2021 Medicare Part B Update – New York County Medical Society

January 27, 2021

2275_1220

Today's Presenters

- Provider Outreach and Education

- James Bavoso
- Katherine Dunphy
- Nathan Kennedy
- Lori Langevin

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Agenda

- Medicare Physician Fee Schedule – Consolidated Appropriations Act 0f 2021
- 2021 Medicare Deductibles and Coinsurance
- 2021 E/M Changes
- COVID-19 Public Health Emergency
- Telehealth
- Your questions

Medicare Physician Fee Schedule

Fee Schedules

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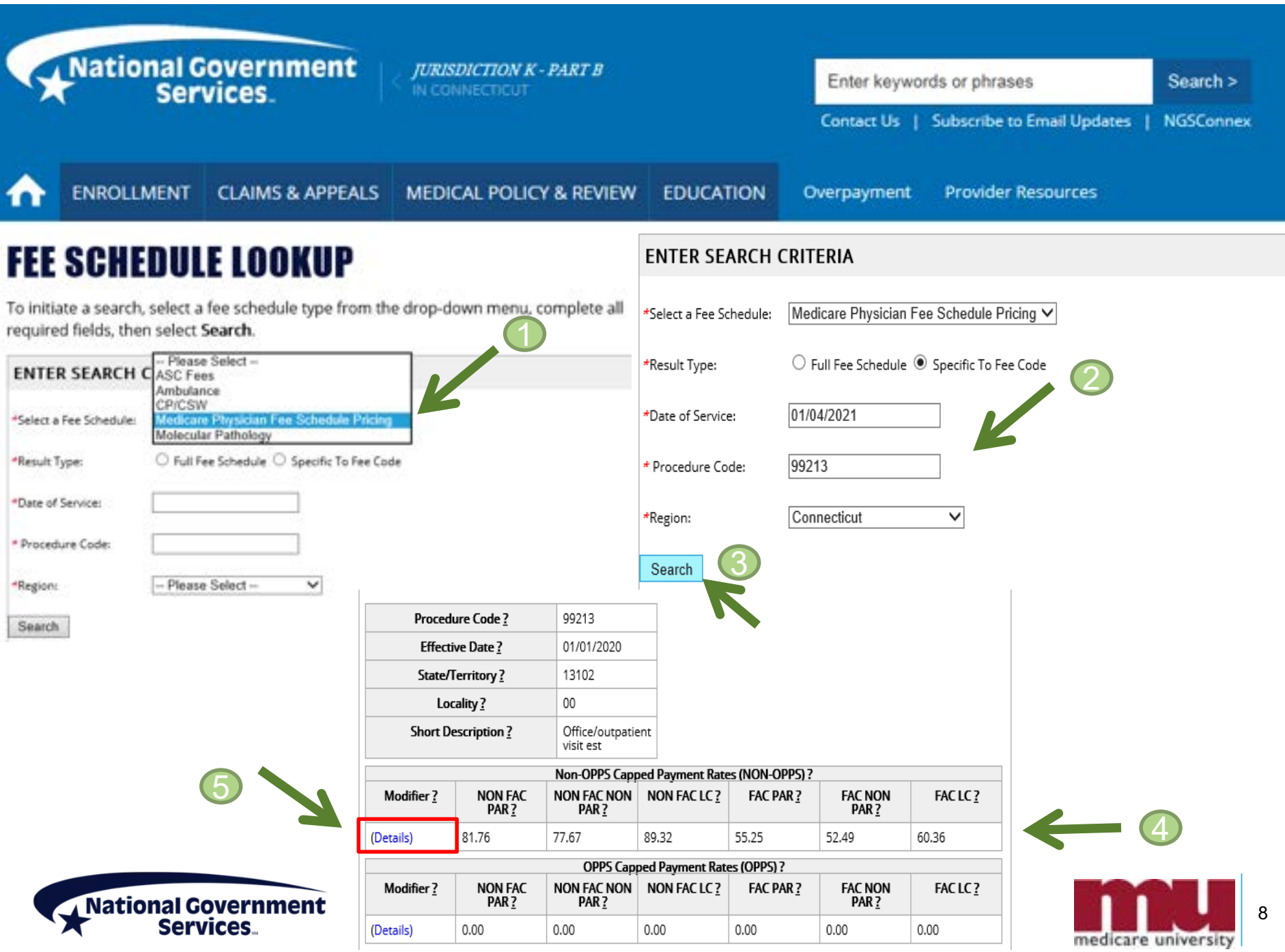
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ENROLLMENT
CLAIMS & APPEALS
MEDICAL POLICY & REVIEW
EDUCATION
Overpayment
Provider Resources
FEE SCHEDULE LOOKUP
To initiate a search, select a fee schedule type from the drop-down menu, complete all required fields, then select Search.
ENTER SEARCH C
*Select a Fee Schedule:
-- Please Select --
ASC Fees
Ambulance
CP/CSW
Medicare Physician Fee Schedule Pricing
Molecular Pathology
*Result Type:
Full Fee Schedule
Specific To Fee Code
*Date of Service:
* Procedure Code:
*Region:
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Search
1
ENTER SEARCH CRITERIA
*Select a Fee Schedule:
Medicare Physician Fee Schedule Pricing
*Result Type:
Full Fee Schedule
Specific To Fee Code
2
*Date of Service:
01/04/2021
* Procedure Code:
99213
*Region:
Connecticut
Search
3
Procedure Code ?
99213
Effective Date ?
01/01/2020
State/Territory ?
13102
Locality ?
00
Short Description ?
Office/outpatient visit est
Non-OPPS Capped Payment Rates (NON-OPPS) ?
Modifier ?
NON FAC PAR ?
NON FAC NON PAR ?
NON FAC LC ?
FAC PAR ?
FAC NON PAR ?
FAC LC ?
(Details)
81.76
77.67
89.32
55.25
52.49
60.36
4
5
OPPS Capped Payment Rates (OPPS) ?
Modifier ?
NON FAC PAR ?
NON FAC NON PAR ?
NON FAC LC ?
FAC PAR ?
FAC NON PAR ?
FAC LC ?
(Details)
0.00
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Fee Schedule Lookup

