

Medicare Telehealth FAQs

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This resource provides the Medicare Telehealth Frequently Asked Questions section (pages 35-45) of the Centers for Medicare & Medicaid Services' *COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing* document. The complete document is available for download on the [CMS website](#).

1. What services can be provided by telehealth during a waiver for the Public Health Emergency (PHE) declared by the Secretary under the section 1135 waiver authority?

Answer: Medicare telehealth services include many services that are normally furnished in-person. CMS maintains a [list of services](#) that may be furnished via Medicare telehealth. These services are described by HCPCS codes and paid under the Physician Fee Schedule. Under the emergency declaration and waivers, these services may be provided to patients by physicians and certain non-physician practitioners regardless of the patient's location. Medicare also pays for certain other services that are commonly furnished remotely using telecommunications technology, but are not considered Medicare telehealth services. These services can always be provided to patients wherever they are located, and include physician interpretation of diagnostic tests, care management services, and virtual check-ins. **New: 4/9/20**

2. Who are the Qualified Providers who are permitted to furnish telehealth services under the PHE waiver?

Answer: The same health care providers are still permitted to furnish Medicare telehealth services under the waiver authority during the Public Health Emergency, including physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish telehealth services within their scope of practice and consistent with Medicare benefit rules that apply to all services. **New: 4/9/20**

3. Is any specialized equipment needed to furnish Medicare telehealth services?

Answer: Currently, CMS allows telehealth services to be furnished using telecommunications technology that has audio and video capabilities that are used for two-way, real-time interactive communication. For example, to the extent that many mobile computing devices have audio and video capabilities that may be used for two-way, real-time interactive communication, they qualify as acceptable technology. [Learn more](#). **New: 4/9/20**

4. Can practitioners provide Medicare telehealth services using their phones?

Answer: Yes, for use of certain phones. Section 1135(b)(8) of the Social Security Act allows the Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. Additionally, CMS amended its regulations through the IFC to remove the potential perception of restrictions on technology that practitioners can use to provide telehealth services. The Office of Civil Rights has also issued guidance allowing covered health care providers to use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk of penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. [Learn more](#). **New: 4/9/20**

5. How does a health care provider bill for telehealth services?

Answer: The IFC directs physicians and practitioners who bill for Medicare telehealth services to report the place of service (POS) code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person. We believe this interim change will maintain overall relativity under the PFS for similar services and eliminate potential financial deterrents to the clinically appropriate use of telehealth. During the PHE, the CPT telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth. Practitioners should continue to bill these services using the CMS1500/837P. **New: 4/9/20**

6. How much does Medicare pay for telehealth services?

Answer: Medicare pays the same amount for telehealth services as it would if the service were furnished in person. **New: 4/9/20**

7. How long will practitioners be able to bill using these new flexibilities?

Answer: The telehealth waiver will be effective until the end of the PHE declared by the Secretary of HHS on January 31, 2020. Billing for the expanded Medicare telehealth services, as well as for the telephone assessment and management, telephone, evaluation and management services, and additional flexibilities for communications technology based services (CTBS) are effective beginning March 1, 2020, and through the end of the PHE. **New: 4/9/20**

8. Can physicians and practitioners let their patients know that Medicare covers telehealth in new locations during the PHE?

Answer: Yes. Physicians and practitioners should inform their patients that services are available via telehealth in new locations, including their homes, during the PHE and educate them on any applicable cost sharing. **New: 4/9/20**

9. Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services? How could a physician or practitioner bill if this were telehealth?

Answer: Services should only be reported as telehealth services when the individual physician or practitioner furnishing the service is not at the same location as the beneficiary. If the physician or practitioner furnished the service from a place other than where the beneficiary is located (a "distant site"), they should report those services as telehealth services. If the beneficiary and the physician or practitioner furnishing the service are in the same institutional setting but are utilizing telecommunications technology to furnish the service due to exposure risks, the practitioner would not need to report this service as telehealth and should instead report whatever code described the in person service furnished. **New: 4/9/20**

10. How are telehealth services different from virtual check-ins and e-visits? How much does Medicare pay for these services?

