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

Coding and payment for digital medicine is a work in progress, but 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. The Digital Medicine Payment Advisory Group (DMPAG) plays an important role by recommending coding solutions and clinical validation literature to support coverage of a number of the new digital medicine modalities. The 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.

OVERVIEW OF DIGITAL MEDICINE SERVICES AND PAYMENT

This resource will provide information on the digital medicine services summarized below. Commercial and private payer coverage will vary, so it will be important to do your research on your practice's payer mix and proactively identify those that may cover some or all of these services. Engage team members who oversee payer contracting and leverage them to initiate conversations with payers over digital medicine coverage.

- Telehealth visits
- Online digital visits
- Remote evaluation of pre-recorded patient information
- Chronic care remote physiologic monitoring
- Interprofessional internet consultations
- Telephone evaluation and management services

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TELEHEALTH VISITS

Synchronous audio/visual visit between a patient and clinician for evaluation and management (E&M).

CODE*	DESCRIPTION
CPT® Code 99201-99205 POS 02 for Telehealth (Medicare) Modifier 95 (Commercial Payers)	Office or other outpatient visit for the evaluation and management of a new patient
CPT® Code 99211-99215 POS 02 for Telehealth (Medicare) Modifier 95 (Commercial Payers)	Office or other outpatient visit for the evaluation and management of an established patient

*A list of all available codes for telehealth services can be found here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Medicare pays for telehealth on a limited basis: when the beneficiary receiving the service is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service.

Check with your payer to determine the appropriate Place of Service (POS) code for your telehealth visits. The AMA is aware that some commercial payers are requiring the use of POS 02 – Telehealth (the location where health services and health-related services are provided or received through a telecommunication system).

ONLINE DIGITAL VISITS

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.

CODE	DESCRIPTION
CPT® Code 99421	Online digital evaluation and management service, for an established patient, for up to seven days, cumulative time during the seven days: 5–10 minutes

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CPT® Code 99422	11–20 minutes
CPT® Code 99423	21 or more minutes
CPT® Code 98970*	Qualified non-physician health care professional online digital assessment and management, for an established patient, for up to seven days, cumulative time during the seven days: 5–10 minutes
CPT® Code 98971*	11–20 minutes
CPT® Code 98972	21 or more minutes
HCPCS Code G2061	Qualified non-physician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the seven days: 5–10 minutes
HCPCS Code G2062	11–20 minutes
HCPCS Code G2063	21 or more minutes
HCPCS Code G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5–10 minutes of medical discussion

*CPT® codes 98970-98971 were modified in 2020 to match the CMS language captured in HCPCS code G2061-G2063.

Additional coverage requirements for use of this code include:

- Advance patient content: Practitioners must obtain advance 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.
- 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 service code to support remote evaluation of recorded video and/or images submitted by an established patient.

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

Additional coverage requirements for use of this code include:

- Advance patient content: Practitioners must obtain advance 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 may be 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.

REMOTE PATIENT MONITORING

Remote patient monitoring (RPM) can be defined as collecting and interpreting physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or qualified health care professional. Payment for RPM is a work in progress, but significant gains have been made in the past few years.

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 (CPT® Code 99091). On January 1, 2019, coverage and payment were also made available for remote chronic care management codes including:

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CODE	DESCRIPTION
CPT® Code 99453	Remote monitoring of physiologic parameter(s) (e.g., 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)
CPT® Code 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)
CPT® Code 99457	Remote physiologic monitoring treatment management services, clinical staff/ physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month: first 20 minutes
CPT® Code 99458	Each additional 20 minutes (List separately in addition to code for primary procedure)
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)

Additional coverage requirements for use of this code include:

- Advance patient consent: Practitioners must obtain advance 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® codes 99457 and 99091 may not be billed together for same billing period and beneficiary.

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TELEPHONE EVALUATION AND MANAGEMENT SERVICE

CPT® codes to describe telephone evaluation and management services have been available since 2008. Relative values are assigned to these services. **Medicare still currently considers these codes to be non-covered.** However, private payers may pay for these services.

CODE	DESCRIPTION
CPT® Code 99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5–10 minutes of medical discussion
CPT® Code 99442	11–20 minutes of medical discussion
CPT® Code 99443	21–30 minutes of medical discussion

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:

CODE	DESCRIPTION
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	11–20 minutes of medical consultative discussion and review
CPT® Code 99448	21–30 minutes of medical consultative discussion and review
CPT® Code 99449	31 minutes or more of medical consultative discussion and review

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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 advance consent for the service and document in the patient's record.

ADDITIONAL RESOURCES

The AMA's Advocacy Resource Center provides materials for physicians and physician advocates focused on state telemedicine issues including private insurance payment policies. Click here to access the AMA Chart of Telemedicine Coverage Laws for Medicaid and private payers.

**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.*