Post COVID-19 Public Health Emergency

Guide

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PUBLISHED AUG, 2023

Introduction:

The Secretary of the Department of Health and Human Services (HHS), Alex Azar, declared the 2019 Novel Coronavirus (2019-nCoV) outbreak a public health emergency on January 31, 2020.

Since then, many policies and procedures for coding, billing, and patient care have changed in order to make prevention, diagnosis, and treatment accessible during this healthcare crisis. This is especially true when it comes to federal programs like Medicare.

On May 11, 2023 the HHS Public Health Emergency formally ended, setting in motion a countdown for the end of these special allowances.

For practice managers, patient-facing or not, this onslaught of changes has far-reaching implications for the success of your practice.

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How to Use This Guide:

This guide is meant to be a robust, but not exhaustive, list of changes stemming from the end of the PHE.

We expect changes to keep coming as the situation evolves and encourage you to keep checking back in with our billing, coding, and credentialing experts for the most up-to-date information.

We've organized this guide's points by Patient, then Patient-Facing Providers, then Practice Managers, Billers, & Coders, where all parties involved must be aware of this information but it's categorized under the party most "far away" from the information source.

We've also included checklists summarizing the information needed by your patients, your patient-facing providers, and your administrative staff to help streamline sharing this information.

Your practice and patient population are unique, and we couldn't possibly account for every need and question at a nuanced level in one guide, but we hope this serves as a helpful framework as policies continue to change.

Please always be sure to carefully consider how this information applies to your specialty, specifically.

Questions?

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Section 1

Changes to COVID-19 Testing, Vaccination, Treatment, and Delegation

What Patients Need to Know:

COVID-19 Vaccination, Testing, and Treatment

- There will continue to be no out-of-pocket costs for COVID-19 vaccinations regardless of insurance status.
- For those with private insurance, diagnostic testing for COVID-19 may require medical management including cost sharing or prior authorization.
- Patients with Traditional Medicare can continue to receive COVID-19 PCR and antigen tests with no cost-sharing when the test is ordered by a physician or certain other healthcare providers, such as physician assistants and certain registered nurses, and performed by a laboratory.
- Patients enrolled in Medicare Advantage plans can continue to receive COVID-19 PCR and antigen tests when the test is covered by Medicare, but their cost-sharing may have changed at the end of the PHE.
- All COVID-19 and related testing performed by a laboratory must now be ordered by a physician or non-physician practitioner.
- Pharmacists are no longer authorized to order COVID-19 tests.
- Post PHE coverage of FDA-authorized COVID-19 serology testing is now at the Medicare Administrative Contractor's (MACs) discretion.
- The program that allowed Medicare beneficiaries to receive up to eight over-the-counter tests per calendar month at no cost, has ended.
- Medicare will continue to cover treatment(s) for patients with COVID-19.

What Patient-Facing Providers Need to Know:

COVID-19 Vaccination and Treatment

- The public cash price requirement for COVID-19 testing has been terminated. Price transparency requirements under other laws and regulations will continue to apply.
- Effective January 1, 2024, CMS will set the payment rate for administering COVID-19 vaccines to align with the payment rate for other Medicare Part B preventative Vaccines; approximately $30.00 per dose.
- Also effective January 1, 2024, CMS will pay for the treatment or for post-exposure prophylaxis of COVID-19 as they pay for biological products under Section 1847A of the Social Security Act, similarly to the way they pay for administering other complex biological products.

COVID-19 Lab Specimen Collection and Testing

- Nurse Practitioners, clinical nurse specialists, certified nurse-midwives, physician assistants, certified registered nurse anesthetists are permanently allowed to supervise diagnostic tests as authorized under state law and licensure (85 FR 84590-84592). These providers are required to continue the statutory relationships with supervising or collaborating physicians.
- CMS will continue to exercise enforcement discretion that allows pathologists to examine digital images and laboratory data at remote locations.
- CMS will continue to allow for expedited lab certification by allowing a Laboratory to begin testing as soon as they receive a CLIA number and pay the laboratory fee.
- Laboratories within a hospital/University hospital campus will continue to be permitted to hold a single certificate for the laboratory sites within the same physical location or street address.
- CLIA will continue to only require Laboratories to follow the manufacturer's instructions for specimen collection devices and media to collect and transport COVID-19 samples.