Answer: Medicare telehealth services are services that would normally occur in person but are instead conducted via telecommunications technology and are paid at the full in person rate. Service such as the virtual check-in, e-visits, remote evaluation, and telephone visits are not services that would normally occur in person, and are not paid as though the service occurred in person. A virtual check-in lets professionals bill for brief (5-10 min) communications that mitigate the need for an in-person visit and can be furnished via any synchronous telecommunications technology visit that would be furnished along with an e-visit is similar to a virtual check-in, but should be reported when a beneficiary communicates with their health care provider through an online patient portal. Telephone visits may be furnished via audio-only telephone whereas the remote evaluation describes the evaluation of a prerecorded video or image provided by the patient. Table 1 illustrates the respective payment rates to the physician or other practitioner; they vary based on the practice setting. **New: 4/9/20**

Table 1: Payment Rates for the Virtual Check In and the E-Visit

HCPCS	Descriptor	Office-based Payment Rate	Facility-based Payment Rate
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	\$15.52	\$13.35
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	\$31.04	\$27.43
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	\$50.16	\$43.67
G2061	Qualified non-physician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes	\$12.27	\$12.27
G2062	Qualified non-physician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes	\$21.65	\$21.65
G2063	Qualified non-physician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes	\$33.92	\$33.56
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	\$14.80	\$13.35

11. What has changed for communication technology-based services (e.g., remote evaluation of patient images/video and virtual check-in) for practitioners who bill for E/M codes?

Answer: During the PHE for COVID-19, HCPCS codes G2010 and G2012, which may only be reported when they do not result in an in-person or telehealth visit, can be furnished to both new and established patients. During the PHE, the required annual beneficiary consent to receive these services may be obtained at the same time that the services are furnished either by the billing practitioner or by staff under general supervision. If the brief communication technology-based service originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional the service would be considered bundled into the previous E/M service and would not be separately billable. **New: 4/9/20**

12. Can other practitioners who do not bill for E/M codes provide communication technology-based services (e.g., remote evaluation of patient images/video and virtual check-in) or telephone assessment and management services during the PHE?

Answer: Yes. During the PHE, the availability of HCPCS codes G2010 and G2012 is broadened to allow certain practitioners, such as physical therapists, occupational therapists, speech language pathologists, licensed clinical social workers, and clinical psychologists, who do not report E/M codes to bill for these services. CMS has also activated CPT codes 98966, 98967, and 98968, which describe assessment and management services conducted over the phone. **New: 4/9/20**

13. Will CMS require specific modifiers to be applied to the existing codes?

Answer: For telehealth services furnished during the PHE, CMS is allowing practitioners to use the POS code that they would have otherwise reported had the service been furnished in person. To identify these services as Medicare telehealth, CMS is requiring that modifier 95 be appended to the claim. There are also three additional scenarios where modifiers are ordinarily required on Medicare telehealth claims. When a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required. When a telehealth service is billed under CAH Method II, the GT modifier is required. Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required. **New: 4/9/20**

14. Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?

Answer: There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home during the public health emergency. The practitioner should report the place of service (POS) code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person. **New: 4/9/20**

15. What about beneficiaries who do not have access to smart phones or other technology that supports two-way, audio and video telecommunications technology?

Answer: The IFC allows physicians and other practitioners to bill for certain telephone assessment, evaluation and management services during the PHE. These services were previously not separately billable. These services may be billed for both new and established patients. **New: 4/9/20**

16. What has changed for communication technology-based services (CTBS) (HCPCS codes G2010 and G2012 - e.g., remote evaluation of patient images/video and virtual check-ins) for practitioners who bill for Evaluation and Management (E/M) services?

Answer: As stated in the CY 2019 PFS final rule, we finalized that if the communications technology-based service originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional, the CTBS would be considered bundled into that previous E/M service and would not be separately billable. Under the policy in the CY 2019 PFS final rule, in instances when the CTBS leads to an E/M service with the same physician or other qualified health care professional, the CTBS is considered bundled into the pre- or post-visit time of the associated E/M service, and therefore, would not be separately billable. However, when the CTBS leads to an E/M visit with a different physician or other qualified health care professional, the CTBS would not be considered bundled into that visit (83 FR 59486) and the CTBS is separately billable. This has not changed during the PHE. **New: 4/9/20**

17. Can consent for multiple CTBS or inter-professional consultations services be obtained at one time?

Answer: Yes. Beneficiary consent may be obtained annually for all CTBS (e.g., remote evaluation of patient images/video and virtual check-ins) or inter-professional consultation services occurring within the year (84 FR 62699). **New: 4/9/20**

18. What does it mean for CTBS (HCPCS codes G2010 and G2012, (e.g., remote evaluation of patient images/video and virtual check-ins) to be initiated by the patient?

Answer: On page 59484 of the CY 2019 PFS final rule, we stated that, for G2012, "We expect that these services will be initiated by the patient, especially since many beneficiaries would be financially liable for sharing in the cost of these services." For G2010, we noted that this service is initiated by the patient (83 FR 59487). This means that the patient must consent to the service before or at the same it takes place and does not prohibit practitioners from educating, on their own initiative, beneficiaries on the availability of the service prior to, or at the same time it takes place. **New: 4/9/20**

19. Can the CTBS (HCPCS codes G2010 and G2012, (e.g., remote evaluation of patient images/video and virtual check-ins) be billed on the same day, by the same practitioner, for the same patient?

