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MOVING CLOSER

TO EMBRACING REMOTE CARE

Remote Care Enters the Mainstream in 2021

CMS updates, clarifies, expands, and adjusts billing codes for remote digital patient care.

Note: It is possible for CMS to provide updates to billing codes or provide additional guidance at any time throughout the year. For the most up-to-date information, check with CMS.

THE VIVID SUMMARY

"One of the pandemic's silver linings is that the value of remote monitoring and telehealth is more demonstrable than ever. As a result, healthcare has taken at least a three-year leap forward in delivering quality care more efficiently and in the comfort and safety of home. Having had a taste of the future, providers are now rapidly embracing it. The downstream impact of this will be an acceleration of value-based relationships, including payer-provider partnerships, to transition care services to virtual and in-home. Healthcare IT must now fast-follow this, with solutions that streamline the billing process and capture the appropriate measures for value-based contracts. The hard part is capturing those measures, requiring the tracking of every patient-provider interaction, a byproduct of remote monitoring. In short, the natural evolution of fee-for-service to value-based care is taking a giant step forward in 2021."

- Eric Rock, Founder & CEO of Vivify Health (part of Optum)

Physicians and patients aren't the only ones with growing interest in telehealth/RPM. The Centers for Medicare and Medicaid Services (CMS) is increasingly recognizing its benefits and is changing its regulations accordingly – which is the subject of this paper.

In the past, reimbursement for telehealth was often limited by originating site and geography. RPM is not a telehealth service, and does not have those restrictions, but there are substantive changes for both during the COVID Public Health Emergency, and for 2021. The requirements to provide and bill for these services may still seem complex and difficult to understand and complete efficiently. These areas have been in focus as CMS looks to improve care and reduce costs for patients in Medicare Part B Fee for Service or in value-based care like Medicare Advantage plans.

This document will explain the changes beginning January 1, 2021 as well as how providers can take advantage of them. It will provide an overview of the requirements for

physician and other qualified health professionals to submit claims to CMS. We strongly recommend conferring with a billing specialist and/or your Medicare Administrative Contractor (MAC) to determine the specifics for your practice. (This report will not include Medicaid strategies, however, since that program is administered state-by-state and requires a separate, more complex discussion.)

It will also stress the importance of providers as a whole taking advantage of the opportunities for telehealth and RPM to guard against CMS removing them in the future due to a lack of utilization and interest.

This paper does not discuss COVID-19 specific policy and regulatory expansions and restriction easement, as many will lapse when the Public Health Emergency ends, unless made permanent by Federal or State action.

Ready?

The Changing Landscape for Telehealth and RPM

Before we examine how specific codes will affect reimbursement, it is important to define what is meant by telehealth and RPM.

Through 2019, the industry was still operating under definitions CMS put in place in 2001. These definitions said telehealth was limited to live, real-time, synchronous voice and video contact; no "store and forward" allowed except for federal demonstration projects in Alaska and Hawaii. The rules also stated the beneficiary must present in a health professional shortage area (HPSA). CMS specified what could be an originating site (skilled nursing facility, hospital, etc.) as well as who qualified as a distant site practitioner (physician, nurse or stipulated medical professional). Finally, CMS limited telehealth services to psychotherapy, pharmacologic management, nutrition therapy, smoking cessation, transitional care management and end stage renal disease services. In 2020, the definition of telehealth became much broader.

Remote Physiologic Monitoring or RPM Codes were introduced for Jan. 1, 2019 and were originally only for chronic conditions and under direct supervision. CMS later issued guidance that allowed acute conditions and care delivered incident to the general supervision of the billing provider. RPM is not considered telehealth, but instead is an Evaluation and Management (E/M) service. As a result, RPM must be performed by providers who can bill E/M services to Medicare. There is additional clarification and guidance in the Physician Fee Schedule Final Rule for 2021.

For those who are new to telehealth and RPM, the new regulations we are about to discuss may seem complex. It is important to note, however, that CMS has been making a concerted effort to make getting reimbursed for telehealth/RPM care easier over the last few years. Vivify has both the technology and the expertise to further simplify the process and help providers use telehealth and RPM to improve patient care and outcomes while creating new revenue streams.