Delegation and Substitute Providers

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What Practice Managers, Billers and Coders Need to Know:

COVID-19 Vaccination, Testing, and Treatment

- CMS will continue to pay approximately $40 per dose for administering COVID-19 vaccines through the end of the 2023 calendar year.
- Most forms of private health insurance, including all Affordable Care Act-compliant plans, must continue to cover COVID-19 vaccines furnished by an in-network health care provider without cost-sharing.
- As a result of the American Rescue Plan Act of 2021 (ARPA), states must provide Medicaid and CHIP coverage, without cost-sharing, for COVID-19 vaccinations, testing, and treatments through September 30, 2024.
- A single certificate for the laboratory sites within the same physical location or street address.
- CLIA will continue to only require Laboratories to follow the manufacturer's instructions for specimen collection devices and media to collect and transport COVID-19 samples.

COVID-19 PHE-Related Coding Changes

- CMS level one E/M visit (CPT code 99211) has resumed its ordinary requirements. This code may now only be used when clinical staff perform services incident to those of another billing physician or practitioner for an established patient, not for services related to COVID-19 diagnostic testing.
- HCPCS codes G2023 and G2024 for Laboratory Specimen collection from a homebound beneficiary or a non-hospital inpatient are no longer payable and will be terminated.
- The 99211 CPT code requirements have returned to pre-PHE rules. CPT 99211 can no longer be billed when clinical staff collect a specimen for COVID-19 diagnostic testing.
- HCPCS codes U0003, U0004, and U0005 are no longer payable and will be terminated.
    - The HCPCS codes were created to ensure a higher payment for COVID-19 clinical diagnostic lab tests making use of high-throughput technologies. Payment rates have reverted to those rates under the clinical laboratory fee schedule.

Section 2

Changes To Telehealth, Remote Evaluations and Monitoring, Virtual Check-Ins, and E-Visits

What Patients Need to Know:

Medicare Telehealth Policies Made Permanent:

- FQHCs and RHCs can permanently act as distant site providers for behavioral/mental telehealth services.
- Rural Emergency Hospitals (RHEs) are permanently eligible to be originating sites for telehealth.
- Medicare patients can receive telehealth services for behavioral/mental health care in their home.
- There are no geographic restrictions for originating site for behavioral/mental telehealth services.
- Behavioral/mental telehealth services can be delivered using audio-only communication platforms.

Medicare Telehealth Policies Extended Only Through December 31, 2024.

- FQHCs and RHCs can serve as a distant site provider for non-behavioral/mental telehealth services.
- Medicare patients can receive telehealth services in their home.
- There are no geographic restrictions for originating site for non-behavioral/mental telehealth services.
- Some non-behavioral/mental telehealth services can be delivered using audio-only communication platforms.
- An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required.
- Telehealth services can be provided by all eligible Medicare providers.

Other Information Regarding Medicare Telehealth Benefits

- The requirement for patients with End-Stage Renal Disease (ESRD) on home dialysis to receive a face-to face visit, without the use of telehealth is back in effect. These patients must receive a face-to face visit at least monthly during the initial three months and at least once every three consecutive months after the initial three-month period.
- Medicare Advantage plans specifically may offer additional telehealth benefits, and patients should review their plan for coverage.
- Flexibility has ended for patients receiving routine home care via telehealth under the hospice benefit.

What Patient-Facing Providers Need to Know:

Visit Requirements

- Provider site visits for moderate and high-risk providers/suppliers are again required and have resumed.
- National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) that require in-person, face-to-face visits for evaluations and assessments are back in effect.
- Physicians are again required to conduct any federally required in-person visits for nursing home residents.
- All Medicare Telehealth Services added during the PHE will remain on the Medicare telehealth list through the end of calendar year (CY) 2023. It is anticipated that the Medicare Telehealth services list will be updated for CY 2024. ***See List of Telehealth Services for Calendar Year 2023 attached.***
- The CMS waiver that allowed practitioners to render telehealth services from their home address without reporting their home address on their Medicare enrollment application is extended through December 31, 2023.