Answer: As long as all requirements for billing both codes are met, and time and effort are not being counted twice, HCPCS codes G2010 and G2012 may be billed by the same practitioner, for the same patient, on the same day. **New: 4/9/20**

20. Can Remote Physiologic Monitoring (RPM) services be furnished to new patients as well as established patients?

Answer: Starting March 1 and for the duration of the PHE, RPM services can be furnished to both new and established patients. We ordinarily require an initiating visit for RPM services, similar to other care management services, but this requirement may be satisfied via a telehealth visit. Regardless, for the duration of the PHE, we are not requiring patients to be established patients in order to receive RPM services. Patients that receive RPM services can be established or new. **Revised: 4/23/20**

21. May clinical staff provide RPM services under general supervision?

Answer: Yes. We finalized in the CY 2020 PFS final rule (84 FR 62698) that RPM services, including but not limited to HCPCS codes 99453, 99454, 99457, 99458, may be provided under the general supervision of the billing practitioner. We note that, beneficiary consent to receive these services may also be obtained by auxiliary personnel under general supervision of the billing practitioner. Further, we note that, as specified in the IFC (85 FR 19245-19246), during the PHE when physicians and other health care professionals are faced with challenges regarding potential exposure risks for themselves and their patients, the direct supervision requirement that applies for most other services that are furnished incident to a physician or other practitioner’s services may be met virtually through audio/video real-time communications technology. We also note that clinical staff are “auxiliary personnel.” According to the 2019 CPT Codebook (p. xii), “A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.” **New: 4/9/20**

22. The prefatory language for the Remote Physiologic Monitoring (RPM) CPT codes 99453, 99454, and 99457 requires that the device used to capture a patient’s physiologic data must be a medical device as defined by the FDA. Can we assume that any device used to capture a patient’s physiologic data whether Class I, Class II, Class III would meet this requirement?

Answer: The device used to capture a patient’s physiologic data must meet the FDA definition of being a medical device. The CPT code descriptor does not indicate that the device must be an FDA approved device. Medical devices are defined on the FDA website as follows: “Medical devices range from simple tongue depressors and bedpans to complex programmable pacemakers with micro-chip technology and laser surgical devices. In addition, medical devices include in vitro diagnostic products, such as general purpose lab equipment, reagents, and test kits, which may include monoclonal antibody technology. Certain electronic radiation emitting products with medical application and claims meet the definition of medical device. Examples include diagnostic ultrasound products, x-ray machines, and medical lasers.” For more information, [visit the FDA’s website](#). **New: 4/9/20**

23. Are beneficiary-provided vital signs sufficient to satisfy that portion of the annual wellness visit (AWV) when conducted via telehealth?

Answer: If the beneficiary is at home and has access to the types of equipment they would need to self-report vital signs (e.g., weight, blood pressure), and if the visit meets all other requirements of the code, this scenario would satisfy the requirements for purposes of billing the AWV code. CMS maintains a [list of services](#) that are normally furnished in-person that may be furnished via Medicare telehealth during the PHE. **Updated: 5/27/20**

24. What telephone-only service codes were finalized as telehealth services for the duration of the PHE?

Answer: For purposes of the PHE for the COVID-19 pandemic, Medicare has added several codes that describe telephone-only services to the list of Medicare telehealth services. These include CPT codes 99441–99443, which describe audio-only telephone evaluation and management (E/M) phone visits with practitioners who can independently bill for E/M services. While these codes are ordinarily limited to established patients, during the PHE, Medicare will make payment for them for both new and established patients. These services are noted on [CMS’ list of telehealth services](#). Please report the POS that would have been used had the service occurred in person for these telephone-only service codes and all other telehealth services during the PHE. In addition, while not currently on the Medicare telehealth services list, during the PHE for COVID-19, CMS pays CPT codes 98966–98968, which describe audio-only telephone assessment and management visits for practitioners who cannot independently bill for E/M phone visits, for example certain therapists, social workers, and clinical psychologists. **New: 5/27/20**

25. If the video connection is disconnected during an audio-video Medicare telehealth visit due to technological issues, can the visit still be billed as Medicare telehealth?