CPT 99213

Modifier Selected: (blank)			
Status ?	A	Global Surgery ?	XXX
Conversion Factor ?	36.0896	Facility Pricing ?	1
Update Factor ?	1.0000	PC/TC ?	0
Work RVU ?	0.97	Preoperative Percentage ?	0%
FAC PE RVU ?	0.40	Interoperative Percentage ?	0%
NON FAC PE RVU ?	1.06	Postoperative Percentage ?	0%
Malpractice RVU ?	0.08	Multiple Surgery ?	0
Work GPCI ?	1.029	Bilateral Surgery ?	0
Practice GPCI ?	1.113	Assistant At Surgery ?	0
Malpractice GPCI ?	1.094	Two Surgeons ?	0
Reduced Therapy Amt ?	0.00	Team Surgery ?	0

CPT 20610

Modifier Selected: (blank)			
Status ?	A	Global Surgery ?	000
Conversion Factor ?	36.0896	Facility Pricing ?	1
Update Factor ?	1.0000	PC/TC ?	0
Work RVU ?	0.79	Preoperative Percentage ?	0%
FAC PE RVU ?	0.41	Interoperative Percentage ?	0%
NON FAC PE RVU ?	0.86	Postoperative Percentage ?	0%
Malpractice RVU ?	0.12	Multiple Surgery ?	2
Work GPCI ?	1.029	Bilateral Surgery ?	1
Practice GPCI ?	1.113	Assistant At Surgery ?	1
Malpractice GPCI ?	1.094	Two Surgeons ?	0
Reduced Therapy	0.00	Team Surgery ?	0

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FEE SCHEDULE LOOKUP

Fee Schedule Assistance

The fee schedule assistance page provides access to information about fee schedule definitions and acronyms.

- Illinois Locality/Area and County Information
- Maine, Massachusetts, New Hampshire, Rhode Island, Vermont Locality/Area and County Information
- New York Locality/Area and County Information

National Fee Schedules

Access the CMS website to view and download the following **national fee schedules**:

- Ambulance Fee Schedule
- Ambulatory Surgical Center (ASC) Payment
- Clinical Laboratory Fee Schedule
- Medicare Part B Drug Average Sales Price
- DMEPOS Fee Schedule

Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Suspended Through March

- Coronavirus Aid, Relief, and Economic Security (CARES) Act suspended the payment adjustment percentage of 2% applied to all Medicare Fee-For-Service (FFS) claims from May 1 through December 31
- Consolidated Appropriations Act, 2021, signed into law on December 27, extends the suspension period to March 31, 2021

Consolidated Appropriations Act 2021

- Provided a 3.75% increase in MPFS payments
- Revised 2021 MPFS conversion factor is $34.8931 (Recalculated from $32.41)
- Reinstated the 1.0 floor on the work GPCI through 2023
- Delayed implementation of the inherent complexity add-on code for E/M service G2211 until CY 2024

2021 Medicare Physician Fee Schedule (MPFS)

- 2021 Physician Fee Schedules and the 2021 Anesthesia Conversion Factors (CFs) are available on our website
- Changes in RVU's include significant increases for E/M visit codes

2021 Medicare Deductibles and Coinsurance

2021 Medicare Deductibles and Coinsurance

2021	Amounts
Part B Deductible	$203
Part B Coinsurance	20%
Part A IH Deductible (first 60 days)	$1484
Days 61st -90th Days	$371
Lifetime reserve day	$742
Skilled Nursing Facilities (21st-100th days)	$185.50

E/M Changes in CY 2021

Summary of Major E/M Revisions for 2021 Office or Other Outpatient Services

- Changes apply only to office and outpatient services
- Extensive E/M guideline additions, revisions, and restructuring
- Deletion of code 99201 and revision of codes 99202-99215
  - 99202 requires straightforward MDM
- Components for code selection
  - MDM or
  - Total time on the date of the encounter

Summary of Revisions for 2021

- E/M level of service for office or other outpatient services can be based on
  - MDM
    - Extensive clarifications provided in guidelines to define elements of MDM
  - Time: Total time spent on date of the encounter
    - Including non-face-to-face services
    - Clear time ranges for each code
- Addition of a shorter 15-minute prolonged service code (G2212)
  - Reported only when visit is based on time and after total time of highest-level service (i.e., 99205 or 99215) has been exceeded

2021 CPT Definition 99202

- 99202: Office or other outpatient visit for the evaluation and management of a new patient, which requires a **medically appropriate history and/or examination and straightforward medical decision making**
- When using time for code selection,15-29 minutes of total time is spent on date of encounter