Virtual Supervision and Oversight

- Effective January 1, 2024 the regulatory definition of direct supervision will return to pre-PHE rules, requiring the supervising physician or practitioner to be “immediately available” to furnish assistance and direction; “virtual” presence of the supervising physician or practitioner will no longer be permitted.
- CMS is exercising enforcement discretion to allow teaching physicians in all teaching settings to be present virtually, through audio/video real-time communications technology. For purposes of billing under the PFS for services, they furnish involving resident physicians through December 31, 2023.
- Only Teaching physicians in residency training sites located outside of a metropolitan statistical area may direct, manage, and review care furnished by residents through audio/video real-time communication technology.

What Practice Managers, Billers, and Coders Need to Know:

Coverage Information

- The CMS waiver allowing Place of Service 02 to be used with modifier 95 for telehealth services that otherwise would have been provided in person continues through December 31, 2024. This allows the provider to receive the complete allowance.
- CMS encourages states to continue to cover Medicaid and CHIP services when they are delivered via telehealth, but Medicaid and CHIP telehealth policies will ultimately vary by state.

Technology Requirements

- The Department of Health and Human Services will no longer accommodate enforcement discretion for their requirement of a HIPAA-compliant platform effective August 9, 2023.

Coding Changes

- Coverage for telehealth and other remote care services varies by private insurance. When covered, private insurance may now impose cost-sharing, prior authorization, or other forms of medical management on telehealth and other remote care services.
- A subsequent inpatient visit could be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233) through December 31, 2023.
- A subsequent skilled nursing facility visit could be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 14 days (CPT codes 99307- 99310) through December 31, 2023.
- Medicare payment for the telephone evaluation and management visits (CPT codes 99441-99443) is still equivalent to the Medicare payment for office/outpatient visits with established patients and has been extended through December 31, 2024.
- All applicable frequency limitation rules are back in effect for Medicare Telehealth Services:
  - Subsequent inpatient services furnished via telehealth limited to once every three days (CPT Codes 99231-99233)
  - Subsequent skilled nursing facility telehealth visits limited to once every 14 days (CPT codes 99307-99310)
  - Critical care telehealth consults codes limited to once per day (HCPCS codes G0508-G0509)

- Only established patients are now eligible for Remote Evaluation, Virtual check ins and e-visit (HCPCS codes G2010, G2012, G2251, and G2252) services.
- The flexibility to obtain annual beneficiary consent for virtual check-in services at the time of service has been made permanent.
- Post PHE, clinicians must have an established relationship with the patient prior to providing remote physiologic monitoring (RPM).
- Post PHE, CPT 99453 and 99454 may only be billed when at least 16 days of data have been collected.

Section 3

Credentialing and Provider Location & Licensure

What Patients Need to Know:

Coverage and Service Availability

- As a result of the end of provisional credentialing, patients may find that their providers no longer accept Medicaid. These patients should be notified and referred to another practice as soon as possible.

What Patient-Facing Providers Need to Know:

Medicare Location and Licensing Requirements

- The waiver for Medicare's requirement that a physician be licensed in the state in which the physician was practicing allowed licensed physicians to bill Medicare for services provided in one or more states beyond their state of enrollment.
- This waiver did not, however, waive state or local government licensure or licensure waiver requirements.
- CMS will continue to defer to state law with regard to provider licensure and practice location rules as they have even before the PHE.
- Physicians and other providers offering telehealth services from their home must now report their home address on their Medicare enrollment if they will continue to provide services from that location.
- Fingerprint-based criminal background check requirements for 5% or greater owners of newly enrolled high-risk categories of providers and suppliers have returned to pre-PHE rules.
- Medicare application fees will continue for institutional providers who are initially enrolling, revalidation, or adding a new practice location.
- Provider Enrollment toll-free hotlines established during the PHE to enroll and deliver temporary Medicare billing privileges have been shut down.