Now with that background let's look more closely at the specific changes coming into play for telehealth/RPM care for Medicare patients in 2021.

CPT code 99091

Originally, all remote patient monitoring was primarily covered under a single Current Procedural Terminology (CPT®) code: 99091. This code covered “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 healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time.”

In 2018, this single code was unbundled to provide more flexibility in where and how RPM was administered, and it has been expanded again. As a result, a recent Spyglass report shows that 88% of physicians have now invested in or are evaluating investments in it. The 2021 rate for both facility and non-facility RPM is $56.88 for each 30-day instance.

Additionally, unlike other codes, such as CPT 99457 and 99458, CPT 99091 must be performed by a physician or other qualified health professional. It is not a treatment management service code but rather a data accession, review, interpretation and modification of care plan code. It doesn’t require interactive communication with the patient or his/her caregiver, nor does it require the data to come from a device. Note that in 2020, CPT codes 99457 and 99091 could not be billed concurrently; however, in 2021, 99091 and 99457 can be billed concurrently for the same patient in the same month if all the requirements for each code are fulfilled.

Chronic Care Remote Physiologic Monitoring Codes

Three CPT codes for physiologic monitoring went into effect January 1, 2019: 99453, which covers set-up of devices and patient education on using the equipment; 99454, which covers the device(s) used for monitoring; and 99457, which covers the actual RPM and treatment management services.

- **Code 99453** can only be used once per episode of care, which makes sense because there will only be one instance of set-up of devices and instruction on how to use them. For 2021, the average payment will be approximately $19.19.

- **Code 99454** can be used once for each 30-day period the approved devices for monitoring and transmission of data to the cloud, platform, EMR, or contact center are in use. For 2021, CMS has issued further guidance that self-measured readings must be automated to the platform/provider for 16 days out of the month. There is an exception for COVID-19-suspected or positive patients, which only requires 2 days of automated daily recordings or alerts. Manually entered data does not qualify for the 16-day requirement. This code can only be billed once per 30-day period per patient, even if multiple devices are supplied to the patient by the provider. Additionally, if the patient pays for the device CMS emphasizes that the provider cannot bill for the device. CMS is raising the amount it will pay to approximately $63.16 in 2021.

- **Also clarified for 2021, auxiliary personnel can provide the services for 99453 and 99454.**

- **Code 99457** received significant attention for 2021. There was a discrepancy on CPT Codes 99457 and 99458 between CMS' Final Rule originally issued in December 2020 and its supporting Fact Sheet.[1] The Final Rule stated only interactive communications was covered while the Fact Sheet said non-face-to-face care management services were covered as well. It now covers both the first 20 minutes each month that clinical staff, the physician or other qualified healthcare professionals spend interactively with the patient or caregiver about the RPM program or specific services within it as well as the additional time spent delivering those services. It pays the same amount regardless of how many parameters are being monitored. In 2021, CMS is slightly reducing the payment to approximately $50.94 non-facility and $31.75 facility based remote physiologic monitoring services.

1 When the discrepancy was discovered Vivify contacted CMS for clarification and was told the Fact Sheet is correct. To this end, CMS issued a Technical Correction on January 19, 2021.

Code 99458

January 1, 2020, CMS added 99458 for patients that require more than the 20 minutes allotted for CPT 99457. In 2021 payment increased to approximately $41.17 for non-facility and approximately $31.75 for facility-based RPM, reflecting a more realistic view of the time and effort involved. The caution is that providers must remember to bill 99457 for the first qualifying 20 minutes of remote care management services each month, then use 99458 in up to two subsequent 20-minute blocks that month. For 2021, these Care Management Services may still be delivered incident to the General Supervision of the billing provider for CPT codes 99457 and 99458.

What this means is that the physician or other qualified healthcare professional[2] supervising the clinical staff delivering the RPM service does not have to be located in the same suite as the person or group delivering the treatment management services, and clinical staff can be employees or contracted labor. Reducing this restriction allows providers to provide more efficient care focused on broader population health management initiatives since aggregating clinical staff in a single contact center can be restricted by space or other resources.