2021 CPT Definition 99203

- 99203: Office or other outpatient visit for the evaluation and management of a new patient, which requires a **medically appropriate history and/or examination and low level of medical decision making**
  - When using time for code selection, 30-44 minutes of total time is spent on date of encounter
- Note changes: no specific history or exam requirements

2021 CPT Definition 99204

- 99204: Office or other outpatient visit for the evaluation and management of a new patient, which requires a **medically appropriate history and/or examination and moderate level of medical decision making**
- When using time for code selection, 45-59 minutes of total time is spent on date of encounter

2021 CPT Definition 99205

- 99205: Office or other outpatient visit for the evaluation and management of a new patient, which requires a **medically appropriate history and/or examination and high level of medical decision making**
- When using time for code selection, 60-74 minutes of total time is spent on date of encounter
- For services 75 minutes or longer, see prolonged services G2212

2021 CPT Definition 99211

- 99211: Office or other outpatient visit for the evaluation and management of an established patient, that may not require the **presence of a physician or other qualified health care professional**
- Usually, presenting problem(s) are minimal

2021 CPT Definition 99212

- 99212: Office or other outpatient visit for the evaluation and management of an established patient, which requires **medically appropriate history and/or examination and straightforward medical decision making**
- When using time for code selection,10-19 minutes of total time is spent on date of encounter

2021 CPT Definition 99213

- 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires **a medically appropriate history and/or examination and low level of medical decision making**
- When using time for code selection, 20-29 minutes of total time is spent on date of encounter
- Note changes: no specific history or exam requirements

2021 CPT Definition 99214

- 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires **a medically appropriate history and/or examination and moderate level of medical decision making**
- When using time for code selection, 30-39 minutes of total time is spent on date of encounter

2021 CPT Definition 99215

- 99215: Office or other outpatient visit for the evaluation and management of an established patient, which requires a **medically appropriate history and/or examination and high level of medical decision making**
- When using time for code selection, 40-54 minutes of total time is spent on date of encounter
- For services 55 minutes or longer, see prolonged services G2212

2021: Selecting Level of Service

- **Effective 1/1/2021**
- Appropriate level of E/M service is based on
  1. Level of the MDM as defined for each service
  2. Total time for E/M services performed on the date of encounter

Medical Decision Making

- Effective 1/1/2021
- Level of medical decision making table
- Guide to assist in selecting the level of MDM
- Used for office or other outpatient E/M services only
- Includes four levels of MDM (unchanged from current levels of MDM)
  - Straightforward
  - Low
  - Moderate
  - High

Medical Decision Making Table

MDM 2020		MDM Effective 1/1/2021
Number of diagnoses or management options	→	Number and complexity of problems addressed at the encounter
Amount and/or complexity of data to be reviewed	→	Amount and/or complexity of data to be reviewed and analyzed
Risk of complications and/or morbidity or mortality	→	Risk of complications and/or morbidity or mortality of patient management

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MDM: Number and Complexity of Problems Addressed at Encounter

- Straightforward
  - Self-limited
- Low
  - Stable, uncomplicated, single problem
- Moderate
  - Multiple problems or significantly ill
- High
  - Very ill

MDM: Amount and/or Complexity of Data to be Reviewed and Analyzed

- Straightforward
  - Minimal or None
- Low (one category only)
  - Two documents or independent historian
- Moderate (one category only)
  - Count: Three items between documents and independent historian; or
  - Interpret; or
  - Confer
- High (two categories)
  - Same concepts as moderate

MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

- Straightforward
  - Minimal risk from treatment (including no treatment) or testing (most would consider this effectively as no risk)
- Low
  - Low risk (e.g., very low risk of severity problems), minimal consent/discussion
- Moderate
  - Would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management
- High
  - Need to discuss higher risk problems that could happen for which physician or other qualified health care professional will watch or monitor

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional** **diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204 **99214**	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

Medical Decision Making Table

To qualify for a particular level of medical decision making, **two of the three** elements for that level of decision making must be met or exceeded **(concept unchanged from current guidelines)**

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

Time: Office and Other Outpatient E/M Services

- Effective 1/1/2021
- Time may be used to select code level in **office or other outpatient services** whether or not counseling and/or coordination of care dominates service
- Time may only be used for selecting level of other E/M services when counseling and/or coordination of care dominates service
- CPT code selection is total time on date of encounter

Time: Office and Other Outpatient E/M Services

- **Total Time** on date of encounter
- Includes physician/other QHP face-to-face and non-face-to-face time
- Time spent by clinical staff is not included
- More than one clinician addressed (count only one person per minute)

Time: Office and Other Outpatient E/M Services

- Physician/other QHP time includes the following activities (when performed)
  - Preparing to see patient (e.g., review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing medically necessary appropriate examination and/or evaluation
  - Counseling and educating patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Referring and communicating with other health care professionals (when not reported separately)
  - Documenting clinical information in electronic or other health record
  - Independently interpreting results (not reported separately) and communicating results to patient/family/caregiver
  - Care coordination (not reported separately)

Time: Office and Other Outpatient E/M Services
New Patient (Total Time on the Date of the Encounter)

New Patient E/M Code	Typical Time (2020)	Total Time (2021)
99201	10 minutes	Code deleted
99202	20 minutes	15-29 minutes
99203	30 minutes	30-44 minutes
99204	45 minutes	45-59 minutes
99205	60 minutes	60-74 minutes

