



## 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/coverage/telehealth/list-services>
      - b. Telehealth services are generally added on annual basis.
      - 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.
    - 3. Two Categories of Coverage
      - a. Permanent - meaning the services will remain on the telehealth listing
    - 4. Provisional – meaning the services will have refinements to telehealth policies based on certain provisions.



#### 4. Delivery of Telehealth Services

- (i) 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.

- (a) 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.

(1) Applicable states are Alaska and Hawaii.

#### 5. Originating Site

- a. Through December 31, 2024, any site within the US, where the patient is located at the time of the telehealth service, including the patient's home.
  - (i) The location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs.
- b. After December 31, 2024:
  - (i) Non-behavioral or mental health visits may have originating site requirements and geographic location restrictions <See *MLN Fact Sheet, Telehealth Services*, February 2024>
  - (ii) Behavioral or mental telehealth, patients can continue to get telehealth wherever they're located, - no originating site requirements or geographic location restriction.
- c. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii.. <Medicare Claims Processing Manual, Pub 100-04, Chapter 12 §190.2.3>

#### 6. 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 dieticians (RD)
- (ix) Nutrition professionals
- (x) Audiologists
- (xi) Occupational therapists
- (xii) Physical therapists
- (xiii) Mental health counselors (MHC)
- (xiv) Marriage and family therapists

#### 7. Frequency Limitations for Specific Services Removed for CY 2024

- a. Removing frequency limitations in 2024 for:
- b. Subsequent inpatient visits;
- c. Subsequent nursing facility visits; and
- d. Critical care consultation

#### 8. Telehealth Billing and Coding

- a. Distant Site Billing
  - (i) Submit the appropriate HCPCS or CPT code identifying the telehealth service.
  - (ii) Place of Service, Effective January 1, 2024

- (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.

(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
- b. POS 10 and modifier -95 are to be used through December 31, 2024, when:
- c. The clinician is in the hospital and the patient in their home, or
- d. Outpatient therapy provided by telehealth by PT, OT, or SLPs

(iii) Modifiers

- (a) 95 - Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

- (1) Opioid Treatment Programs will use for counseling and therapy provided using audio-video only technology.

- (b) 93- Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system"

(1) Used by Opioid Treatment Programs (OTP), RHCs, and FQHCs

a. For OTP, modifier -93 should only be used for counseling and therapy using audio-only technology.

(c) 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.

b. Originating Site

(i) HCPCS code Q3014 describes the Medicare telehealth originating site facility fee.

(a) Separately billable

(b) CY 2024 Payment - \$29.96

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.

9. New Telehealth Codes for CY 2024

a. CPT codes 0591T - 0593T for health and well-being coaching services, have been added on a temporary basis

- b. HCPCS G0136 - Social Determinants of Health Risk Assessment, was added on a permanent basis.

## II. Communications Based Technology Services

- A. 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.

- 1. Types of services that are not ordinarily furnished in person <2019 MPFS Final Rule>

### B. Virtual Check-Ins – HCPCS Codes G2010-G2012 and G2250-G2251

- 1. To be used by providers who can bill evaluation and management services:
  - a. 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.
  - b. 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.
- 2. For use by nonphysician qualified health care professionals who cannot bill evaluation and management (E/M) codes:
  - a. 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.

- b. 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.
- 3. Covered in all areas - not limited to rural geographic locations.
  - a. Normally limited to established patients.
    - (i) COVID PHE -during the PHE, the services can be furnished to new or established patients.
      - (a) New patient applicability terminated May 11, 2023.
  - b. Correct Reporting
    - (i) The services must be 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).
- 4. 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.



Version 04/25/2024  
Check for Updates

Version 04/25/2024  
Check for Updates



## Telehealth Services



### What's Changed?

- Added new CPT and HCPCS codes for CY 2024 (page 3)
- Added new and expanded telehealth services (pages 3-4)
- Extended use of modifier 95 (page 5)
- Added the CY 2024 originating site facility fee amount (page 5)

Substantive content changes are in dark red.