2 According to CMS, a qualified healthcare professional is an individual who is qualified by education, training, licensure/regulation (where applicable), and facility privileging (where applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from clinical staff, which is defined as a staff member who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional services, but who does not individually report that professional service. Examples of a qualified healthcare professional include nurse practitioners, certified nurse specialists, physician assistants, clinical social workers and physical therapists.

Virtual Check-ins by Healthcare Professionals

- **HCPCS code G2012**, enables Medicare Part B Providers (physicians or qualified health professionals) to bill for 5-10-minute technology-enabled remote conversations with established patients. Examples include real-time audio-only telephone interactions and synchronous, two-way audio interactions enhanced with video or other data.

- **HCPCS code G2012** is in effect as long as the conversation isn't related to evaluation and management (E/M) services provided in the previous seven days or doesn't lead to an E/M service or procedure within the next 24 hours or soonest available appointment (if more than 24 hours). There are no other restrictions on the frequency of these check-ins, making this code particularly appropriate for chronic care management (CCM) patients.

For 2021, the payment will rise to approximately $14.66 for non-facility and $13.26 for a facility. It is important to understand one provider can bill for CCM and RPM for the same patient in the same month but clinical staff or the provider must spend at least 20 minutes separately on each. Additionally, two physicians, such as a primary care physician (PCP) and a specialist, cannot bill for CCM in the same month.

Chronic Care Management (CCM) Codes for 2 or More Conditions

Chronic Care Management began in 2015, with improvements in 2017, and more changes in 2020. These codes for non-face-to-face time apply to working with patients in CCM programs who have two or more conditions. CMS recognized that helping these patients manage their chronic conditions is time-consuming but pays huge dividends in keeping them healthier (and out of the ED or inpatient stays).

Because they are time-based codes, the tools being used to document the encounters must be accurate in the way they capture time spent. The data must then be transferred to a certified electronic medical records (EMR) system for billing to CMS. CCM requires that patients have 24/7 access to physicians or other qualified healthcare professionals or clinical staff to address urgent needs.

HCPCS Code G0506 is an add-on code to the CCM initiating visit that describes the work of the billing practitioner in a comprehensive assessment and care planning to patients outside of the usual effort described by the initiating visit code. In 2021, this will pay approximately $62.44 for Non-Facility, and $45.42 in the Facility setting.

> Unlike RPM, Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Critical Access Hospitals (CAH) can bill the Chronic Care Management Codes. HCPCS Code G0511: RHCs and FQHCs should only use this code for CCM when the requirements for CPT codes 99490, 99487, 99491, or 99484 are met. The Relative Value Unit (RVU) for G0511 is .85.

Code 99490

CPT code 99490 is for 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:

- **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.**

In 2021 CPT 99490 pays approximately $41.17 for non-facility and $31.75 for facility-based treatment.

Code 99439 replaces G2058 in 2021 for additional time increments

- **Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month. In the CY 2021 Medicare Physician Fee Schedule Rule, CMS finalized that this code may be billed concurrently with TCM when reasonable and necessary. The 2021 rates are approximately $37.94 for non-facility and $28.27 facility.**

For both 99487 and 99489, CMS requires inclusion of establishing, implementing, substantially revising, or monitoring a comprehensive care plan. CMS further clarifies by stating: The comprehensive care plan for all health issues typically includes, but it not limited to, the following elements: problem list; expected outcome and prognosis; measurable treatment goals; cognitive and functional assessment; symptom management; planned interventions; medical management; environmental evaluation; caregiver assessment; interaction and coordination with outside resources and practitioners and providers; requirements for periodic review; and when applicable, revision of the care plan.

Code 99487

CPT code 99487 covers the first 60 minutes of clinical staff or QHP or provider time for moderately or highly complex CCM. The 2021 rates will be approximately $91.77 non-facility and $51.29 facility.

Code 99489

CPT code 99489 is for high or moderate complexity patients who require more time, covering an additional 30 minutes in the same billing cycle as 99487. The 2021 rates will be approximately $43.97 non-facility and $25.82 facility.

Self-Measured Blood Pressure

In some circumstances, patients will be asked to measure their blood pressure themselves on a prescribed basis, then report the readings to their physicians. These readings can be taken using their own device or one supplied to them by their physician. Any device used for this purpose must be validated for clinical accuracy prior to use.