Time: Office and Other Outpatient E/M Services

Established Patient (Total Time on the Date of the Encounter)

Established Patient E/M Code	Typical Time (2020)	Total Time (2021)
99211	5 minutes	Time component removed
99212	10 minutes	10-19 minutes
99213	15 minutes	20-29 minutes
99214	25 minutes	30-39 minutes
99215	40 minutes	40-54 minutes

Prolonged Services (G2212)

- **Effective 1/1/2021**
- Shorter prolonged services code to capture each 15 minutes of physician/other QHP work beyond time captured by office or other outpatient service E/M code
- Used only when office/other outpatient code is selected using time
- For use only with 99205, 99215
- Prolonged services of less than 15 minutes should not be reported

Prolonged Services (G2212)

- Prolonged service **with or without** direct patient contact on date of an office or other outpatient service
- G2212 descriptor: Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact
- List separately in addition to codes 99205, 99215 for office or other outpatient E/M services

Prolonged Services

- Use G2212 in conjunction with 99205, 99215
- Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416
- Do not report G2212 for any time unit less than 15 minutes

Prolonged Service New Patient Coding

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99205 x 1 and G2212 x 3 or more for each additional 15 minutes	119 or more

*Total time is the sum of all time, with and without direct patient contact and including prolonged time, spent by the reporting practitioner on the date of service of the visit

Prolonged Service Established Patient Coding

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84- 98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

*Total time is the sum of all time, with and without direct patient contact and including prolonged time, spent by the reporting practitioner on the date of service of the visit

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COVID-19 Public Health Emergency

Special Disclaimer and Suggested Actions

- During COVID-19 PHE information and instructions may change and will turn to prior instructions following PHE
  - Extended to 1/20/2021
- Vital to ensure providers receive latest information
- Take steps to ensure you have access to the latest updates by signing up for listserv messaging
  - CMS Listserv and
  - National Government Services Email Updates
- Routinely check
  - CMS Current Emergencies web page and
  - NGS COVID-19 web page

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Modifier CR

- Modifier CR (catastrophe/disaster related)
  - Used on professional and outpatient institutional claims
  - CR modifier is not required on telehealth services
- Mandatory coding for any claim for which Medicare payment is conditioned on presence of "formal waiver" including Section1135 waiver
- Used to identify claims that are/may be impacted by specific payer/health plan policies related to national or regional disaster

CS Modifier

- CS modifier waives cost sharing requirements
  - MLN Matters® *SE20011 Revised: Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)*
- DOS on/after 3/18/2020: Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits
  - Append CS modifier to E/M service performed
    - When E/M service leads to COVID-19 testing
    - Allows E/M to be paid at 100% of the fee schedule

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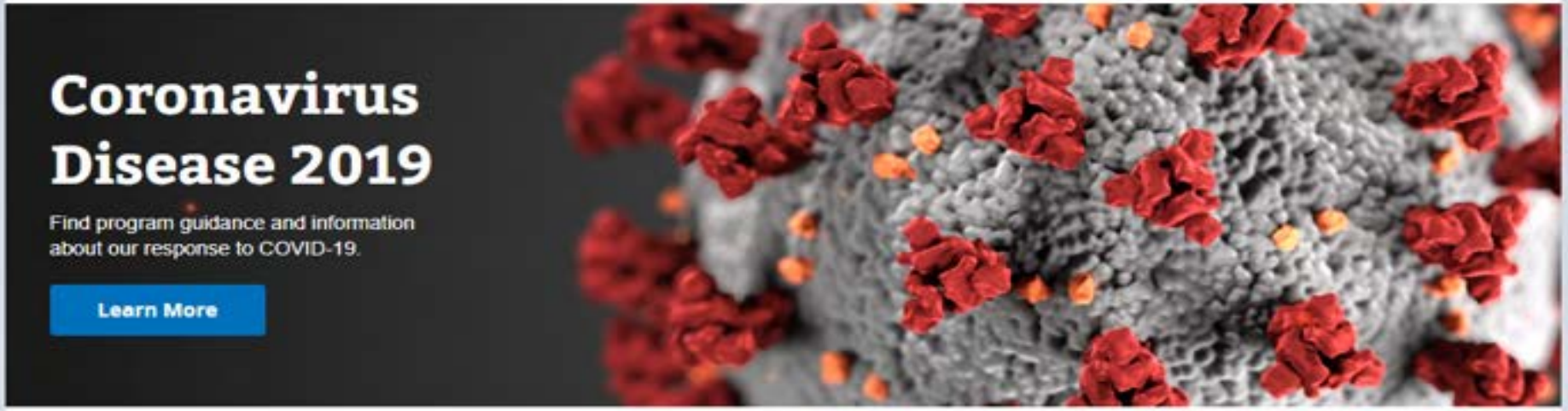


We're putting patients first.

We pledge to put patients first in all of our programs – Medicaid, Medicare, and the Health Insurance Exchanges. To do this, we must empower patients to work with their doctors and make health care decisions that are best for them.

This means giving them meaningful information about quality and costs to be active health care consumers. It also includes supporting innovative approaches to improving quality, accessibility, and affordability, while finding the best ways to use innovative technology to support patient-centered care.

But we can't and we don't do all of this alone. Learn more about how we are working together to ensure all patients get the very best health care.