Answer: Practitioners should report the code that best describes the service. If the service was furnished primarily through an audio-only connection, practitioners should consider whether the telephone evaluation and management or assessment and management codes best describe the service, or whether the service is best described by one of the behavioral health and education codes for which we have waived the video requirement during the PHE for the COVID-19 pandemic. If the service was furnished primarily using audio-video technology, then the practitioner should bill the appropriate code from the Medicare telehealth list that describes the service. Note that CPT codes 99441–99443, which describe audio-only telephone

E/M phone visits with practitioners who can independently bill for E/M services, have been added to the Medicare telehealth list for the purposes of the PHE for the COVID-19 pandemic, and payment rates for these codes are set to be the same as the analogous in-person E/M visits. **New: 5/27/20**

26. How should the CS modifier, which removes application of beneficiary cost sharing (deductible and co-payment), be applied to telehealth services and/or E/M visits?

Answer: The CS modifier should be applied for certain evaluation and management services related to COVID-19 testing, whether they are furnished in person or via telehealth. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635. Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020, and the end of the PHE; result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital evaluation and management services

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

For services furnished on or after March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing waiver for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.

Additionally, the CPT telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth. And the billing practitioner should report the POS code that reflects the place the service would have been furnished if furnished in person. **New: 5/27/20**

27. Do Medicare telehealth services require CR (“catastrophe/disaster related”) modifier and/or DR (“disaster related”) condition code?

Answer: No, the CR and DR modifiers are not necessary for Medicare telehealth services. **New: 5/27/20**

28. What codes can emergency physicians use if they want to perform telehealth services?

Answer: ED physicians can perform telehealth services from any location. CMS has temporarily added the ED E/M codes (CPT codes 99281–99285), the critical care codes (CPT codes 99291 and 99292), and the observation codes (CPT codes 99217–99220, 99224–99226, and 99234–99236) to the list of Medicare telehealth services for the duration of the COVID-19 PHE. When delivering emergency telehealth services, ED physicians should use the code that most accurately reflects that service and use the same place of service code that they would have used if that service was delivered in-person. The CPT telehealth modifier, modifier 95, should be applied to claim lines that describe services furnished via telehealth. For example, regardless of location, ED physicians who are delivering emergency services can use the ED E/M codes with place of service 23 (ED) and apply modifier 95. When a practitioner furnishes services to a patient who is at the same location, such as when the

practitioner and patient are in different areas of the same hospital, the services are not considered telehealth services. Instead, the services should be reported as in person services. **New: 5/27/20**

29. How should telehealth services be documented in the medical record (e.g., face-to-face time, preparation time)?

Answer: We expect the same level of documentation that would ordinarily be provided if the services furnished via telehealth were conducted in person. **New: 5/27/20**

30. Can Physician Assistants (PAs) provide and bill for Inter-professional Telephone/Internet/Electronic Health Record Consultations (codes 99446–99449 and 99451)?

Answer: Yes, a PA can furnish these inter-professional consultation services, and the usual billing rules for PA services apply. **New: 5/27/20**

31. How should practitioners bill for audio-only services that last longer than 30 minutes?

Answer: During the PHE for the COVID-19 pandemic, Medicare has added to the list of telehealth services CPT codes 99441–99443, which describe audio-only phone visits with practitioners who can independently bill for E/M services, and CPT codes 98966–98968, which describe audio-only phone visits with practitioners who cannot independently bill for E/M services (for example certain therapists, social workers, and clinical psychologists). CPT codes 99443 and 98968 describe 21–30 minutes of medical discussion, respectively for each practitioner type; but there are no CPT codes available to describe medical discussions lasting longer than 30 minutes. **New: 5/27/20**

32. Is beneficiary consent required for virtual check-ins, e-visits, audio-video telehealth visits, and/or telephone-only E/M telehealth visits?

Answer: Beneficiary consent to receive virtual check-ins and e-visits is required although it may be obtained once annually and, during the PHE for the COVID-19 pandemic, consent may be obtained at the same time the service is furnished. Similar to services furnished in person, the patient’s consent is not required to be noted on the medical record for telehealth services furnished using interactive audio-video technology. The audio-only phone visits also do not require the patient’s consent to be noted in the medical record. **New: 5/27/20**

33. Should practitioners use the same telehealth billing codes if the audio-video or audio-only appointment includes Teletype (TTY), relay services, accessible software, interpreter services support, or other means of effective communication?

Answer: Yes, if a practitioner receives TTY, relay services, accessible software, interpreter services support, or other means of effective communication, then they would use the same billing codes for when they don’t need TTY, relay services, accessible software interpreter services, or other means of effective communication. Practitioners cannot charge patients more for a telehealth visits if the patient requires TTY relay services, accessible software, interpreter services or other means of effective communication. **New: 5/27/20**

34. Are services designated on the telehealth list as non-covered by Medicare eligible for payment during the PHE?

Answer: No. Services that are currently non-covered remain so unless subsequent rulemaking is undertaken to make them covered services. These services were added to the telehealth list for informational purposes only, to reflect stakeholder requests. **New: 5/27/20**