What Practice Managers Need to Know:

Medicaid Provisional Provider Enrollment

- Providers accepting Medicaid through the New York State Department of Health's provisional temporary enrollment must submit a full enrollment application that meets all requirements for Medicaid participation, that has been reviewed and approved by the NYSDOH by November 11, 2023.
- The NYSDOH will terminate the enrollment of, and cease payments to, providers who are provisionally and temporarily enrolled and fail to meet this updated requirement.

Medicare Enrollment and Opt-Out Flexibilities

- Medicare revalidation actions are back in motion; revalidation letters began rolling back out in November 2021 with due dates in early 2022.
- Normal application processing timelines have resumed, and CMS will no longer expedite any pending or new applications from providers and suppliers.
- Opt-Out enrollment status procedures have returned to Pre-PHE rules.
- The waiver permitting Medicare Administrative Contractors (MACs) to accept opt-out cancellation requests through email, fax, or phone during the PHE, where providers were not required to provide separate written notice of cancellation of their opt-out status, has been terminated.
- The general level of supervision for non-surgical extended-duration therapeutic services, enabled through the PHE has been made permanent policy.
- Pre PHE-Incident to Physician's service rules will be reinstated on January 1, 2024.
- Beneficiary informed consent to receive services furnished by auxiliary personnel will return to pre-PHE rules Janaury 1, 2024.

National Government Services Inc. (NGS) Medicare:

- Effective June 12, 2023 COVID-19 PHE hotlines were disconnected and provider enrollment and revalidation flexibilities have ended.

Highmark BCBS WNY:

- Providers are once again required to have a Drug Enforcement Agency (DEA) number for the state they are practicing in.
- This is one of many PHE flexibilities ending for Highmark BCBS WNY Providers, the grace period for which ended effective July 6, 2023.

Section 4

Other Administrative Processes

What Patient-Facing Providers Need to Know

Documentation Requirements

- Permanent policy was adopted to simplify medical record documentation requirements for physicians and certain non-physician practitioners. The policy allows the billing clinician to review and verify, rather than re-document.

MIPS Submissions and Medicare Appeals

- Individual MIPS eligible clinicians who did not submit any MIPS data by the deadline of March 31, 2022 will automatically have all four MIPS performance categories reweighted to 0% and receive a neutral payment adjustment in the 2023 payment year.
- Medicare, Medicare Advantage and Part D requests for appeals and appeal processing must again meet the pre-PHE regulatory requirements.

Stark Law Provisions

- The blanket waivers applied to certain provisions of the Stark Law were terminated at the end of the PHE. Physicians and entities must comply with all provisions of the Stark Law once again.

Hospital Stays

- The waiver of the Medicare three-day qualifying hospital stay (QHS) requirement prior to a Medicare-covered SNF stay is no longer in effect for the Medicare fee-for-service program.

Drug, Procedure, and Equipment Requirements

- Volume requirements contained in the NCDs for percutaneous Left Atrial Appendage Closure, Transcatheter Aortic Valve Replacement, Transcatheter Mitral Valve Replacement, and Ventricular Assist Devices will return to Pre-PHE enforcement.
- Signature and proof of delivery requirements have been reinstated for Part B drugs and Durable Medical Equipment (DME).
- Clinical indications in the LCDs for therapeutic continuous glucose monitors are now required to be enforced post-PHE.
- Clinical restrictions in NCDs and LCDs on respiratory-related devices, home infusion pumps, and home anticoagulation therapy will return to pre-PHE enforcement.
- Automatic policy does not apply to groups, virtual groups, or Advanced Payment Model Entities.
- The Extreme and Uncontrollable Circumstances' (EUC) application request should have been submitted for reweighting of one or more performance categories due to the impact of the PHE.

What Practice Managers, Billers and Coders Need to Know:

Staffing Decisions

- At the close of the PHE, the Chief Medical Officer or equivalent no longer has the authority to make supervising staffing decisions where NCDs and LCDs require a specific practitioner type or physician specialty to furnish or supervise a service.

