Coding, Billing, and Reimbursement Updates

Telehealth and Telecommunication Services

The Centers for Medicare and Medicaid Services (CMS) recognizes the increasing role of telehealth and telecommunications in patient care. Therefore, several new HCPCS and CPT codes were created and/or approved for reimbursement under the physician fee schedule (PFS) for **2019**.

New HCPCS Code: Brief Communication Check-In

HCPCS Code	Description	Technology	Patient Type	Provider Type	Verbal Consent Requirements	Frequency Limitations
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.	Real-time audio-only telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission	Established patients only.	Physician or qualified healthcare provider. May not be reported by clinical staff.	Verbal consent must be noted in the medical record for each reported service	None in 2019.

Reporting Information

- **Check with your local MAC for further guidance on reporting.**
- G codes describe temporary procedures and services that do not have a CPT code equivalent. In general, they are only for use within the CMS system and may not be reportable to private payers.
- If the "check-in" originates from a related E/M service provided with the previous seven days by the same physician or qualified healthcare professional, it would be bundled into the previous E/M service and NOT separately reportable. If the "check-in" leads to an E/M service with the same physician or qualified healthcare professional, it would also NOT be separately reportable.
- Though there are no frequency limitations in 2019, CMS will be monitoring utilization to determine whether limitations are needed.

New HCPCS Code: Remote Evaluation of Pre-Recorded Patient Information

HCPCS Code	Description	Technology	Patient Type	Provider Type	Verbal Consent Requirements	Frequency Limitations
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	Real-time audio-only telephone interactions *in addition to* synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission	Established patients only	Physician or qualified healthcare professional	Require consent that could be verbal or written, including electronic confirmation that is noted in the medical record for each billed service	None in 2019

Medicare Reporting Guidelines

- **Check with your local MAC for further guidance on reporting.**
- G codes describe temporary procedures and services that do not have a CPT code equivalent. In general, they are only for use within the CMS system and may not be reportable to private payers.
- The patient follow-up referred to in the code description could take place via phone call, audio/video communication, secure text messaging, email, or patient portal communication.
- When the review of the patient-submitted image and/or video results in an in-person E/M office visit with the same physician or qualified health care professional, the service will be considered bundled into that office visit and not separately reportable. when the remote service originates from a related E/M service provided within the previous 7 days by the same physician or qualified health care professional that this service will be considered bundled into that previous E/M service and also will not be separately reportable.

Reimbursement Updates

Payment Update: Interprofessional Internet Consultation (CPT ® codes 99451, 99452, 99446, 99447, 99448, and 99449)

CMS finalized separate payment for CPT codes 99451 (new CPT ® code for 2019), 99452 (new CPT ® code for 2019), 99446, 99447, 99448, and 99449 which describe "Interprofessional Telephone/ Internet/Electronic Health Record Consultations"

CPT ® Code	Code Description
99446	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447	11-20 minutes of medical consultative discussion and review
99448	21-30 minutes of medical consultative discussion and review
99449	31 minutes or more of medical consultative discussion and review
99451 *New CPT ® Code	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
99452 *New CPT ® Code	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/ requesting physician or other qualified health care professional, 30 minutes

Reporting Guidelines

CPT Guidelines

- The patient may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem.
- If the telephone/Internet/electronic health record consultation leads to a transfer of care or other face-to-face service (eg, a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported.
- If more than one telephone/Internet/electronic health record contact(s) is required to complete the consultation request (eg, discussion of test results), the entirety of the service and the cumulative discussion and information review time should be reported with a single code.
- Telephone/Internet/electronic health record consultations of less than five minutes should not be reported.
- The codes may only be reported once in a 7-day time period
- The codes should not be reported if the sole purpose of the consultation is to arrange a transfer of care or a face-to-face visit.

Reporting Guidelines (continued)

Medicare Guidelines

- CMS is following the guidelines for Interprofessional Internet Consultations as outlined in the 2019 CPT Professional Edition.
- CMS will require documentation of verbal patient consent in advance.
- The services are limited to practitioners who can independently report E/M services.

Evaluation and Management (E/M) Documentation Guideline Updates

As of **January 1**, **2019**, CMS is simplifying some Evaluation and Management (E/M) documentation requirements:

Current	As of January 1, 2019
Currently, Review of Systems and Past, Family, and/or Social History (PFSH) obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information.	CMS has expanded their documentation policies as follows: **History and Exam** For history and exam for established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed. The practitioner does not need to re-record the list of required elements if there is evidence the practitioner reviewed the previous information and updated it as needed. **Chief Complaint and History** For chief complaint and history for *new and established* patient office/outpatient visits, practitioners do not need to re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary. The practitioner simply needs to indicate they reviewed and verified the information.

Practitioners do have the option to continue the current process of entering, re-entering, and bringing forward information. Per CMS, "The option to continue current documentation processes may be particularly important for practitioners who lack time to adjust workflows, templates and other aspects of their work by **January 1, 2019**."

Looking Ahead

CMS finalized several items for calendar year **2021**. It is important to note these **may be subject to change** before the implementation in 2021.

New HCPCS Codes

Prolonged Evaluation and Management Services

Many stakeholders expressed concern regarding Prolonged Services CPT code 99354 (Prolonged Evaluation and Management, direct patient contact, first hour), stating the required 60-minute threshold is difficult to meet. In response, CMS developed HCPCS code "GPRO1" which describes a Prolonged Evaluation and Management Service up to **30** minutes.

Code Description

GPRO1 -Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; 30 minutes (List separately in addition to code for office or othe r outpatient Evaluation and Management or psychotherapy service)

Visit Complexity Inherent to Certain Specialist Visits

For calendar year 2021, CMS is finalizing an add-on code for "visit complexity inherent to non-procedural specialty care."

Code Description

GCG0X- Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urol ogy, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit)

Evaluation and Management Documentation Requirements

CMS has finalized new documentation guidelines for **CY 2021**. These new guidelines will allow for more flexibility with the aim of reducing administrative burden. Providers will have the option of using either the current E/M documentation guidelines (1995 or 1997), medical decision making (MDM), or time to select the appropriate level of an E/M service.

Reimbursement for Evaluation and Management Services

For CY 2021, CMS is finalizing a single payment rate for levels 2 through 4 E/M office/outpatient visits. A separate payment rate will be established for a level 5 E/M visit for new and established patients.

Questions regarding coding, billing, and reimbursement can be sent to billingandcoding@asco.org.