Top 5 resources

- Manuals
- Medicare coverage database
- CMS forms
- Transmittals
- MLN Homepage

Spotlight

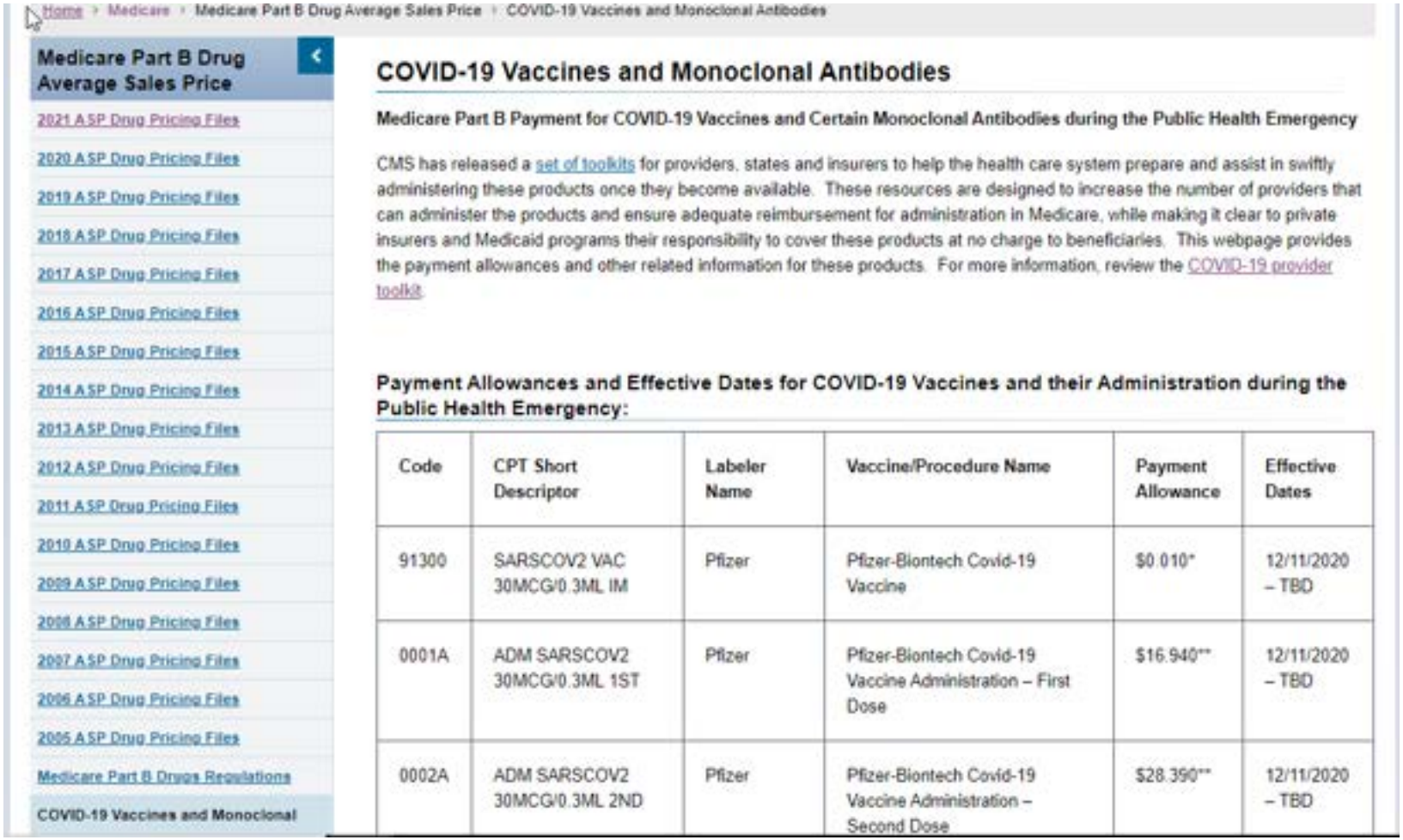
CMS news

www.NGSMedicare.com

COVID-19 Vaccine Codes: Updated Effective Date for Moderna and Biontech

- Effective December 11, 2020, FDA issued an Emergency Use Authorization for the Pfizer-Biontech Covid-19 Vaccine
- Effective December 18, 2020, FDA issued an Emergency Use Authorization for the Moderna COVID 19 Vaccine
- During the PHE, Medicare will cover and pay for the administration of the vaccine
- Bill only for the vaccine administration code
  - Do not include the vaccine product code when the vaccines are free

Codes for the 2019-Novel Coronavirus (COVID-19)



Home > Medicare > Medicare Part B Drug Average Sales Price > COVID-19 Vaccines and Monoclonal Antibodies

Medicare Part B Drug Average Sales Price

- 2021 ASP Drug Pricing Files
- 2020 ASP Drug Pricing Files
- 2019 ASP Drug Pricing Files
- 2018 ASP Drug Pricing Files
- 2017 ASP Drug Pricing Files
- 2016 ASP Drug Pricing Files
- 2015 ASP Drug Pricing Files
- 2014 ASP Drug Pricing Files
- 2013 ASP Drug Pricing Files
- 2012 ASP Drug Pricing Files
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- 2008 ASP Drug Pricing Files
- 2007 ASP Drug Pricing Files
- 2006 ASP Drug Pricing Files
- 2005 ASP Drug Pricing Files
- Medicare Part B Drugs Regulations
- COVID-19 Vaccines and Monoclonal

COVID-19 Vaccines and Monoclonal Antibodies

Medicare Part B Payment for COVID-19 Vaccines and Certain Monoclonal Antibodies during the Public Health Emergency

CMS has released a set of toolkits for providers, states and insurers to help the health care system prepare and assist in swiftly administering these products once they become available. These resources are designed to increase the number of providers that can administer the products and ensure adequate reimbursement for administration in Medicare, while making it clear to private insurers and Medicaid programs their responsibility to cover these products at no charge to beneficiaries. This webpage provides the payment allowances and other related information for these products. For more information, review the COVID-19 provider toolkit.