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Checklist for Patient-Facing Providers

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COVID-19 Vaccination and Treatment

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Delegation and Substitute Providers

- [ ] The fee-for-time compensation (Locum Tenens) and reciprocal billing arrangements rules will return to the pre-COVID guidelines. The same substitute physician may not be used for more than 60 continuous days. The order to U.S. armed forces active-duty remains the only exception to the 60-day rule. Refer to section 1842(b)(6)(D)(iii) of the Social Security Act to review the Centers for Medicare & Medicaid Services (CMS) detailed modification.

- [ ] The flexibility that allowed the treating physical or occupational therapist who develops or is responsible for the maintenance program or plan to delegate the performance of the relevant maintenance therapy services to a therapy assistant when clinically appropriate has been made permanent.

- [ ] The requirement for patients in the hospital to be under the care of a physician has been reinstated post PHE.

Visit Requirements

- [ ] Provider site visits for moderate and high-risk providers/suppliers are again required and have resumed.

- [ ] National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) that require in-person, face-to-face visits for evaluations and assessments are back in effect.

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Checklist for Practice Managers, Billers, and Coders

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COVID-19 Vaccination, Testing, and Treatment

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- [ ] Medicare patients can receive telehealth services for behavioral/mental health care in their home.
- [ ] There are no geographic restrictions for originating site for behavioral/mental telehealth services.
- [ ] Behavioral/mental telehealth services can be delivered using audio-only communication platforms.

Medicare Telehealth Policies Extended Only Through December 31, 2024.

- [ ] FQHCs and RHCs can serve as a distant site provider for non-behavioral/mental telehealth services.
- [ ] Medicare patients can receive telehealth services in their home.
- [ ] There are no geographic restrictions for originating site for non-behavioral/mental telehealth services.
- [ ] Some non-behavioral/mental telehealth services can be delivered using audio-only communication platforms.
- [ ] An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required.
- [ ] Telehealth services can be provided by all eligible Medicare providers.

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Other Information Regarding Medicare Telehealth Benefits

- [ ] The requirement for patients with End-Stage Renal Disease (ESRD) on home dialysis to receive a face-to face visit, without the use of telehealth is back in effect. These patients must receive a face-to face visit at least monthly during the initial three months and at least once every three consecutive months after the initial three-month period.

- [ ] Medicare Advantage plans specifically may offer additional telehealth benefits, and patients should review their plan for coverage.

- [ ] Flexibility has ended for patients receiving routine home care via telehealth under the hospice benefit.

Other Information Regarding Medicare Telehealth Benefits

- [ ] As a result of the end of provisional credentialing, patients may find that their providers no longer accept Medicaid.

Post COVID-19 Public Health Emergency

List of Telehealth Services for Calendar Year 2023

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UPDATED MAY 9, 2023

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated May 9, 2023			
Code	**Short Descriptor**	**Can Audio-only Interaction Meet the Requirements?**	**Medicare Payment Limitations**
0362T	Bhv id suprt assmt ea 15 min		
0373T	Adapt bhv tx ea 15 min		
77427	Radiation tx management x5		
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		Non-covered service
90901	Biofeedback train any meth		
90951	Esrd serv 4 visits p mo <2yr		
90952	Esrd serv 2-3 vsts p mo <2yr		
90953	Esrd serv 1 visit p mo <2yrs		
90954	Esrd serv 4 vsts p mo 2-11		
90955	Esrd srv 2-3 vsts p mo 2-11		
90956	Esrd srv 1 visit p mo 2-11		
90957	Esrd srv 4 vsts p mo 12-19		
90958	Esrd srv 2-3 vsts p mo 12-19		
90959	Esrd serv 1 vst p mo 12-19		
90960	Esrd srv 4 visits p mo 20+		
90961	Esrd srv 2-3 vsts p mo 20+		
90962	Esrd serv 1 visit p mo 20+		
90963	Esrd home pt serv p mo <2yrs		
90964	Esrd home pt serv p mo 2-11		
90965	Esrd home pt serv p mo 12-19		
90966	Esrd home pt serv p mo 20+		
90967	Esrd svc pr day pt <2		
90968	Esrd svc pr day pt 2-11		
90969	Esrd svc pr day pt 12-19		
90970	Esrd svc pr day pt 20+		
92002	Eye exam new patient		
92004	Eye exam new patient		
92012	Eye exam establish patient		
92014	Eye exam&tx estab pt 1/>vst		
92507	Speech/hearing therapy	Yes	

