RPM/CCM Reimbursement Guide

As recently as three years ago, CMS limited Medicare reimbursement for telehealth to live, real-time, synchronous voice and video contact. CMS's reimbursement rules were very restrictive. They required that the patient be present in a health professional shortage area and limited where telehealth could occur and the type of services a clinician could provide.

While CMS reimbursed for remote patient monitoring services, reimbursement was limited. Recent changes have greatly expanded reimbursement for telehealth and remote patient monitoring.

Providers may now receive Medicare payment for a broad range of telehealth services. These include:

- Telehealth visits (A visit with a provider that uses telecommunication systems between a provider and a patient.)
- Virtual check-ins with established patients (brief check-ins with patients via telephone or another telecommunications device to decide whether an office visit or other service is needed)
- e-visits (communication between a patient and their provider through an online portal)

Medicare has also created reimbursement codes that are specific to certain health conditions. These include:

- Telehealth visits with patients having two or more chronic conditions
- Telehealth visits with patients having one chronic or high-risk condition
- Interactive communication with patients experiencing a transition in care settings
- Behavioral health services
- Clinical assessment of dialysis patients
- Treatment of substance use disorders, including opioids

Recent Medicare reimbursement changes have also expanded reimbursement for remote patient monitoring. Providers may now receive Medicare payment for providing the following remote patient monitoring services:

- The supply and provisioning of devices used for remote patient monitoring programs

- The set-up and patient education on remote patient monitoring equipment
- The remote monitoring of physiological data as part of the patient's treatment management services
- Interactive time spent between a caregiver and a patient (up to three separate sessions lasting a minimum of 20 minutes)

Payment for these services will enable Medicare beneficiaries to stay in close contact with their caregivers, reduce avoidable health care expenses and experience a level of convenience that was not previously possible.

The following table describes many of the most common telehealth and remote patient monitoring services reimbursable by Medicare. For a complete listing of reimbursable services, visit: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Billing Code	**What it Covers**	**Who Can Bill**	**How Often**	**What Medicare Pays**
Telehealth Visits				
99202-99205	Telehealth-enabled office or other visits for **new patients**	Medicare Part B Providers or Qualified Health Professionals	Once	$73.97 – $224.36

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
99211-99215	Telehealth-enabled office or other visits for **established patients**	Medicare Part B Providers or Qualified Health Professionals	No limitation	$23.03 – $183.19
G0425-27	Telehealth consultations	Medicare Part B Providers or Qualified Health Professionals	No limitation	$101.19 – $200.29
G0406-08	Follow-up inpatient telehealth consultations furnished to beneficiaries in a hospital or SNF	Medicare Part B Providers or Qualified Health Professionals	No limitation	$38.38 – $103.28
Virtual Check-ins				
G2010	A brief (5-10 minutes) check via	Medicare Part B Providers	No limitation	$12.21

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
G2012	telephone or other telecommunications device to decide whether an office visit or other service is needed. It may also include a remote evaluation of recorded video and/or images submitted by an established patient.	or Qualified Health Professionals		$14.66
e-visits				
99421-423	Patient-initiated communications between an established patient and their provider through a HIPAA-compliant secure platform.	Medicare Part B Providers or Qualified Health Professionals that can bill for E/M services.	Once during a 7-day period	$15.00 – $47.46

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
Remote Patient Monitoring				
99091	The 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. In this instance, a QHP is qualified by education, training, licensure/regulation (when applicable). The code requires a minimum of 30 minutes of interpretation and review.	To bill for CPT Code 99091, the initial provider service must occur in the physician's office or other applicable sites. Additionally, only a physician or QHP may perform these services, distinguishing it significantly from 99457, in which a clinical staff member can provide services "incident to."	Once in a 30-day billing period.	$56.88

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
99453	The initial set-up of devices, training, and education on the use of monitoring equipment and any services needed to enroll the patient on-site.	Not specified; not required to be clinical staff (Practice Expense Only Code)	Once per patient, only first month of reading for 99454	$19.19
99454	The supply and provisioning of devices used for RPM programs.	Not specified; not required to be clinical staff (Practice Expense Only Code)	Once in a 30-day billing period; required 16 days of readings	$63.16
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99457	The remote monitoring of physiologic data as part of the patient's treatment management services. To receive reimbursement, the physician, QHP, or other clinical staff must provide RPM treatment management	Those in indirect general supervision of clinical staff	Once per month	$50.94

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
	services for at least 20 minutes per month.			
99458	Each additional 20 minutes of remote monitoring and treatment management services provided.	Those in indirect general supervision of clinical staff	Once per month	$41.17
Chronic Care Management				
99490	The first full 20 minutes of **non-complex** Chronic Care Management of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements:	Medicare Part B Providers or Qualified Health Professionals	Once per month	$41.17

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
	· Multiple (2 or more) chronic conditions expected to last at least 12 months or until the death of the patient; · Chronic conditions place the patient at significant risk of death, acute exacerbation, decompensation, or functional decline; · Comprehensive care plan established, implemented, revised, or monitored.			
99487	The first 60 minutes of clinical staff or QHP or provider time for moderately or **highly complex** CCM.	Medicare Part B Providers or Qualified Health Professionals	Once per month	$91.77
99489	An additional 30 minutes of time spent in the same billing cycle as 99487 with high or	Medicare Part B Providers or Qualified Health Professionals	Once per month	$43.97

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
	moderate complexity patients who require more time.			
Principal Care Management				
G2064	An interaction between a **physician or non-physician practitioner** with a patient with one chronic disease or high-risk condition lasting at least 30 minutes per calendar month.	Medicare Part B Providers or Qualified Health Professionals	Once per month	$90.37
G2065	An interaction between **clinical staff** with a patient with one chronic disease or high-risk condition lasting at least 30 minutes per calendar month.	Medicare Part B Providers or Qualified Health Professionals	Once per month	$38.73

Billing Code	What it Covers	Who Can Bill	How Often	What Medicare Pays
Transition Care Management				
99495	Transitional Care Management services, including interactive contact with the moderately complex patient within two days of discharge, with a face-to-face visit within 14 days of discharge.	Medicare Part B Providers or Qualified Health Professionals	Once per discharge	$207.96
99496	Extra care incentives for highly complex patients with interactive contact within two days of discharge for TCM services, with a face-to-face visit within seven (7) days of discharge.	Medicare Part B Providers or Qualified Health Professionals	Once per discharge	$281.59