Code 99473

This code is used when the patient will be performing self-measured blood pressure monitoring (SMBP). It is a one-time charge for when a physician practice staff member provides training, device setup and calibration of an SMBP device validated for clinical accuracy for patients when patients are instructed to monitor their blood pressure at home. The 2021 rate is $11.51 for both non-facility and facility providers.

Code 99474

New to 2021, this code covers when patients are instructed to take separate self-measurements of two consecutive readings one minute apart twice daily over a 30-day period (minimum of 12 readings). It covers collecting data reported by the patient and/or caregiver to the physician or other qualified healthcare professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient. The 2021 rates are approximately $15.00 for non-facility and $8.72 facility, which covers the 30-day period.

Principal Care Management (PCM)

For patients with one chronic disease or high-risk condition, codes were introduced in 2020. These new HCPCS codes for Principal Care Management services may be utilized for comprehensive care management services of at least 30 minutes of physician or other qualified healthcare professional time per calendar month where one complex chronic condition lasts at least 3 months, is the focus of the care plan, the patient is at risk of hospitalization or has been recently hospitalized and the condition requires development or revision of disease-specific care plan, frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to co-morbidities.

- **HCPCS code G2064** is for at least 30 minutes of physician and non-physician practitioner time per calendar month. In 2021, these rates will change to $90.73 facility and $76.77 facility.

- **HCPCS code G2065** is for at least 30 minutes of clinical staff time per calendar month. In 2021 the payment of approximately $39.00 will be the same for both facility and non-facility settings.

- **CODE G0511** FQHCs and RHC can bill the service for Principal Care Management, too, using general care management HCPCS code G0511 (20m or more of clinical staff time, per calendar month), either alone or with other payable services on an RHC or FQHC claim. This code has a Relative Value Unit (RVU) of .85.

Transitional Care Management and Behavioral Health Codes

To adequately service patients in both a transitional care and principal care fashion, specific codes are allotted and employed for each.

Transitional Care Management (TCM)

CPT code 99495 and 99496 are for transitional care management (TCM), i.e., ensuring prompt contact with patients within 2 days of discharge. TCM codes describe management of a patient's transition from acute care or certain outpatient stays to a community setting, with a face-to-face visit, once per patient within 30-days post-discharge. The contact must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care. If two or more separate attempts are made in a timely manner, but are unsuccessful and other transitional care management criteria are met, the service may be reported. This could include ensuring that moves, from one site of care to another (such as from a hospital or outpatient center to a home, skilled nursing facility or hospice), go smoothly and that patient needs continue to be met. PCPs and other Medicare Part B providers can manage (and bill for) this process. According to the Rural Health Information Hub, Home Health RHCs and FQHCs can bill for the face-to-face visit component of TCM as an RHC or FQHC visit. TCM services can be billed as a visit if it is the only medical service provided on that day with a RHC or FQHC practitioner and it meets the TCM billing requirements. If TCM is furnished on the same day as another visit, only one visit can be billed.

RHCs and FQHCs may not bill for CCM and TCM services, or another program that provides additional payment for care management services (outside of the RHC AIR or FQHC PPS payment), for the same beneficiary during the same time period.

Modifier -95 should be used.

- **CPT code 99495 covers TCM services including interactive contact with the moderately complex patient within 2 days of discharge, with a face-to-face visit within 14 days of discharge. The 2021 rates increase significantly to approximately $207.96 non-facility and $145.16 facility.**
- **CPT code 99496 offers extra care incentives for highly complex patients with interactive contact within 2 days of discharge for TCM services, with a face-to-face visit within seven (7) days of discharge. The 2021 rates continue to offer incentives at approximately $281.59 for non-facility and $197.49 for facility-based services.**

Links:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

https://familymedicine.med.uky.edu/sites/default/files/TCM-CPT.pdf

https://www.acponline.org/practice-resources/business-resources/coding/what-practices-need-to-know-about-transition-care-management-codes

https://www.ruralhealthinfo.org/care-management/transitional-care-management

Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Management Services

This code set also offers additional revenue opportunities while helping to remove barriers to patient activation and engagement in their plans of care.