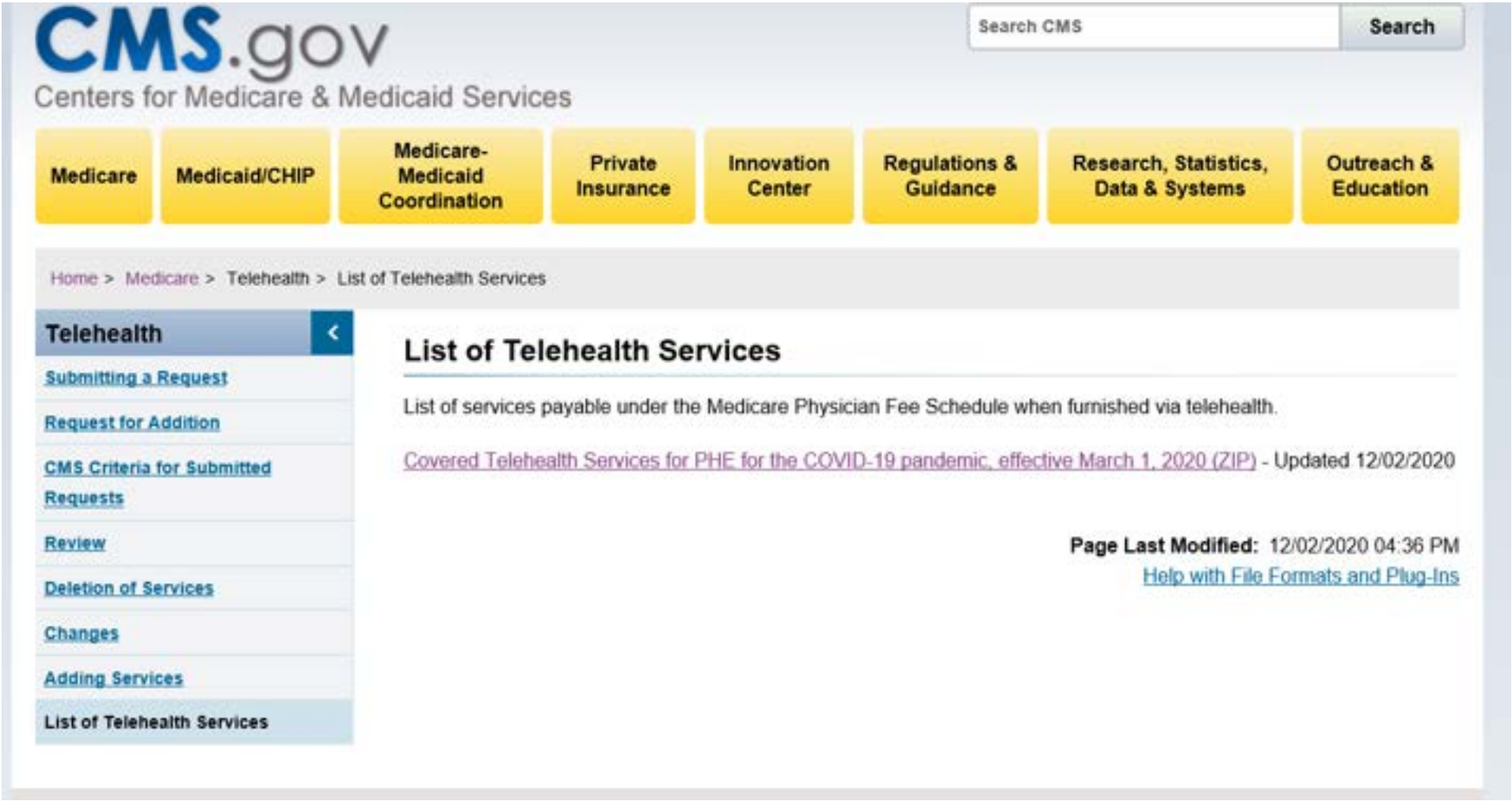
Payment Allowances and Effective Dates for COVID-19 Vaccines and their Administration during the Public Health Emergency:

Code	CPT Short Descriptor	Labeler Name	Vaccine/Procedure Name	Payment Allowance	Effective Dates
91300	SARSCOV2 VAC 30MCG/0.3ML IM	Pfizer	Pfizer-Biontech Covid-19 Vaccine	$0.010*	12/11/2020 – TBD
0001A	ADM SARSCOV2 30MCG/0.3ML 1ST	Pfizer	Pfizer-Biontech Covid-19 Vaccine Administration – First Dose	$16.940**	12/11/2020 – TBD
0002A	ADM SARSCOV2 30MCG/0.3ML 2ND	Pfizer	Pfizer-Biontech Covid-19 Vaccine Administration – Second Dose	$28.390**	12/11/2020 – TBD