We pay for specific Medicare Part B services that a physician or practitioner provides via 2-way, interactive technology (or telehealth). Telehealth substitutes for an in-person visit, and generally involves 2-way, interactive technology that permits communication between the practitioner and patient.

During the COVID-19 public health emergency (PHE), we used emergency waiver and other regulatory authorities so you could provide more services to your patients via telehealth. Section 4113 of the [Consolidated Appropriations Act, 2023](#) extended many of these flexibilities through December 31, 2024, and made some of them permanent.

The COVID-19 public health emergency (PHE) ended at the end of the day on May 11, 2023. View [Infectious diseases](#) for a list of waivers and flexibilities that were in place during the PHE.

## Originating Sites

An originating site is the location where a patient gets physician or practitioner medical services through telehealth. Before the COVID-19 PHE, patients needed to get telehealth at an originating site located in a certain geographic location.

Through December 31, 2024, all patients can get telehealth wherever they're located. They don't need to be at an originating site, and there aren't any geographic restrictions.

After December 31, 2024:

- For non-behavioral or mental telehealth, there may be originating site requirements and geographic location restrictions
- For behavioral or mental telehealth, all patients can continue to get telehealth wherever they're located, with no originating site requirements or geographic location restrictions

## Distant Sites

A distant site is the location where a physician or practitioner provides telehealth. Before the COVID-19 PHE, only certain types of distant site providers could provide and get paid for telehealth. Through December 31, 2024, all providers who are eligible to bill Medicare for professional services can provide distant site telehealth.

## Telehealth Requirements

### Technology

- For most non-behavioral or mental telehealth, you must use 2-way, interactive, audio-video technology. Section 4113 of the Consolidated Appropriations Act, 2023 allows you to use audio-only telehealth for some non-behavioral or mental telehealth through December 31, 2024.
- For behavioral or mental telehealth, you may use 2-way, interactive, audio-only technology.

## Other Requirements

- For Alaska or Hawaii federal telemedicine demonstrations only, you may send medical information to a physician or practitioner by telehealth to review later
- Through December 31, 2024:
  - You may use telehealth to conduct hospice care eligibility recertification
  - For behavioral or mental telehealth, you don't have to conduct an in-person visit within 6 months of the initial telehealth visit or annually thereafter
  - We've extended the [Acute Hospital Care at Home Program](#), which heavily relies on telehealth for hospitals to provide inpatient services, including routine services, outside the hospital

## Currently Covered Telehealth

CY 2024, we're adding new codes to the list of Medicare telehealth services, including:

- CPT codes 0591T - 0593T for health and well-being coaching services, which we're adding on a temporary basis
- HCPCS code G0136 for Social Determinants of Health Risk Assessment, which we're adding on a permanent basis

We recommend you:

- See the complete [List of Telehealth Services](#)
- Review [Provider Billing Medicare FFS Telehealth](#) for billing and coding information for Medicare Fee-for-Service claims

## New for CY 2024

Based on several telehealth-related provisions of the [Consolidated Appropriations Act](#) (CAA), 2023 and the CY 2024 PFS [final rule](#), we're:

- Expanding the scope of telehealth originating sites for services provided via telehealth to include any site in the U.S. where the patient is at the time of the telehealth service, including a person's home
- Expanding the definition of telehealth practitioners to include qualified occupational therapists (OTs), physical therapists (PTs), speech-language pathologists (SLPs), and audiologists
- Adding mental health counselors and marriage and family therapists as distant site practitioners for purposes of providing telehealth services