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated May 9, 2023			
Code	**Short Descriptor**	**Can Audio-only Interaction Meet the Requirements?**	**Medicare Payment Limitations**
92508	Speech/hearing therapy	Yes	
92521	Evaluation of speech fluency	Yes	
92522	Evaluate speech production	Yes	
92523	Speech sound lang comprehen	Yes	
92524	Behavral qualit analys voice	Yes	
92526	Oral function therapy		
92550	Tympanometry & reflex thresh		
92552	Pure tone audiometry air		
92553	Audiometry air & bone		
92555	Speech threshold audiometry		
92556	Speech audiometry complete		
92557	Comprehensive hearing test		
92563	Tone decay hearing test		
92565	Stenger test pure tone		
92567	Tympanometry		
92568	Acoustic refl threshold tst		
92570	Acoustic immitance testing		
92587	Evoked auditory test limited		
92588	Evoked auditory tst complete		
92601	Cochlear implt f/up exam <7		
92602	Reprogram cochlear implt <7		
92603	Cochlear implt f/up exam 7/>		
92604	Reprogram cochlear implt 7/>		
92607	Ex for speech device rx 1hr		
92608	Ex for speech device rx addl		
92609	Use of speech device service		
92610	Evaluate swallowing function		
92625	Tinnitus assessment		
92626	Eval aud funcj 1st hour		
92627	Eval aud funcj ea addl 15		
93750	Interrogation vad in person		
93797	Cardiac rehab		
93798	Cardiac rehab/monitor		
94002	Vent mgmt inpat init day		
94003	Vent mgmt inpat subq day		
94004	Vent mgmt nf per day		
94005	Home vent mgmt supervision		Bundled code
94625	Phy/qhp op pulm rhb w/o mntr		
94626	Phy/qhp op pulm rhb w/ mntr		
94664	Evaluate pt use of inhaler		
95970	Alys npgt w/o prgrmg		
95971	Alys smpl sp/pn npgt w/prgrm		
95972	Alys cplx sp/pn npgt w/prgrm		
95983	Alys brn npgt prgrmg 15 min		
95984	Alys brn npgt prgrmg addl 15		

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated May 9, 2023			
Code	**Short Descriptor**	**Can Audio-only Interaction Meet the Requirements?**	**Medicare Payment Limitations**
96105	Assessment of aphasia		
96110	Developmental screen w/score		Non-covered service
96112	Devel tst phys/qhp 1st hr		
96113	Devel tst phys/qhp ea addl		
96116	Nubhvl xm phys/qhp 1st hr	Yes	
96121	Nubhvl xm phy/qhp ea addl hr	Yes	
96125	Cognitive test by hc pro		
96127	Brief emotional/behav assmt	Yes	
96130	Psycl tst eval phys/qhp 1st	Yes	
96131	Psycl tst eval phys/qhp ea	Yes	
96132	Nrpsyc tst eval phys/qhp 1st	Yes	
96133	Nrpsyc tst eval phys/qhp ea	Yes	
96136	Psycl/nrpsyc tst phy/qhp 1st	Yes	
96137	Psycl/nrpsyc tst phy/qhp ea	Yes	
96138	Psycl/nrpsyc tech 1st	Yes	
96139	Psycl/nrpsyc tst tech ea	Yes	
96156	Hlth bhv assmt/reassessment	Yes	
96158	Hlth bhv ivntj indiv 1st 30	Yes	
96159	Hlth bhv ivntj indiv ea addl	Yes	
96160	Pt-focused hlth risk assmt	Yes	
96161	Caregiver health risk assmt	Yes	
96164	Hlth bhv ivntj grp 1st 30	Yes	
96165	Hlth bhv ivntj grp ea addl	Yes	
96167	Hlth bhv ivntj fam 1st 30	Yes	
96168	Hlth bhv ivntj fam ea addl	Yes	
96170	Hlth bhv ivntj fam wo pt 1st		Non-covered service
96171	Hlth bhv ivntj fam w/o pt ea		Non-covered service
97110	Therapeutic exercises		
97112	Neuromuscular reeducation		
97116	Gait training therapy		
97129	Ther ivntj 1st 15 min		
97130	Ther ivntj ea addl 15 min		
97150	Group therapeutic procedures		
97151	Bhv id assmt by phys/qhp		
97152	Bhv id suprt assmt by 1 tech		
97153	Adaptive behavior tx by tech		
97154	Grp adapt bhv tx by tech		
97155	Adapt behavior tx phys/qhp		
97156	Fam adapt bhv tx gdn phy/qhp		
97157	Mult fam adapt bhv tx gdn		
97158	Grp adapt bhv tx by phy/qhp		
97161	Pt eval low complex 20 min		
97162	Pt eval mod complex 30 min		
97163	Pt eval high complex 45 min		
97164	Pt re-eval est plan care		