Eligible conditions are classified as any mental, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants BHI services. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner and may be refined over time.

Collaborative Care Management (CoCM)

CoCM includes a team of three individuals to provide care: the Behavioral Healthcare Manager, the Psychiatric Consultant and the Treating (Billing) Practitioner for enhanced care management support for patients receiving behav- ioral health treatment, and enabling regular psychiatric inter-specialty consultation.

Code 99492

CPT code 99492 addresses initial psychiatric collaborative care management (CoCM), specifically the first 70 minutes in the first month of treatment. The 2021 rate is approxi- mately $154.23 for non-facility and $93.86 for facility billing.

Code G2214

For 2021, CMS had proposed GCOL1 for providers to bill shorter time segments than allowed by CPT 99492. In the Final Rule CMS settled on CPT G2214. Defined as “Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional”. The required elements listed for billing CPT code 99493 will also be required elements for billing G2214. The 2021 rate is approximately $65.31 for non-facility and $35.82 for facility billing.

Code 99493

If more psychiatric collaborative care management (CoCM) is required, CPT code 99493 covers the first 60 minutes of psychiatric collaborative care management in a subsequent month. The 2021 rate is approximately $154.23 for non-facility and $102.59 for facility billing.

Code 99494

If the initial or subsequent psychiatric collaborative care management requires more time than is allotted in CPT codes 99492 or 99493, CPT code 99494 provides payment for each additional 30-minute encounter in any calendar month. The 2021 rates are approximately $58.97 per half hour for non-facility and $40.82 for facility billing. This code can be billed more than once if additional time is required.

General Behavioral Health Integration

BHI is typically utilized in conjunction with other care management services like CCM, TCM, and RPM, above.

Code 99484

Finally, CPT code 99484 covers behavioral health integration (BHI) services that require at least 20 minutes of clinical staff time for models of care other than CoCM that may also include "core" service elements such as assessment and monitoring, care plan revision for patients whose outcome is not improving as desired, or promoting a continuous relationship with a designated care team member. In 2021 it pays approximately $46.76 for non-facility and $30.71 for facility billing. Again, this code can be billed more than once in a month. Beneficiaries may, but are not required to have, co-morbid, chronic, or other medical condition(s) that are being managed by the billing practitioner, enabling concurrent billing of those services.

New CPT Codes for Behavioral Health in 2021

Code G2212 new for 2021

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 QHP, with or without direct patient contact. This code takes the place of 99417 and pays approximately $33.00 for facility and non-facility settings.

The other change that may affect billing procedures is that 99201 will be deleted. The new guidance says to use 99202 for times beginning at 15-29 minutes, which pays approximately $74.30 for facility and $49.60 for non-facility settings; and then advance in 15-minute increments with 99205 for 60-74 minutes which pays approximately $224.60 for facility and $186.00 for non-facility settings.

Links:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-paid

https://aims.uw.edu/sites/default/files/CMS_FinalRule_BHI_CheatSheet.pdf

Consolidations of Consent for All Services

CMS' ad hoc approach to moving slowly into population health management created some confusion for patients in terms of giving consent for various services. Under Medicare Part B they had to sign one consent form for CCM, another for RPM, another for virtual check-ins and a fourth for TCM via telehealth.

Sometimes they even had to sign individual consent forms for the same services per episode of care. Both patients and providers were frustrated by the cumbersome, time-consuming process. There was tremendous confusion as patients believed they had already signed a consent form for one service when, in fact, they had signed it for a different service.

All of that has been consolidated, which means patients under Medicare Part B need only sign a single form to consent to receiving all covered telehealth and RPM services. Consent may also be obtained at the time of service for RPM. The only caveat is that providers must explain what the patient's co-pay for all of these Part B services will be, typically 20%.

Of course, if the patient is dual-eligible (qualifies for Medicare and Medicaid) or has supplemental insurance that co-pay may be $0. Providers will need to have their messaging, documentation, billing and accounting in order to understand what the patient's payment situation is so they can accurately calculate and collect the co-pays.