- Continuing payment for telehealth services rural health clinics (RHCs) and federally qualified health centers (FQHCs) provided using the methodology established for those telehealth services during the PHE
- Delaying the requirement for an in-person visit with the physician or practitioner within 6 months before initiating mental health telehealth services, and, again, at subsequent intervals as the Secretary determines appropriate, as well as similar requirements for RHCs and FQHCs
- Allowing teaching physicians to use audio or video real-time communications technology when the resident provides Medicare telehealth services in all residency training locations through the end of CY 2024
- Removing frequency limitations in 2024 for:
  - Subsequent inpatient visits
  - Subsequent nursing facility visits
  - Critical care consultation
- Allowing hospitals and other providers of PT, OT, SLP, diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services that remain on the Medicare Telehealth Services List to continue to bill for these services when provided remotely in the same way they've been during the PHE and the remainder of CY 2023, except that:
  - For outpatient hospitals, patients' homes no longer need to be registered as provider-based entities to allow for hospitals to bill for these services
  - The 95 modifier is required on claims from all providers, except for Critical Access Hospitals (CAHs) electing Method II, as soon as hospitals needing to do so can update their systems

## Telehealth Billing & Payment

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- Bill covered telehealth to your Medicare Administrative Contractor (MAC). They pay you the appropriate telehealth amount under the Physician Fee Schedule (PFS).
- Submit professional telehealth claims using the appropriate CPT or HCPCS code.
- If you performed telehealth through asynchronous telehealth, add the telehealth GQ modifier with the professional service CPT or HCPCS code. You're certifying you collected and sent the asynchronous medical file at the distant site from a federal telemedicine demonstration conducted in Alaska or Hawaii.
- Distant site practitioners billing telehealth under the CAH Optional Payment Method II must submit institutional claims using the GT modifier.
- 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. The payment is 80% of the PFS distant site facility amount for the distant site service.

- Place of Service (POS) Codes:
  - For 2023, continue billing telehealth claims with the POS indicator you'd bill for an in-person visit
  - Use modifier 95 when the clinician is in the hospital and the patient is in the home, as well as for outpatient therapy services provided via telehealth by qualified PTs, OTs, or SLPs through December 31, 2024
  - Starting January 1, 2024, use:
    - POS 02-Telehealth to indicate you provided the billed service as a professional telehealth service when the originating site is other than the patient's home
    - POS 10-Telehealth for services when the patient is in their home

## 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. The payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge (\$28.64 for CY 2023 services and **\$29.96 for CY 2024 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 coinsurance. See MLN Matters Article [MM12982](#) to learn about the CY 2023 Medicare Physician Fee Schedule Final Rule Summary.

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

## Telehealth Home Health: New G-Codes

Starting January 1, 2023, you may voluntarily report the use of telehealth technology in providing home health (HH) services on HH payment claims. See MLN Matters Article [MM12805](#) for more information.

Starting July 1, 2023, you must include on HH claims:

- G0320: Home health services you furnish using synchronous telehealth you render via real-time audio-video telehealth
- G0321: Home health services you furnish using synchronous telehealth you render via telephone or another real-time, interactive, audio-only telehealth
- G0322: The collection of physiologic data the patient digitally stores or transmits to the HH agency



When using the 3 codes above:

- Report the use of remote patient monitoring that spans a number of days as a single line item showing the start date of monitoring and the number of days of monitoring in the Units field
- Submit services you provide via telehealth in line-item detail
- Report each service as a separate dated line under the appropriate revenue code for each discipline providing the service
- Document in the medical record to show how telehealth helps to achieve the goals outlined in the plan of care
- Only report these codes on Type of Bill 032x
- Only report these codes with revenue codes 042x, 043x, 044x, 055x, 056x, and 057x

## Consent for Care Management & Virtual Communication Services

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We require patient consent for all services, including non-face-to-face services. You may get patient consent at the same time you initially provide the services. Direct supervision isn't required to get consent. In general, auxiliary personnel under general supervision of the billing practitioner can get patient consent for these services. The person getting consent can be an employee, independent contractor, or leased employee of the billing practitioner.

## Resources

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- [Section 190 of the Medicare Claims Processing Manual, Chapter 12](#)
- [Telehealth Policy Changes after the COVID-19 PHE](#)
- [Tips for Telehealth Success](#)

## 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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