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated May 9, 2023			
Code	**Short Descriptor**	**Can Audio-only Interaction Meet the Requirements?**	**Medicare Payment Limitations**
97165	Ot eval low complex 30 min		
97166	Ot eval mod complex 45 min		
97167	Ot eval high complex 60 min		
97168	Ot re-eval est plan care		
97530	Therapeutic activities		
97535	Self care mngment training	Yes	
97537	Community/work reintegration		
97542	Wheelchair mngment training		
97750	Physical performance test		
97755	Assistive technology assess		
97760	Orthotic mgmt&traing 1st enc		
97761	Prosthetic traing 1st enc		
97763	Orthc/prostc mgmt sbsq enc		
97802	Medical nutrition indiv in	Yes	
97803	Med nutrition indiv subseq	Yes	
97804	Medical nutrition group	Yes	
98960	Self-mgmt educ & train 1 pt		Bundled code
98961	Self-mgmt educ/train 2-4 pt		Bundled code
98962	Self-mgmt educ/train 5-8 pt		Bundled code
98966	Hc pro phone call 5-10 min	Yes	
98967	Hc pro phone call 11-20 min	Yes	
98968	Hc pro phone call 21-30 min	Yes	
99202	Office/outpatient visit new		
99203	Office/outpatient visit new		
99204	Office/outpatient visit new		
99205	Office/outpatient visit new		
99211	Office/outpatient visit est		
99212	Office/outpatient visit est		
99213	Office/outpatient visit est		
99214	Office/outpatient visit est		
99215	Office/outpatient visit est		
99221	Initial hospital care		
99222	Initial hospital care		
99223	Initial hospital care		
99231	Subsequent hospital care		
99232	Subsequent hospital care		
99233	Subsequent hospital care		
99234	Observ/hosp same date		
99235	Observ/hosp same date		
99236	Observ/hosp same date		
99238	Hospital discharge day		
99239	Hospital discharge day		
99281	Emergency dept visit		
99282	Emergency dept visit		
99283	Emergency dept visit		