Monthly Telehealth ESRD-related Dialysis Clinical Assessments

Another area in which telehealth/RPM has been expanded is end stage renal disease (ESRD). Patients with ESRD who are on dialysis generally receive monthly clinical assessments from their nephrologists. On November 2, 2020, CMS issued a final rule updating Medicare payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services for 2021. Under the final rule, the 2021 ESRD PPS base rate will be $253.13

Also, Medicare Advantage enrollment by individuals with ESRD is expected to accelerate beginning in 2021, when section 170006 of the 21st Century Cures Act (Cures Act) lifts the current enrollment restrictions. Until recently, most of these clinical assessments had to be performed in-person. The only exceptions were for patients in rural areas who would have to travel great distances to attend these assessments; they were allowed to choose telehealth visits instead.

- **End-Stage Renal Disease (ESRD)-related services are included in the monthly capitation payment of CPT codes: 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961. Payments in 2021 range from $1,201.99 for 90951 to $301.78 for 90961.**

- **End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients of younger than 2 years of age to seniors, include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents and various services in CPT codes 90963 to 90970 can now be delivered via telehealth, meaning patients with ESRD receiving dialysis at home, qualifies as their home is now an originating site for the monthly assessment. CMS payment will vary depending on the codes that are appropriate for the patient's age and assessments. As a result, both patients and providers can fulfill their obligations (and providers can capture the revenue) without placing undue travel stress on patients going through difficult times. Payments in 2021 range from approximately $622.15 for 90963 to $9.84 for 90970.**

This, incidentally, is an area where Vivify is uniquely qualified to help. Vivify's Bring Your Own Device (BYOD) solutions in particular can help providers deliver connected care to their ESRD patients to both monitor their day-to-day progress and enable video conferencing with their provider team.

Opioid and Substance Abuse Disorders

Telehealth was also approved in 2020 for treating substance abuse disorder (including opioids) with or without a co-occurring mental health disorder. Assessments can now be performed in the home rather than requiring an office visit. There are no restrictions on geographic location, which is good news for elderly and other patients with mobility or transportation challenges wrestling with opioid or other substance abuse issues.

In 2020, CMS added three Communication Technology-Based Services codes enabling providers to bill Medicare for telehealth services included in bundled episodes of care for opioid abuse treatment, including care delivered to the home. The HCPCS codes for these services are:

- **G2086 is for at least 70 minutes of treatment for opioid use disorder during the first month, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling. The approximate 2021 fee is $399.98 for non-facility, $289.71for facility billing.**
- **G2087 is for at least 60 minutes in a subsequent month. The approximate 2021 fee is $355.60 for non-facility, $282.93 for facility billing.**
- **G2088 covers each additional 30 minutes beyond the first two hours of office-based treatment for opioid use disorder in any month. The approximate 2021 fee is $67.62 for non-facility, $33.97 for facility billing.**
- **G2077 covers periodic assessments for 2021, CMS clarifies that these assessments may be done by telephone for the duration of the COVID-19 PHE, but will permit them to be offered via telehealth (non audio-only) after the conclusion of the PHE.**

As with ESRD patients, Vivify's solutions can get providers up and running quickly in this largely untapped revenue source.

Links:

https://mhealthintelligence.com/news/cms-expands-telehealth-coverage-for-opioid-abuse-disorder-treatment

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/FeeLookup

MORE CHANGES Expected

This document covers many of the changes and updates that took effect January 1, 2021. But as RPM and telehealth continue to prove their effectiveness in improving health outcomes, reducing costs and increasing patient engagement and provider satisfaction, providers should expect more changes to come in the future. Hopefully, many of the changes enacted for the COVID-19 Public Health Emergency (PHE) will become permanent, and telehealth and RPM will continue to enjoy strong bilateral support in Congress.

This is good news for providers from a financial aspect as well, as it allows them to increase revenue, while operating more effectively and efficiently.

CMS is definitely committed to expanding the use of telehealth and RPM. Vivify stands ready to partner with providers to help them succeed on this journey.

This paper presented general policies and reimbursement amounts and does not include every change for 2021 Please consult your billing specialist and your Medicare Administrative Contractor (MAC) for Part B for your particular services provided and your billing situation.

Sources

https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f

https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1

https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/AAFP%20Summary%20of%20the%202021%20Medicare%20Physician%20Fee%20Schedule%20Final%20Rule.pdf

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