MARCH 2020 UPDATE TO MEDICARE'S CODES G2010 & G2012
PUBIC HEALTH EMERBENCY CHANGES

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Please note this is a temporary paper in effect as long as the Center for Medicare and Medicaid deems it is necessary due to the Public Health emergency.

Two charts follow on the succeeding pages—one for Code G2010 and one for Code G2012. This supplements the article that was written in 2019. If and when these waivers are rescinded this article will be rescinded as well.

REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION
(HCPCS CODE G2010)

Comments in BLUE with * indicate CMS Waiver or Rule in effect during the COVID-19 Crisis

Code Descriptor	▪ (Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward). ***Applies to both new and established patients.** ▪ Includes interpretation with follow-up with the patient within 24 business hours. ▪ Does not originate from a related E/M service provided within the previous 7 days. ▪ Does not lead to an E/M service or procedure within the next 24 hours or soonest available appointment. **If this occurs do not bill the G code.** ▪ The code is **not** subject to Medicare telehealth restrictions.
Allowed Services Description	▪ The scope of this service is limited to the evaluation of **pre-recorded** video and/or images. ▪ The follow-up with the patient can take place via telephone call, audio/video communication, secure text messaging, email, or patient portal.
Medical Necessity	▪ Throughout the document it is iterated and re-iterated "each of these services must be medically reasonable and necessary to be paid by Medicare." On my website there is a three-part series on Medical Necessity under Audits and Compliance entitled "Medical Necessity Can You Define That Please?" This is the foundation for coverage of services for the Medicare program. The articles may be used to determine whether or not an office visit or other service is warranted.
CMS Categorization	▪ CMS **does not** consider this service to be a standard telehealth service and will therefore issue payment under the physician fee schedule (MPFS). Codes are **not** subject to Medicare geographic indexes and other telehealth restrictions.
Chart Documentation	▪ Each encounter must have a written or verbal **informed consent** and the **clinical findings** should be documented in the patient's chart as you would in a face-to-face encounter, including the reason for the request. **See my article on telehealth chart documentation on the website.**
Billing Time Limitations	▪ The virtual check-in encounter cannot be billed within 7 days after an in-person office visit nor can it be billed within 24 hours after a face-to-face encounter. ▪ The virtual check-in encounter is considered bundled in the above instance with the prior office

	visit encounter. This is a stand-alone service that can be billed as long as the above parameters are followed. ▪ This service is distinct from the virtual check-in service (G2012) in that this service involves the practitioner's evaluation of a **patient-generated still or video image transmitted by the patient**, **and the subsequent communication of the practitioner's response to the patient**; while the **virtual check-in** service describes a service that **occurs in real time** and does not involve the **asynchronous transmission of any recorded image**.
Patient Cost Sharing	▪ Patients are responsible for cost sharing for this service (co-payments). ***Physicians may waive this.**
New versus Established Patients	▪ This service may be rendered *only to established patients* since the practitioner needs to have an existing relationship with the patient and a basic knowledge of the patient's medical condition and needs in order to perform this service**. *Applies to new or established patients.** ▪ CMS is using the Current Procedural Terminology (CPT) definition of an established patient, namely, one who has received professional services from the physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice. **.** ***Applies to new or established patients.**
Informed Consent for the Service	▪ **Verbal or written consent** for the service must be documented in the chart notes made for the encounter and CMS notes such consent must be entered into the medical record for each encounter.
Practice Utilization	▪ Utilization of the code G2010 will be monitored by CMS. CMS has not established specific frequency utilization limits. ***Under 1135 Waiver these audits will not occur.**
Privacy	▪ Practices need to comply with any applicable privacy and security laws, including the HIPAA Privacy Rule. ***Under 1135 Waiver HIPAA Privacy waived**
Pricing	▪ If the virtual interaction results in an office visit, then the virtual visit will be bundled into the office visit. ▪ Pricing was set based on a rate lower than the current E/M in-person visits to reflect the low work time and intensity and to account for the resource costs and efficiencies associated with the use of communicative technology. ▪ 2020 National Average Payment for Non-Facility practitioners is $12.271 and for Facility practitioners is $9.38.

BRIEF COMMUNICATION TECHNOLOGY-BASED SERVICE – VIRTUAL CHECK-IN (HCPCS CODE G2012)

Comments in BLUE with * indicate CMS Waiver or Rule in effect during the COVID-19 Crisis

Code Descriptor	▪ HCPCS code 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). ***Applies to both new and established patients.**
Allowed Services Description	▪ CMS allows real-time audio-only telephone interaction in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission.
Medical Necessity	▪ Throughout the document it is iterated and re-iterated "each of these services must be medically reasonable and necessary to be paid by Medicare." On my website (address noted above) there is a three-part series on Medical Necessity under Audits and Compliance entitled "Medical Necessity Can You Define That Please". This is the foundation for coverage of services for the Medicare program. Medical necessity is the determinant of whether or not any service is eligible for coverage and payment.
CMS Categorization	▪ CMS does **not** consider this service to be a telehealth service and will therefore issue payment under the physician fee schedule (PFS). Codes are **not** subject to Medicare geographic indexes and other telehealth restrictions.
Chart Documentation	▪ Each encounter must have an **informed consent** and the **clinical findings** are to be documented in the patient's chart as you would with a face-to-face encounter. ▪ The final rule states that no service-specific chart documentation requirements are listed; however, do not be lulled into complacency. The practitioner should document the same way as is mandated for a face-to-face encounter. Follow-up with the patient is mandatory and documentation of such must be entered into the chart. ▪ **See my article on telehealth chart documentation on the website.**

Billing Time Limitations	▪ The virtual check-in encounter **cannot be billed within 7 days after an in-person office visit nor can it be billed within 24 hours after a face-to-face encounter.** The check-in encounter is considered bundled in the above two instances with the office visit encounters. This is a stand-alone service that can be billed as long as the above parameters are followed.
Patient Cost Sharing	▪ Patients are responsible for cost sharing for this service (co-payments). ***Physicians may waive this.**
New versus Established Patients	▪ This service may be rendered *only to established patients* since the practitioner needs to have an existing relationship with the patient and a basic knowledge of the patient's medical condition and needs in order to perform this service. CMS is using the CPT definition of an established patient, namely, one who has received professional services from the physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice. **.** ***Applies to new or established patients.**
Informed Consent for the Service	▪ **Verbal consent** for the service must be documented in the chart notes made for the encounter and CMS notes such consent must be entered into the medical record for each encounter.
Practice Utilization	▪ Utilization of the code G2012 will be monitored by CMS. CMS has not established specific frequency utilization limits. ***Under 1135 Waiver these audits will not occur**
Privacy	▪ Practices need to comply with any applicable privacy and security laws, including the HIPAA Privacy Rule. ***Under 1135 Waiver these audits will not occur**
Pricing	Pricing was set based on a rate lower than the current E/M in-person visits to reflect the low work time and intensity and to account for the resource costs and efficiencies associated with the use of communicative technology. National Average Payment for Non-Facility practitioners is $14.79 and for Facility practitioners is $13.35.