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated May 9, 2023			
Code	**Short Descriptor**	**Can Audio-only Interaction Meet the Requirements?**	**Medicare Payment Limitations**
99284	Emergency dept visit		
99285	Emergency dept visit		
99291	Critical care first hour		
99292	Critical care addl 30 min		
99304	Nursing facility care init		
99305	Nursing facility care init		
99306	Nursing facility care init		
99307	Nursing fac care subseq		
99308	Nursing fac care subseq		
99309	Nursing fac care subseq		
99310	Nursing fac care subseq		
99315	Nursing fac discharge day		
99316	Nursing fac discharge day		
99341	Home visit new patient		
99342	Home visit new patient		
99344	Home visit new patient		
99345	Home visit new patient		
99347	Home visit est patient		
99348	Home visit est patient		
99349	Home visit est patient		
99350	Home visit est patient		
99406	Behav chng smoking 3-10 min	Yes	
99407	Behav chng smoking > 10 min	Yes	
99441	Phone e/m phys/qhp 5-10 min	Yes	
99442	Phone e/m phys/qhp 11-20 min	Yes	
99443	Phone e/m phys/qhp 21-30 min	Yes	
99468	Neonate crit care initial		
99469	Neonate crit care subsq		
99471	Ped critical care initial		
99472	Ped critical care subsq		
99473	Self-meas bp pt educaj/train		
99475	Ped crit care age 2-5 init		
99476	Ped crit care age 2-5 subsq		
99477	Init day hosp neonate care		
99478	Ic lbw inf < 1500 gm subsq		
99479	Ic lbw inf 1500-2500 g subsq		
99480	Ic inf pbw 2501-5000 g subsq		
99483	Assmt & care pln pt cog imp		
99495	Trans care mgmt 14 day disch		
99496	Trans care mgmt 7 day disch		
99497	Advncd care plan 30 min	Yes	
99498	Advncd care plan addl 30 min	Yes	
G0108	Diab manage trn per indiv	Yes	
G0109	Diab manage trn ind/group	Yes	
G0270	Mnt subs tx for change dx	Yes	

LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated May 9, 2023			
Code	**Short Descriptor**	**Can Audio-only Interaction Meet the Requirements?**	**Medicare Payment Limitations**
G0296	Visit to determ ldct elig	Yes	
G0316	Prolonged hospital inpatient or observation care		
G0317	Prolonged nursing facility evaluation and management service		
G0318	Prolonged home or residence evaluation and management		
G0396	Alcohol/subs interv 15-30mn	Yes	
G0397	Alcohol/subs interv >30 min	Yes	
G0406	Inpt/tele follow up 15	Yes	
G0407	Inpt/tele follow up 25	Yes	
G0408	Inpt/tele follow up 35	Yes	
G0410	Grp psych partial hosp 45-50		Statutory exclusion
G0420	Ed svc ckd ind per session	Yes	
G0421	Ed svc ckd grp per session	Yes	
G0422	Intens cardiac rehab w/exerc		
G0423	Intens cardiac rehab no exer		
G0425	Inpt/ed teleconsult30	Yes	
G0426	Inpt/ed teleconsult50	Yes	
G0427	Inpt/ed teleconsult70	Yes	
G0438	Ppps, initial visit	Yes	
G0439	Ppps, subseq visit	Yes	
G0442	Annual alcohol screen 15 min	Yes	
G0443	Brief alcohol misuse counsel	Yes	
G0444	Depression screen annual	Yes	
G0445	High inten beh couns std 30m	Yes	
G0446	Intens behave ther cardio dx	Yes	
G0447	Behavior counsel obesity 15m	Yes	
G0459	Telehealth inpt pharm mgmt	Yes	
G0506	Comp asses care plan ccm svc	Yes	
G0508	Crit care telehea consult 60		
G0509	Crit care telehea consult 50		
G0513	Prolong prev svcs, first 30m	Yes	
G0514	Prolong prev svcs, addl 30m	Yes	
G2086	Off base opioid tx 70min	Yes	
G2087	Off base opioid tx, 60 m	Yes	
G2088	Off base opioid tx, add30	Yes	
G2211	Complex E/M visit add on	Yes	Bundled code
G2212	Prolong outpt/office vis	Yes	
G3002	Chronic pain tx monthly b		
G3003	Addition 15m pain mang		
G9685	Acute nursing facility care		
S9152	Speech therapy, re-eval		Not valid for Medicare purposes

Resources

CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency (updated 5/19/2023)

Laboratories fact sheet.

Medicare Program; CY 2020 Revisions to Payment Policies

Physician and Other Clinicians: CMS Flexibilities to Fight Covid-19 fact sheet.

Quality Payment Program

Section 1847A of the Social Security Act

Telehealth policy changes after the COVID-19 public health emergency

MedPractice MadePerfect Resource Hub

Federal Register - Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

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