Telehealth Services

Reminders for Telehealth Services

- On/after 3/1/2020 and for duration of PHE
  - Bill audio or audio/video telehealth service with modifier 95 (professional telehealth service from a distant site)
  - POS equal to what it would have been (if were performed FTF) in the absence of a PHE
  - CR modifier not required on telehealth services
  - Telehealth services are professional services billed as distant site
  - Teaching physician may use audio/video telecommunications during key portions of service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Private Insurance
Innovation Center
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List of Telehealth Services
List of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.
Covered Telehealth Services for PHE for the COVID-19 pandemic, effective March 1, 2020 (ZIP) - Updated 12/02/2020
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Help with File Formats and Plug-Ins

LIST OF MEDICARE TELEHEALTH SERVICES for PHE for the COVID-19 pandemic effective March 1 2020-updated December 1 2020				
Cod	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements	Medicare Payment Limitations
77427	Radiation tx management x5	Temporary Addition for the PHE for the COVID-19 Pandemic		
90785	Psytx complex interactive		Yes	
90791	Psych diagnostic evaluation		Yes	
90792	Psych diag eval w/med srvcs		Yes	
90832	Psytx w pt 30 minutes		Yes	
90833	Psytx w pt w e/m 30 min		Yes	
90834	Psytx w pt 45 minutes		Yes	
90836	Psytx w pt w e/m 45 min		Yes	
90837	Psytx w pt 60 minutes		Yes	
90838	Psytx w pt w e/m 60 min		Yes	
90839	Psytx crisis initial 60 min		Yes	
90840	Psytx crisis ea addl 30 min		Yes	
90845	Psychoanalysis		Yes	
90846	Family psytx w/o pt 50 min		Yes	
90847	Family psytx w/pt 50 min		Yes	
90853	Group psychotherapy		Yes	
90875	Psychophysiological therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered service
90951	Esrd serv 4 visits p mo <2yr			
90952	Esrd serv 2-3 vsts p mo <2yr	Available up Through the Year in Which the PHE Ends		
90953	Esrd serv 1 visit p mo <2yrs	Available up Through the Year in Which the PHE Ends		

Services Added to the Medicare Telehealth List on a Category 1 Basis

- For CY 2021, CMS is finalizing the addition of the following list of services to the Medicare telehealth list
  - Group psychotherapy - 90853
  - Psychological and neuropsychological testing - 96121
  - Domiciliary, rest home, or custodial care services - 99334-99335
  - Home visits - 99347-99348
  - Cognitive assessment and care planning services - 99483
  - Visit complexity inherent to certain office/outpatient E/M - G2211
  - Prolonged services - G2212
- Category 1 means permanent telehealth services

Addition of Services to the Medicare Telehealth List on a Category 3 Basis

- Category 3 - services added to the Medicare telehealth list during the COVID-19 PHE that will remain on the list through the calendar year in which the PHE ends
  - Domiciliary, rest home, or custodial care services - 99336-99337
  - Home visits - 99349-99350
  - Emergency department visits - 99281-99285
  - Nursing facilities discharge day management - 99315-99316
  - Psychological and neuropsychological testing- 96130-96133; 96136-96139

Addition of Services to the Medicare Telehealth list on a Category 3 Basis

- Therapy services, physical and occupational therapy - 97161-97168; 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507
- Hospital discharge day management - 99238-99239
- Inpatient neonatal and pediatric critical care - 99469, 99472, 99476
- Continuing neonatal intensive care services - 99478-99480
- Critical care services - 99291-99292
- End-stage renal disease monthly capitation payment - 90952, 90953, 90956, 90959, 90962
- Subsequent observation and observation discharge day management - 99217; 99224-99226

Originating Site

- Definition: Where the patient is located during telehealth service
  - Geographic restrictions waived
  - Originating site now includes patient home
  - No originating Part B site fee payable when patient is at home

Distant Site Services

- Distant site practitioners bill Part B Medicare for professional services furnished via telehealth
  - Submit appropriate CPT/HCPCS code
  - Modifier 95 mandatory on all telehealth claims during PHE
    - Indicates service rendered via telehealth
  - Use POS as would apply if seeing the patient face-to-face (e.g., POS 11, 21, 23)
  - No reduction in payment under MPFS

Expanded Services

- CMS added additional services to telehealth
  - Many additional E/M codes, including critical care
  - Expanded coverage to telephone E/M (99441-99443)
  - Audio only services for some HCPCS codes
  - Psychological/neuropsychological testing
  - Therapy services, physical and occupational therapy, all levels
  - Radiation treatment management services
  - Remote patient monitoring
- Virtual Check-Ins, E-Visits and Telephone
  - G2010, G2012, G2061-G2063, 99421-99423
  - 98966-98968
    - **Note: These codes are not telehealth**

Telephone Services

- 99441-99443
  - Physicians (including osteopaths, podiatrists, and optometrists), dentists, nonphysician practitioners (including nurse practitioner, clinical nurse specialist, physician assistant, certified nurse midwife) and maxillofacial surgeon
  - Telephone E/M service by practitioner or qualified health care professional
  - 4/30/2020 added to telehealth services; use modifier 95
- 98966-98968
  - Clinical psychologists, PT/OT/SLP, optometrists, nonphysician practitioners (including nurse practitioner, clinical nurse specialist, physician assistant, certified nurse midwife), LCSWs, registered dietitians and nutrition professionals
  - Telephone assessment and management service
  - **Not on the CMS list of telehealth codes**

Telehealth Documentation

- Same as any face-to-face patient encounter, except a statement needed indicating service was telehealth, along with
  - Patient location
  - Provider location
  - Names of all persons participating in the telemedicine service and their role in the encounter
- Time-based services, document start/stop time or total time
- Teaching physician may use audio/video telecommunications during key portions of service

Resources

- AMA CPT Evaluation and Management ama-assn.org/cpt-office-visits
- Access the Module
- CPT® E/M Office or Other Outpatient and Prolonged Services Code and Guideline Changes
- The above PDF includes the official E/M CPT guidelines effective January 1, 2021
- CPT® E/M Office Revisions Level of Medical Decision Making (MDM)
- Revisions to reporting CPT E/M office visits: Time
- Revisions to reporting CPT E/M office visits: MDM
- E/M health plan webinar: Overview of changes proposed for 2021
- Videos to guide you step-by-step
- 10 tips to prepare your practice for E/M office visit changes

National Government Services

medicare university

Resources

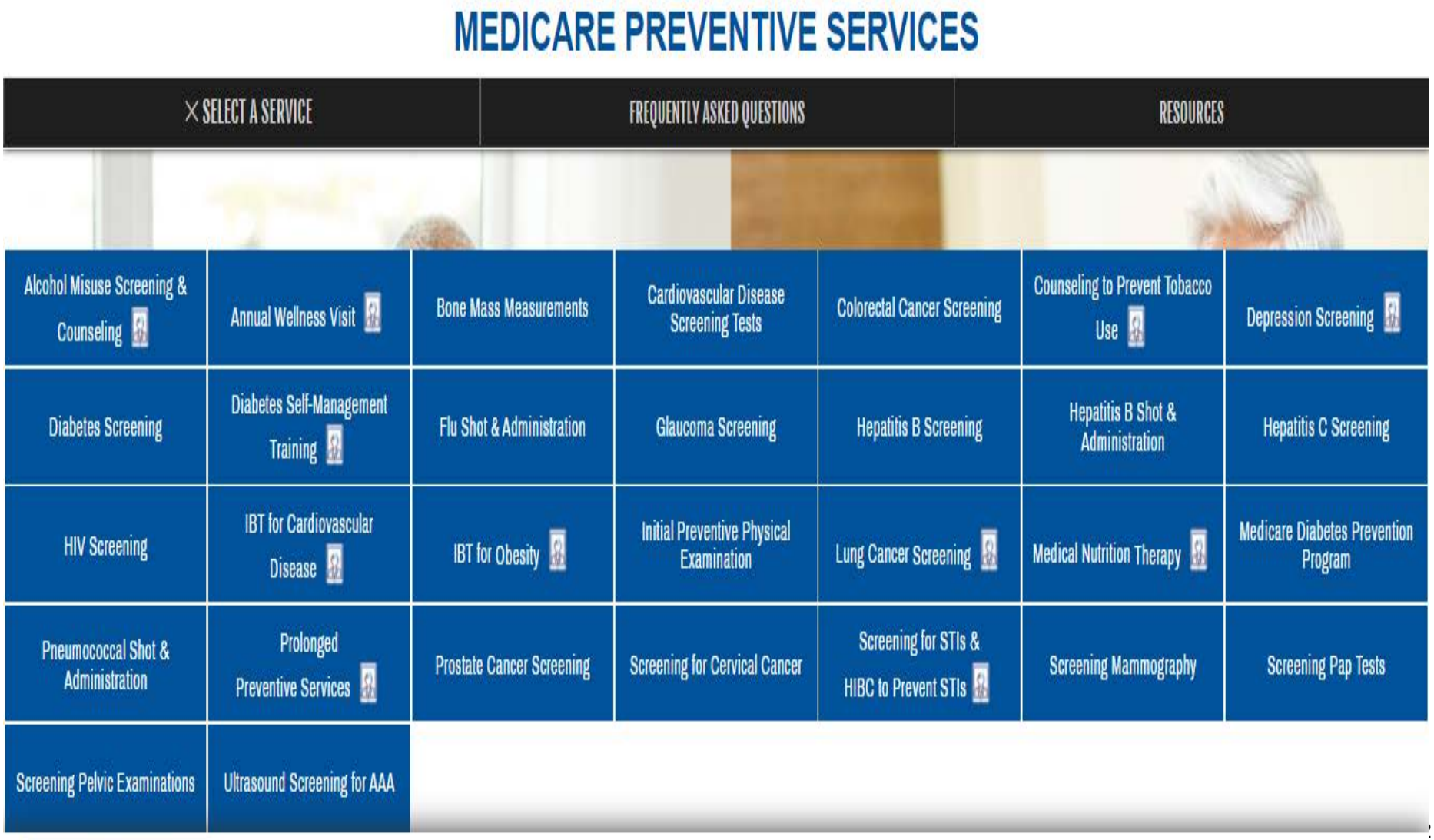
- Final Rule
- Physician Fee Schedule Final Rule
  - Fact sheet
- Quality Payment Program Final Rule
  - Fact sheet and FAQs
- Medicare Diabetes Prevention Program
  - Fact sheet

Preventive Services

Preventive Services Educational Tool

- So important at this time
- Who is Covered
- Frequency
- What the Beneficiary Pays
- ICD-10-CM Codes
- Share the message about the preparing to receive Covid-19 vaccinations.

MLN Educational Tool – Preventive Services Chart (ICN 006559)



Thank You!

- Questions?

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